PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	5/25/2021	**To:**	5/27/2021
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections LLC
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PROGRAM MANAGER INFORMATION			
Name of PM:		**Organization:**	Creative Corrections LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Atlanta Field Office
Field Office Director	Thomas P. Giles
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C) OIC
Field Office HQ physical address:	180 Ted Turner Drive, SW; Atlanta, GA 30303
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Stewart Detention Center		
Physical address:	146 CCA Rd Lumpkin, GA 31815		
Mailing address: (if different from above)	P.O. Box 248 Lumpkin, GA 31815		
Telephone number:	229-838-5000		
Facility type:	D-IGSA		
PREA Incorporation Date:	9/19/2017		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	229-838-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Assistant Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	229-838-

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	Click or tap here to enter text.

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

Directions: Discuss the audit process to include the date of the audit, names of all individuals in attendance, audit methodology, description of the sampling of staff and detainees interviewed, description of the areas of the facility toured, and a summary of facility characteristics.

The Prison Rape Elimination Act (PREA) audit of the Stewart Detention Center (SDC) was conducted on May 25-27, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Thomas Eisenschmidt and (b) (6), (b) (7)(C) contractors employed by Creative Corrections, LLC. The Auditors were provided guidance and review during the audit report writing and review process by the Immigration and Customs Enforcement (ICE) PREA Program Manager, (b) (6), (b) (7)(C) and Assistant Program Manager, (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The SDC is privately owned by CoreCivic and operates under contact with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains adult male and female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at SDC are from Mexico, Guatemala, and Cuba. SDC is located in Lumpkin, Georgia.

ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g. a health pandemic. The process is divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. During the Pre-Audit phase. During the Pre-Audit phase, the Auditor completes a review of the documentation, including detainee, staff, contractor, and volunteer files; investigative files; policy and procedures: and supplemental documentation needed to confirm the facility's compliance with the PREA regulations. The second phase, the Remote Interview phase, consists of interviews with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers (either through a virtual conference platform or conference line). The third phase, the On-site audit phase is scheduled when the environment is safe for the ICE federal staff, facility staff, detainees, and Auditors. This phase mirrors a traditional PREA audit with a facility tour, observation of facility practices, and follow-up from the prior phases, as needed. Full compliance is contingent upon the on-site review of any additional documentation to determine all subparts of the standard were appropriately handled per the standard's requirement and upon the Auditor's review of notes and information gathered during the on-site visit.

This is the second ICE PREA audit for SDC; it was originally scheduled for June 2020 but was postponed due to the COVID-19 health pandemic. SDC was then placed into the contingency audit process and the audit period was expanded to cover the period of June 2019 through August 17, 2020. This expanded audit period allowed the Auditors to not only review the documentation submitted for the originally scheduled audit date, but also additional documentation submitted as part of the contingency audit process.

Approximately three weeks prior to the contingency audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents. The documentation was provided through SharePoint. The main policy that provides facility direction for PREA is 14-2, Sexual Abuse Prevention and Response. All the provided documentation, policies, and PAQ were reviewed by the Lead Auditor. A tentative daily time schedule was provided by the Lead Auditor for the contingency Remote Interview phase of the audit. The Lead Auditor requested to review 9 staff personnel and training records, 1 contractor personnel and training record, 10 detainee detention files, 10 detainee medical files, and 5 detainee investigative files prior to the contingency portion of the audit. The Lead Auditor also reviewed the facility's website, http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea.

At the beginning of the Remote Interview audit phase conducted on August 18, 2020, brief introductions were made and the detailed schedule for the remote interviews was covered. The Lead Auditor provided an overview of the contingency audit process and methodology used to demonstrate PREA compliance. The Lead Auditor explained the audit process is designed to assess compliance through written policies and procedures, and to determine whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Lead Auditor further explained compliance with the PREA standards would be determined based on a review of policy and procedures, observations made during the facility on-site visit, additional on-site documentation review, and staff and detainee interviews. It was shared that no correspondence was received by any detainees, staff, or other individual prior to the contingency audit phase. In the timeframe before the Remote Interview audit phase, the facility provided the requested information used for the random selection of detainees and staff to be interviewed including an alphabetic and housing listing of all detainees at the facility, lists of staff by duty position and shifts, and a list of volunteers and contractors on duty during the contingency audit.

There were 33 formal detainee interviews, randomly selected from the housing units, all of which were conducted through Cisco WebEx during the contingency Remote Interview phase. Twenty-three detainees interviewed were limited English proficient (LEP) and required the use of Language Services Associates (LSA), a contract language interpretative service, provided through Creative Corrections. A total of 45 staff interviews were conducted. Except for two contractors, the SDDO, and a DO, the remaining interviews were conducted with CoreCivic staff either randomly chosen or interviewed based on their specific title. Specifically, specialized staff interviewed included the Warden, PSA Compliance Manager, three medical and mental health staff, the Administration/Human Resources staff, two non-security volunteers/contractors, investigator, Learning and Development Manager, Grievance Officer, the staff responsible for Retaliation Monitoring, the RHU Supervisor, Classification Officer, Chaplain, SDDO, DO, a community advocate, and four intake staff. There were no volunteers available to interview at the time of the interviews due to COVID-19.

At the conclusion of the Remote Interview audit phase on August 19, 2020, an exit briefing was held via teleconference. The Lead Auditor advised the facility that in addition to the Provisional Report being issued based on the results of the contingency audit phases, there will be an on-site tour of the facility scheduled at a later time. There will be no standards determinations provided at the time of the Provisional Report. While on-site, more documentation and interviews of staff/detainees may need to take place. In addition, Auditors will need to observe intake operations and other facility practices during the On-Site audit phase.

The third phase, the On-site audit phase, was scheduled when it was deemed the environment was safe for the ICE federal staff, facility staff, detainees, and Auditors. Prior to the on-site audit phase, the Auditor requested updated facility information and received additional documentation from the ERAU Team Lead and facility staff which was provided to the Auditor. The on-site visit was conducted on May 25-27, 2021, and consisted of a facility tour, interviews of staff and detainees, and review of follow-up documentation.

The count at the time of the on-site visit was 398-males and 298-females. There are six general population living units. Three of these units are secure cells and three are open dormitory. Units 1 & 2 are female living areas. The remaining four units are male general population living areas. There are

two restricted housing units (RHU) located in building 7. The male RHU 7A consists of 38 individual cells. The female restricted unit 7B consists of 45 cells.

There were 13 sexual abuse allegations reported during the audit period according to the facility. The Lead Auditor reviewed five sexual abuse allegations prior to the Remote Interview phase and four while on-site. All 13 allegations were referred to ICE OPR and the Stewart County Sheriff. None were deemed criminal. Of the 13 completed investigations, nine were allegations of detainee-on-detainee and four were staff-on-detainee. With regard to the detainee-on-detainee allegations, five were determined to be unsubstantiated, two unfounded, and two substantiated. The investigative outcomes of the four staff-on-detainee allegations were as follows: one case was substantiated, two unsubstantiated, and one unfounded.

The entry briefing was conducted at 8:30 a.m. on May 25, 2021. In attendance were:

Russell Washburn - Warden
(b) (6), (b) (7)(C) – Prevention of Sexual Assault (PSA) Compliance Manager
(b) (6), (b) (7)(C) - Assistant Warden
(b) (6), (b) (7)(C) - Quality Assurance Manager
(b) (6), (b) (7)(C) - Chief of Security
(b) (6), (b) (7)(C) - Assistant Chief of Security
(b) (6), (b) (7)(C) Mailroom Supervisor
(b) (6), (b) (7)(C) - Commissary/Warehouse Supervisor
(b) (6), (b) (7)(C) Recreation Coordinator
(b) (6), (b) (7)(C) - Human Resource Manager
(b) (6), (b) (7)(C) Shift Supervisor
(b) (6), (b) (7)(C) Investigator
(b) (6), (b) (7)(C) Safety Manager
(b) (6), (b) (7)(C) Unit Manager
(b) (6), (b) (7)(C) Recreation Supervisor
(b) (6), (b) (7)(C) Unit Manager
(b) (6), (b) (7)(C) Case Manager
(b) (6), (b) (7)(C) - Unit Manager
(b) (6), (b) (7)(C) Unit Manager
(b) (6), (b) (7)(C) Case Manager
(b) (6), (b) (7)(C) Business Manager
(b) (6), (b) (7)(C) Unit Manager
(b) (6), (b) (7)(C) Acting Officer in Charge (AOC), ICE, ERO
(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE, ERO
(b) (6), (b) (7)(C) Deportation Officer (DO), ICE, ERO
(b) (6), (b) (7)(C) DO, ICE, ERO
(b) (6), (b) (7)(C) - Certified PREA Auditor, Creative Corrections
(b) (6), (b) (7)(C) Certified PREA Auditor, Creative Correction
(b) (6), (b) (7)(C) Inspection and Compliance Specialist, ICE/OPR/ERAU (by telephone)

The Auditor introductions were completed, and the Lead Auditor provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Lead Auditor explained the audit process is designed to assess compliance through written policies and procedures and to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards will be determined based on the review of policies and procedures, observations made at the time of the facility tour, review of documentation, and the results of interviews with both staff and detainees.

The Auditors shared that they received no correspondence from any detainee before the on-site visit. The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific categories) including an alphabetic and housing listing of all detainees detained at the facility, lists of staff by duty position and shifts, and a list of volunteers/contractors on duty during the contingency audit.

On May 27, 2021, an exit briefing was held in the facility conference room.

In attendance were:

Russell Washburn - Warden
(b) (6), (b) (7)(C) –PSA Compliance Manager
(b) (6), (b) (7)(C) - Assistant Warden
(b) (6), (b) (7)(C) - Quality Assurance Manager
(b) (6), (b) (7)(C) - Chief of Security
(b) (6), (b) (7)(C) Shift Supervisor
(b) (6), (b) (7)(C) AOC, ICE, ERO
(b) (6), (b) (7)(C) SDDO, ICE, ERO
(b) (6), (b) (7)(C) DO, ICE, ERO
(b) (6), (b) (7)(C) DO, ICE, ERO
(b) (6), (b) (7)(C) - Certified PREA Auditor, Creative Corrections
(b) (6), (b) (7)(C) Certified PREA Auditor, Creative Corrections
(b) (6), (b) (7)(C) Inspection and Compliance Specialist, ICE/OPR/ERAU (by telephone)
(b) (6), (b) (7)(C) Assistant Program Manager, Creative Corrections (by telephone)

The Auditors spoke briefly about their observations. Each remarked about how knowledgeable the staff was about sexual safety. They were able to give some preliminary findings but informed them that it was too early to determine the outcome. Detainees interviewed had a good understanding of PREA and knew what mechanisms are in place at SDC to report incidents of sexual misconduct if needed. The Auditors thanked the CoreCivic staff and ICE staff for their cooperation during the audit.

SUMMARY OF AUDIT FINDINGS

Directions: Discuss audit findings to include a summary statement of overall findings and the number of provisions which the facility has achieved compliance at each level: Exceeds Standard, Meets Standard, and Does Not Meet Standard.

Number of Standards Exceeded: 2
§115.17 Hiring and promotion decisions
§115.31 Staff Training

Number of Standards Met: 34
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.33 Detainee education
§115.35 Specialized training: Medical and Mental Health Care
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of audits.

Number of Standards Not Met: 3
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.71 Criminal and Administrative Investigations

Number of Standards Not Applicable: 2
§115.14 Juvenile and family detainees
§115.18 Upgrades to facilities and technologies

PROVISIONS

Directions: In the notes, the auditor shall include the evidence relied upon in making the compliance or non-compliance determination for each provision of the standard, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Corrective Action Plan Final Determination, accompanied by information on specific corrective actions taken by the facility. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable. For any provision identified as Not Applicable, provide an explanation for the reasoning. If additional space for notes is needed, please utilize space provided on the last page.

§115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(c)(d): Policy 14-2 states "CoreCivic has mandated zero-tolerance towards all forms of sexual abuse. Such conduct is prohibited by this policy and will not be tolerated, to include detainee-on-detainee sexual abuse and staff on detainee sexual abuse." The Warden indicated this policy outlines SDC's approach to preventing, detecting, and responding to sexual abuse incidents. He further stated the policy informs staff and detainees about the facility's sexual abuse and assault prevention and intervention program and their zero-tolerance policy. The 12 random staff interviews all confirmed their awareness of the significant elements of the policy. The facility provided documentation that policy 14-2 was approved by the ICE OIC in March of 2020. The PSA Compliance Manager stated she reports directly to the Warden at SDC and verified she is the point of contact for the agency's PREA Coordinator. She also confirmed she has enough time and authority to oversee the facility efforts to comply with the zero-tolerance policy. The PSA Compliance Manager title is located in a prominent position of authority on the organizational chart.

§115.13 - Detainee supervision and monitoring.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "the CoreCivic Facility Support Center (FSC) to develop, in coordination with the facility, comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and review those guidelines at least annually. The facility is required to ensure enough supervision of detainees, through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating these staffing levels and determining the need for video monitoring, the following factors shall be taken into consideration: generally accepted detention and correctional practices; any judicial findings of inadequacy; all components of the facility's physical plant; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; recommendations of sexual abuse incident review reports; and any other relevant factors, including but not limited to the length of time detainees spend in agency." The Warden confirmed the staffing levels at SDC for the supervision of the detainees were established prior to the contract agreement and are currently based on direct supervision with a ratio of one detention officer to six detainees. He also stated the facility can request, through ICE, additional staff if there are operational changes needed and through their annual staffing review analysis performed by the PSA Compliance Manager. The PSA Compliance Manager indicated in her interview that she conducts this annual review in May of each year utilizing form 14-2I-DHS, Annual PREA Staffing Plan Assessment, and forwards it to the Warden for his review and then to the FSC PREA Coordinator. The Auditors were provided a copy of the 2019 staffing review that addressed all the requirements of subpart (c) of the standard. The PSA Compliance Manager informed the Auditors that the 2020 staffing review was completed but has not been finalized. The Auditors observation of staffing and review of the facility staffing plan appears appropriate for the number of detainees assigned during the on-site visit.

(d): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires "staff, including supervisors, to conduct frequent unannounced facility rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds shall be documented in the applicable log (Administrative Duty Officer, post log, shift report, etc.). Employees are prohibited, by this policy, from alerting other employees that supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility. This practice shall be implemented for all shifts and all areas where detainees are permitted." The interviews conducted with line staff from each shift confirmed their knowledge of the policy to not notify other staff about supervisory rounds being conducted. During the on-site visit, the Auditors observed signatures of shift supervisors and Executive staff members in area logbooks that were randomly checked demonstrating rounds on each shift. The shift supervisors indicated rounds are made on each shift to include all areas detainees have access to.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

SDC does not accept juveniles or family detainees. This was confirmed in the PAQ, during interviews conducted with the Warden, PSA Compliance Manager, and the personal observations by both Auditors while on-site.

§115.15 - Limits to cross-gender viewing and searches.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(b)(c)(d): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that specifies "pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Pat-down searches of female detainees by male staff shall not be conducted unless in exigent circumstances." The policy further requires "all cross-gender frisk/pat-searches performed be documented." The facility PAQ and the PSA Compliance Manager indicated SDC had no cross-gender pat-searches conducted in the audit period. The search training curriculum is part of the PREA training that staff receive annually. The security staff interviewed detailed for the Auditors the conditions by which a cross-gender pat-search may be performed, and they were the same requirements outlined in policy and required by the standard. There was no cross-gender pat searches during the audit period.

(e)(f): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 and policy 5.1, Incident Reporting, that specifies "strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner." This policy further requires if a strip search of any detainee does occur, the search shall be documented on the 5-1 B Notice to Administration (NTA). The 12 security staff interviewed acknowledged the conditions under

which a strip search and body cavity search may be performed at SDC. Interviews with the Warden and PSA Compliance Manager indicated SDC conducted 25 strip searches during the previous 12 months. The PSA Compliance Manager indicated the searches were conducted on routine admissions to the RHU and reasonable suspicion of suspected contraband possession. The Auditors randomly reviewed the 5-1 Notice to Administration utilized for strip searches and reviewed the facility logbook for cross-gender searches. The documentation was compliant with the standard and 14-2 policy requirements.

(g): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires SDC to "allow detainees to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement which shall only be conducted by medical staff." This policy further requires "employees of the opposite gender to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." The random male and female staff interviewed confirmed their requirement to announce their presence every time they enter any area where detainees of the opposite gender may be showering, changing clothes, or performing bodily functions. The Auditors interviewed 30 random detainees; the majority of which confirmed staff of the opposite gender announce themselves prior to entering their living areas or areas where they may be showering. During the on-site visit, both Auditors heard announcements being made of opposite gender staff upon entering areas where detainees are likely to be showering, performing bodily functions, or changing clothing

(h): SDC is not a Family Residential Center; therefore, this subpart provision is not applicable.

(i): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that prohibits "the searching or physically examining of a detainee for the sole purpose of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner." During the 12 random security staff interviews, each staff person confirmed their knowledge of the prohibition of searching or physically examining any detainee to determine their genital status.

(j): The search curriculum, "Guidance in Cross-Gender and Transgender Pat-Searches," is part of the PREA training and requires pat-down searches be conducted in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and policy, including officer safety. The Auditors interviewed random male and female detention officers from each shift, 12 in total, with each indicating that training on detainee searches is provided to them in pre-service and during annual refresher training. They indicated they are tested on this information and sign an acknowledgement form indicating they received and understand it. During the 12 random security staff interviews, each staff person confirmed their knowledge and their responsibility to perform all pat-down searches in a professional and respectful manner. During the on-site visit, the Auditors conducted a review of training files and verified the search training curriculum and training received met the subpart requirements.

§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "the facility ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. When necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall accommodate the detainee by; providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary; and providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication. Information provided to detainees will be available in both English and Spanish, including, but not limited to written information provided to detainees at intake, and in orientation; PREA information posted on housing unit bulletin boards; and orientation videos." According to interviews conducted with five intake staff, all detainees arriving at SDC receive the CoreCivic Handbook, DHS-prescribed ICE Sexual Abuse and Assault Awareness Information pamphlet, and the ICE National Detainee Handbook (if available in their language).The CoreCivic Handbook is available in English and Spanish formats. The ICE National Detainee Handbook is available at the facility in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). The DHS-prescribed Sexual Abuse and Assault Awareness pamphlet is available through ICE in nine languages: English, Spanish, Arabic, Haitian Creole, French, Hindi, Portuguese, Punjabi, and Chinese. SDC only had copies available in English and Spanish at the time of the site visit. Two informational videos, PREA and Know your Rights, run continuously in the intake area and in each housing unit. These videos are in English and Spanish only. The intake staff also indicated when a detainee arrives not speaking one of the 11 languages provided through the ICE handbook, staff utilize the language line (Language Line Services) to provide sexual safety information to the detainee. The intake staff interviews also confirmed that when confronted with a detainee that may be hearing impaired or deaf, information is provided to them in writing or through use of the text telephone (TTY). Those who are blind or with limited sight are provided individualized service by the intake staff to include reading information to the detainee if needed. The intake staff indicated when dealing with a detainee with low intellect or limited reading skills it would require referral to a supervisor, medical or mental health staff based on the detainee limitation. LEP detainees are provided assistance by staff through interpretative services, either through available staff or Language Line Solutions. The Auditors were provided a manuscript that is read to the detainee outlining the sexual safety required information in subpart (a) in standard 115.33. The detainee signs that sheet and the interpreter's name is entered on the document as well. Interviews conducted with 14 limited English proficient (LEP) detainees indicated they had not received this information in a format they could understand; however, signed sheets by the detainee receiving information was documented in the detention files reviewed by the Auditor.

(c): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires "interpretation services to be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." The policy further requires "LEP detainees be provided in-person or telephonic interpretation services. The facility will provide access to the Language Line or other similar translation service at no cost to the detainee." During interviews with the 12 random detention officers, each confirmed they were aware of the policy restrictions on interpreters as outlined in the facility policy. A thorough review of nine investigative case files indicated that in four of the nine investigations reviewed, the detainee was provided an interpreter (staff member). The SDC

Investigator confirmed the facility has five Spanish-speaking staff that can be used as interpreters in administrative investigations; typically, the backup investigator is used as an interpreter, if available. She further stated if an interpreter is not available, or it is a language SDC does not have an interpreter for, then SDC would utilize their contracted language line.

§115.17 - Hiring and promotion decisions

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(e)(f): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that specifies "to the extent permitted by law, CoreCivic will decline to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in this activity." The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0, requires "anyone entering into or remaining in government service, employee or contractor must undergo a thorough background examination for suitability and retention." The Division Chief of the OPR Personnel Security Unit (PSU), (b) (6), (b) (7)(C), informed Auditors who attended training in Arlington, Virginia in September 2018, that candidate suitability for all employment applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Applicants are questioned directly about any such previous misconduct both during their background check and during the job interview process and a positive response to any of those specific questions are grounds for unsuitability including material omissions or making false or misleading statements in their application. The Human Resources (HR) staff person interviewed stated the facility would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated the employee is required to sign a release of information document in this case. She also stated the facility, along with ICE, would request information from prior institutions where the prospective candidate was previously employed during background checks. She confirmed that as outlined in SDC policy 14-2, the facility may decline to hire or promote and may terminate employment based on material omissions such as misconduct, or the provision of materially false information. The Auditor reviewed 14 employee files and found ICE approvals to hire the staff member prior to their actual start date.

(c)(d): Federal Statute 731.105 requires "background reinvestigations to be conducted on all staff and contractors, having detainee contact with detainees, every five years." The Division Chief of the OPR PSU confirmed that ICE conducts these background checks on contractors and staff. SDC exceeds the requirement of the five-year updated background check as a background check is conducted through the National Crime Information Center (NCIC) on SDC staff, contractors, and volunteers annually by the HR Personnel Investigator. The Auditors were provided 14 employee files (CoreCivic employees, promoted employees, and contractors) demonstrating background checks were performed on them prior to hiring. Those promoted had updated documentation attesting to no PREA-related incidents. The Auditors also requested the status of the ICE background investigations, five-year recheck, for eight employees (four CoreCivic and four ICE) at SDC, and found each was current and up to date.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): These subparts of the standard are not applicable based on the facility PAQ and interview with the Warden confirming SDC has not expanded or modified the existing facility or updated video monitoring equipment since the previous audit in 2017.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires "SDC follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developmentally appropriate for youth where applicable, and as appropriate, shall be adapted from or otherwise based on the most recent edition of the Department of Justice's Office on Violence Against Women publication, 'A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,' or similarly comprehensive and authoritative protocols developed after 2011." The facility's Investigator confirmed she follows the evidence protocols she was provided in her training and obtains the physical evidence needed for her administrative investigations. PREA allegations may also be investigated through OPR or DHS. The agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. OPR will coordinate with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS OIG, OPR, or the local law enforcement agency, the Assistant FOD would assign an administrative investigation to be conducted. The Auditors concur, after a thorough review of nine investigative files, that uniform evidence protocols were followed during the administrative investigations.

(b)(c)(d): The Auditors determined compliance with these subparts of the standard based on review of the memorandum of understanding (MOU) between the Lily Pad SANE Center and SDC states it will provide medical forensic examinations for victims of sexual assault, and for the removal of physical evidence from any aged person suspected of having committed an act of sexual assault/abuse. This MOU also agrees to provide detainee victims of sexual abuse access to a victim advocate for emotional support services during the examination and any law enforcement interview. The interview with the victim advocate from Lily Pad confirmed forensic exams are performed in their building by a Sexual Abuse Forensic Nurse Examiner (SANE) and the victim is provided a trained victim advocate during the exam, as well as, when interviewed by law enforcement. The Health Services Administrator (HSA) confirmed that any services provided to a victim would be without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the allegation. The facility had no forensic examinations conducted during the audit period based on interviews with the PSA Compliance Manager, HSA, and review of the facility PAQ. The review of the investigative files also confirmed no forensic exams were performed.

(e) The Auditors determined compliance with this subpart of the standard based on review of the MOU with the Stewart County Sheriff's Office. This MOU requires that in any incident involving the PREA, SDC will contact the Sheriff's Office and provide them with all allegations of sexual abuse involving potentially criminal behavior. In return, the investigating agency (Stewart County Sheriff's Office) will provide a case number and additional assistance if needed. This MOU was established in May 2020 with no sunset date. Although the MOU does not specifically address the requirement of subpart (e), the facility did provide written document to the Sheriff requesting their Department comply with subparts (a) through (e) of the standard. SDC has heard nothing back from them. In each of the investigative files reviewed, the Auditors found notifications noted to the Sheriff.

§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d)(e)(f): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires the Warden to "ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse. Retention of such investigative documents are to be maintained for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." SDC policy 14-2 also requires "all allegations of sexual abuse/assault be referred for criminal investigation to the Stewart County Sheriff's Office and ICE ERO with the legal authority to conduct criminal investigations and each allegation be investigated administratively by the facility." This policy further requires every allegation of sexual abuse be reported to the Facility Administrator. Policy 5.1, Incident Reporting, requires SDC, in accordance with ICE Performance-Based National Detention Standards (PBNDS), 2.11: Sexual Abuse and Assault Prevention and Intervention, that all allegations of sexual abuse or assault are to be immediately reported to ICE OPR, and any other required entities based on the nature of the allegation. The interview with the ICE SDDO confirmed she is notified of all allegations of sexual abuse at SDC and makes all notifications to the Joint Intake Center (JIC) or the DHS OIG, and the appropriate ICE ERO FOD. The Warden and PSA Compliance Manager confirmed, that per policy 14-2, all allegations of sexual abuse are reported to CoreCivic Leadership. The JIC assesses all sexual abuse allegations reported to them, to determine whether the allegation is referred to the DHS OIG or OPR. The DHS OIG has the first right of refusal on all staff, volunteer, or contractor-on-detainee sexual abuse allegations and the OPR reviews and assesses all detainee-on-detainee sexual abuse allegations. Once the allegation referred to the DHS OIG is reviewed and accepted, OPR would not investigate. If refused by the DHS OIG, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR, the investigation is conducted in accordance with OPR policies and procedures and coordinated with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation. The ERO would assign an administrative investigation to be completed. All investigations are closed with a report of investigation. The Agency's policy 11062.2 outlines the evidence and investigative protocols. The SDC Investigator confirmed administrative investigations at SDC are conducted by trained investigators and documentation of these investigations are maintained for as long as the alleged abuser is detained or employed by CoreCivic, plus an additional five years. The Auditors conducted in-depth reviews of nine administrative investigations and cursory review of the remaining cases completed and closed within the audit period. Each case was referred to the local law enforcement (Sheriff) as required and in compliance with the standard. The protocols for ICE investigations and CoreCivic investigations are found on their respective web pages (www.ICE.gov/prea) and (http://www.corecivic.com/the-prison-rape-elimination- act-of-2003-prea).

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires SDC "training on the facility's Sexual Abuse and Assault Prevention and Intervention Program to be included in the training for all new employees, and to also be included in annual refresher training thereafter. The policy further requires the training to ensure facility staff are able to fulfill their responsibilities under the DHS PREA standards, and shall include: the facility's zero-tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal sexual behavior; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need- to-know in order to make decisions concerning the detainee victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, (LGBTI) or gender nonconforming detainees; instruction on reporting knowledge or suspicion of sexual abuse and/or assault; and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and or assault." The 14-2A-DHS Policy Acknowledgement form shall be completed by each employee, serving as verification of the employee's review, and understanding of this policy's contents. The Auditors reviewed five random training files (staff, contractor, and volunteer) and observed signed staff acknowledgment forms. The random 12 SDC staff and 2 ICE staff interviewed by Auditors confirmed they had received PREA pre-service training and annual refresher training. Those interviewed confirmed the instruction they received included the requirements outlined in subpart (a) of the standard. The interview with the Learning and Development Manager and the review of the training curriculum confirmed the subpart (a) requirements are part of the training curriculum. The Learning and Development Manager also confirmed that all staff were trained on PREA in 2020 and 80% of staff have currently received refresher training. The Auditor reviewed a print-out listing staff completion of this training. The Auditors indicated the facility exceeds this standard as the requirement for refresher training is every two years and SDC requires and provides this training annually.

§115.32 - Other training.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "the facility to ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed how to report such incidents." The Learning and Development Manager confirmed all contractors receive the identical PREA training that SDC staff receive. She also indicated the contractors must document by signature their understanding of this training. The Auditors interviewed two contractors, and each confirmed they had received the agency and facility's sexual abuse

training that included their responsibilities on prevention, detection, reporting, and response policies and procedures. Due to the current pandemic, volunteers were not available to interview. The Learning and Development Manager indicated the volunteers receive much of the same training and required annual refresher training that staff and contractors receive absent the training on searches. The Auditors reviewed random training files of a contractor and volunteer (2) and confirmed each contained the signed training Acknowledgement document.

§115.33 - Detainee education.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "upon admission, all detainees be notified of the facility's zero-tolerance policy on sexual abuse and assault through the orientation program and the ICE National Detainee Handbook. Detainees are to be provided with information (orally and in writing) about the facility's Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program." The Warden and PSA Compliance Manager confirmed detainees are to be provided information on the facility's zero-tolerance policy for all forms of sexual abuse or assault; the name of the facility PSA Compliance Manager, and information about how to contact her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS OIG and ICE OPR investigation processes; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. Detainees arriving at SDC are supposed to receive the ICE National Detainee Handbook, (available in 11 of the most prevalent languages), the CoreCivic handbook, and view two informational videos, PREA and Know your Rights. The videos and CoreCivic handbook are in English and Spanish. Random interviews conducted with 33 detainees resulted in 14 indicating they had never received orientation information (video) or written materials in a language or format they understood. As noted in 115.16, when staff is providing orientation materials to a detainee that may be hearing impaired or deaf, the information is provided to them in writing or through use of the text telephone (TTY). Those who are blind or with limited sight are provided individualized service by the intake staff to include reading information to the detainee if needed. The intake staff indicated when dealing with a detainee with low intellect or limited reading skills would require referral to a supervisor, medical, or mental health staff based on the detainee limitation. LEP detainees are provided assistance by staff through interpretative services, either through available staff or Language Line Solutions. The Auditor was able to review documentation and confirmed by detainee signature that each of the 14 detainees received orientation materials.

(d): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires SDC to "post the DHS-prescribed Sexual Assault Awareness Information notice, the name of the PSA Compliance Manager, and the name of local organization(s) that can assist detainees who have been victims of sexual abuse on all housing unit bulletin boards." The Auditors observed, in each of the housing units and areas where detainees have access, the posting of this DHS-prescribed Sexual Assault Awareness Information notice and the name of the PSA Compliance Manager. The Auditors also observed the name of the local victim advocate (Lily Pad) with contact information in each of the areas as well. Random detainee interviews also confirmed their knowledge of the poster and the required information.

(e)(f): The Auditors determined compliance with this subpart of the standard after review of policy 14-2 outlining the intake process and interviews with five intake staff and the classification officer. Each of them confirmed that detainees, upon arrival, receive both the DHS-prescribed Sexual Assault Awareness Information pamphlet and a copy of the ICE National Detainee Handbook. During the 33 detainee interviews, most detainees confirmed they had received copies of these documents and signed for receipt of them.

§115.34 - Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires the facility "to provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. The provided training is to cover interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process." SDC has a primary investigator and a backup investigator in her absence. During interview with the primary investigator, she indicated she had received her training through the National Institute of Correction (NIC). The Auditor verified the training "Investigating Sexual Abuse in Confinement Setting." The curriculum does not meet the ICE PREA standard requirements for the cross-agency coordination requirement. The cross-agency coordination was not documented through any other training curriculum. The Investigators must provide documentation that they have received this cross-agency coordination training.

DOES NOT MEET: The cross-agency coordination training element was not documented through any training curriculum or certificates. The facility must provide documentation, i.e., updated training curriculum, certificates of training, sign-in sheets indicating they have received the cross-agency coordination training.

Agency policy 11062.2 states "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The Auditors reviewed the ICE OPR Investigation Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The Auditors reviewed the agency provided rosters of trained investigators on SharePoint and determined the documentation was in accordance with the training requirements of this standard.

§115.35 - Specialized training: Medical and mental health care.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b): These subparts of the standard do not apply to SDC as the facility medical department is operated by CoreCivic.

(c): The Auditors determined compliance with the subparts of the standard based on the interview with the HSA and review of policy 14.2 that requires that "the Health Services Department is responsible for medical stabilization and assessment of the victim until transported to an outside medical provider, if medically indicated, for collection of evidence and any necessary medical treatment." The HSA indicated that facility medical staff would stabilize the alleged victim for transport but do not participate in the sexual assault forensic medical examinations or evidence gathering. She stated forensic examinations are performed by a SANE at Lily Pad. The Auditors reviewed two random medical training files and found their training complete and up to date. The HSA confirmed all her staff has received the required training. This policy 14.2 was approved by the ICE ERO OIC.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "all detainees to be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility. The 14-2B-DHS Sexual Abuse Screening Tool form or electronic Offender Management System (OMS) version will be utilized to complete the initial screening." This document utilizes the following criteria to assess the detainees risk of abusiveness and victimization: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as LGBTI or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. During the interviews with five intake officers, each indicated that in addition to this screening instrument, staff tasked with screening conduct a thorough review of all available records provided by ICE that can assist them with the risk assessment to include any information about prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility. The classification officer confirmed detainees are kept separate from general population in the intake area until the vulnerability assessment and classification processes are completed. She indicated this is usually completed within their first three hours of arrival but no longer than 12 hours. The Auditors reviewed four detainee detention files and found completed risk assessments were conducted utilizing the 14-2B-DHS Sexual Abuse Screening Tool and completed on the day of the detainees' arrival. Interviews with 33 random detainees also confirmed their classification and risk assessment were completed within their first couple hours after arriving at SDC. All of the random detainees confirmed that they remained in the intake area until they were classified and within 12-hours.

(e): Policy 14-2 requires SDC "reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The reassessment of the detainee's risk level of victimization or abusiveness will be conducted by the appropriate case manager or a staff member utilizing the 14-2B-DHS Sexual Abuse Screening Tool." The 2011 PBNDS requires that the reassessment on detainees alleging sexual abuse be conducted within 24 hours of the allegation. A review of four random investigative and detention files confirmed in three cases the reassessment was conducted after three days and the fourth was conducted two weeks after the allegation. The facility needs to conduct these reassessments within the 24-hour PBNDS-2011 requirement. The Auditors did review a detention detainee file who was at SDC over 90 days and his reassessment was conducted as required by policy and the standard on the 61st day

DOES NOT MEET: The reassessments of detainees that reported sexual abuse were not completed in a timely manner. The facility must complete reassessments of detainees that reported sexual abuse within 24-hours. The facility must provide updated training with staff on the policy and standard requirement and provide documentation of the staff training. The facility must provide reassessments of five detainees that reported sexual abuse within the appropriate time-frame, if applicable, to demonstrate compliance.

(f): The Auditor determined compliance with these subparts of the standard based on review of policy 14-2 that requires "detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked about whether the detainee has a mental, physical or developmental disability; identifies as LGBTI or gender non-conforming; experienced prior sexual victimization or has any concerns about his physical safety." The Classification Officer and the five intake officers confirmed detainees are not disciplined for refusing to answer any of the questions asked from the 14-2B-DHS Sexual Abuse Screening Tool.

(g): The Auditor determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "the facility to implement appropriate protections on responses to questions asked pursuant to the risk screening for potential risk of sexual victimization or sexually abusiveness, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees." The PSA Compliance Manager and the Classification Officer informed the Auditor that completed 14-2B-DHS Sexual Abuse Screening Tool forms are maintained in the detainee's central file, with a copy forwarded to the detainee's medical record. These files are secured under a restricted key.

§115.42 - Use of assessment information.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires "the facility to use the information obtained from the 14-2B-DHS assessment conducted at initial screening in the consideration of housing, recreation, work programming, and other activities." The Classification Officer confirmed these assignments are made on an individualized basis to ensure the safety of the detainee. Her review includes the vulnerability assessment, the medical assessment, and the DHS Record of Deportable/Inadmissible Alien (Form I-213) document, when available. The Auditors reviewed four detention files while on-site and found individualized assessments for each detainee within the file.

(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "in deciding whether to house a transgender or intersex detainee in a male housing unit or female housing unit or when making other housing and programming assignments for such detainees, the facility shall consider the transgender or intersex detainee's gender self- identification and an assessment of the effect of placement and shall consider on a case-by-case basis whether such a placement would ensure the detainee's health and safety. The facility shall consult with a medical and/or mental health professional as soon as practicable on this assessment." This policy further requires, "the facility should not base placement decisions on transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee. A detainee's self-

identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well." The PSA Compliance Manager and Classification Officer informed the Auditor that transgender detainees are typically not placed at SDC by ICE. Both stated that if placed there, a transgender or intersex detainee would be reviewed per policy, including reassessed every six months, and arrangements made to allow to shower separately if requested. According to the PSA, this would be accomplished when detainee movement would be curtailed (count time). There were no transgender or intersex detainees for the Auditors to interview during the on-site examination. However, the Auditors reviewed a transgender detainee's file who was no longer housed at SDC; the file demonstrated an assessment performed on form 14-9A (Transgender/Intersex Assessment and Treatment Plan) conducted on 2/4/2021 and reassessed on 3/23/2021 because of an incident. The detainee wasn't housed at SDC long enough for a six-month reassessment. This 14-9A form requests information from the detainee about their concerns about safety and anything that he/she may want the facility to consider (showers).

§115.43 - Protective custody.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(e)(f): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "the use of administrative segregation to protect detainees at high risk for sexual abuse and assault be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort." The policy further states "detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE FOD to determine if ICE can provide additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If access to programs, privileges, education, or work opportunities is restricted, the facility shall document the reason for it." The Auditors interviewed the Segregation Supervisor who indicated he does not remember segregation ever being used for a vulnerable detainee. The Warden also indicated segregation would not be used to protect a vulnerable detainee. He stated there are six infirmary beds if needed and are available. He also stated that if the use of segregation were ever used for that purpose, he would notify the FOD within 72 hours. He confirmed the use of segregation to protect a vulnerable detainee would be his last option and the placement would be conducted in accordance with the 14-2 policy that was developed in consultation with the ICE ERO OIC.

(d): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires "a supervisory staff member conduct a review within 72 hours of the detainee's placement in segregation to determine whether segregation is still warranted." The policy further requires "a supervisory staff member conduct, at a minimum, an identical review after the detainee has spent seven days in Administrative Segregation, and every week thereafter for the first 30 days and every 10 days thereafter." The Segregation Supervisor confirmed SDC has not needed to do any reviews during the audit period, but if one were done, it would be documented by the supervisor in accordance with the policy.

§115.51 - Detainee reporting

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "the facility to provide multiple ways for detainees to privately report sexual abuse. It further requires detainees to be encouraged to immediately report being pressured, receiving threats, or instances of sexual abuse as well as possible retaliation by other detainees or employees for reporting sexual abuse and staff neglect or violation of responsibilities that may have contributed to such incidents." The policy states that "detainees who are victims of sexual abuse have the option to report an incident to a designated employee other than an immediate point-of-contact line officer by using any of the following methods: submitting a request to meet with Health Services staff and/or reporting to a Health Services staff member during sick call; calling the facility's 24 hour toll-free notification telephone number; verbally telling any employee, including the facility Chaplain; forwarding a letter, sealed and marked "confidential" to the Warden or any other employee; calling or writing someone outside the facility who can notify facility staff; contacting the respective consular office; and/or forwarding a letter to the FSC (Facility Support Center) PREA Coordinator." Detainees may also make telephone calls or file written reports to consulates and/or consular offices. The policy also indicates that "detainees may anonymously report any pressure, threat or instance of sexual violence/misconduct directly to the DHS OIG." The PSA Compliance Manager informed the Auditor the contact and reporting information is provided to detainees in the orientation materials provided at intake and on posters throughout the facility. The Auditors checked the Detainee Reporting Information Line (DRIL) from multiple housing locations and were able to make contact to report an allegation. However, the person receiving reports at the DRIL line required the Auditors to provide a name and indicated that supplying a name is a requirement. This reporting line is supposed to allow for anonymous reporting. Furthermore, the Auditor was not able to contact the DRIL and make a report without using a detainee PIN. The agency and facility must ensure DRIL will accept detainee reports of sexual abuse allowing the detainee to remain anonymous upon request. However, the facility provides detainees with the consulate numbers and the OIG line to meet the requirement of having at least one means for detainee to report to a public or private agency not associated with the facility and remain anonymous. While on-site the Auditors interviewed four detainees who claimed they were never provided information on how report by staff although they were aware of how to report this information. The Auditors reviewed their detention files and found signed documents by the detainee that they received this information.

Recommendation: The agency and facility need to correct processes related to the DRIL if they intend to utilize the DRIL as a method in which the detainee can anonymously report an allegation of sexual misconduct. The DRIL employee stated the detainee must provide a name and indicated that supplying a name is a requirement; the agency must address this issue. Furthermore, the facility must provide a method in which the detainee can contact the DRIL without providing an identifying PIN. If the agency intends for the DRIL to be used as an anonymous reporting method, they must ensure the DRIL will consistently accept anonymous reports and not require the detainee to provide any identifying information. Additionally, the agency should ensure the ICE National Detainee Handbook and ICE Sexual Abuse and Assault Awareness Pamphlet reflect the same reporting information as it relates to the DRIL's ability to accept anonymous reports; the former simply provides it as a reporting mechanism while the latter states it will accept anonymous reports.

(c): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires "employees must take all allegations of sexual abuse seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports and they should be reported to the facility investigator." The PSA Compliance Manager, facility investigator, and facility PAQ confirmed that the facility had 13 reported allegations of sexual abuse during the audit period. Allegations of sexual assault at SDC were made in the following manner: 1 was made through the grievance office, 2 were reported non-security staff, and the remaining 10 were made to

security staff. The facility investigator informed the Auditor that in each case where the incident was presented to staff verbally, the staff documented it or requested the detainee document it in writing. The Auditor observed written allegations in the nine investigative files reviewed. The Auditors interviewed 12 random staff who confirmed their knowledge of the policy requirement that they are to accept and immediately report allegations of sexual abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors.

§115.52 - Grievances.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d)(e): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that states "alleged PREA incidents submitted through the grievance system will be processed as an Emergency Grievance in accordance with policy 14-5 Inmate/Resident Grievance Procedures and will not be processed through the CoreCivic facility detainee grievance procedure. Detainees may bypass or terminate the verbal/informal grievance process at any point and proceed directly to the formal grievance stage. Should a report be submitted and received as a detainee grievance, it will immediately be referred to the facility investigator or Administrative Duty Officer (ADO)." The Grievance Supervisor confirmed her office accepts, as a grievance, any allegation of sexual abuse, assigns it a grievance number, and processes it as an emergency grievance. The Grievance Supervisor further stated that she does not impose a time limit on when a detainee may submit a grievance regarding the allegation of sexual abuse regardless of when it occurs and would ensure medical emergencies are referred to the medical department immediately. The Grievance Supervisor also indicated that her office had received an allegation of sexual abuse within the last 12 months and processed it as an emergency grievance issuing a response within the standard and policy time requirements, including notification to the ICE SDDO who in turn makes all ICE notifications. The allegation was investigated and was one of the 13 reported sexual abuse allegations during the audit period. Decisions on this type of grievance (emergency) are responded to within two days of receipt and responses to an appeal of the grievance decision are responded to within four days. The SDDO interview confirmed the one allegation made through grievance process was reported to her and she made all ICE required notifications.

(f): The Auditors determined compliance with this subpart of the standard based on review of the CoreCivic detainee handbook that states "detainees may obtain assistance in filing a grievance from another detainee, the housing officer or other facility staff, family members, or legal representatives." Interviews with 12 random security staff confirmed their knowledge of the grievance process to report allegations of sexual abuse by detainees and their responsibility to take reasonable steps to expedite requests for assistance from these other parties. The Grievance Supervisor confirmed that assistance was not requested by any detainees who reported sexual abuse through the grievance office. The random detainees interviewed were all aware of the grievance office, but all were not aware that they could utilize family members or legal representatives. The grievance process is outlined in the Stewart detainee handbook and policy 14-5.

§115.53 - Detainee access to outside confidential support services.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "SDC to maintain or attempt to enter into MOU or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support for immigrant victims of crimes." The policy further requires, "SDC establish, in writing, procedures to include outside agencies in the facility's sexual abuse prevention and intervention protocols, if such resources are available." As noted in standard 115.21, SDC has an MOU with Lily Pad to provide detainee victims of sexual abuse emotional support and crisis intervention services during the forensic exam and interviews with police. The victim advocate from Lily Pad stated that her agency provides emotional support and crisis intervention service to victims of abuse regardless of when it occurred and is not a reporting agency. The PSA Compliance Manager indicated phone and mail contact information for Lily Pad is posted for detainees in their living area with a notice indicating to the extent this contact is monitored. The facility's Investigator and PSA Compliance Manager confirmed that contact with Lily Pad is confidential and the telephone calls and mail to this agency is not monitored. The Auditors observed this monitoring information in the housing units during the on-site visit. They also indicated they provide each detainee alleging sexual abuse this contact information for Lily Pad within the first hour of being made aware of the allegation. The nine investigative files thoroughly reviewed noted that the detainees were provided this advocacy information. As noted previously, the Auditors did observe contact information for Lily Pad in each of the living areas. The majority of detainees questioned about this victim advocate weren't aware of Lily Pad or their services even though the information is posted in the living areas.

§115.54 - Third-party reporting.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

The Auditors determined compliance with this subpart of the standard based on review of the CoreCivic public website that states that anyone can report an allegation or suspected incident of sexual abuse or sexual harassment, including detainees, staff, or third parties. At SDC, there are multiple options to make a report including but not limited to: sending a letter to the Warden, notifying any staff member either verbally or in writing or by calling the PREA hotline numbers posted at their facility. Staff and third parties may contact the CoreCivic's Ethics and Compliance Hotline: 1-866-757-4448 or e-mail http://www.corecivic.ethicspoint.com. The website outlines the agency's methods of receiving third-party reports of sexual abuse or assault on behalf of detainees. The PSA Compliance Manager and Investigator stated SDC had no allegations of sexual abuse reported by a third-party within the audit period. The Auditors observed third-party reporting information in the detainee visiting process areas during the on-site visit. Random detainee interviews confirmed their knowledge of third-party reporting if needed. As previously noted in 115.51, the facility received no allegation of sexual abuse through the DRIL line or any other third-party means..

§115.61 - Staff reporting duties.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "all employees to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility in accordance with this policy, whether or not the area is under CoreCivic's management authority; retaliation against detainees or employees who have reported such an incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation." The policy further states that "employees who fail to report allegations may be subject to disciplinary action and apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, and as specified in

this policy, to make treatment, investigation, and other security and management decisions." This policy was reviewed and approved by the ICE ERO OIC. Interviews with 12 random staff confirmed their knowledge of CoreCivic's reporting requirements outlined by the policy and reinforced in their PREA training received annually. Interviews with staff also confirmed their knowledge of reporting sexual abuse outside their chain of command, (i.e., directly to the Warden, if needed). The Auditors reviewed the training curriculum for pre-service and annual refresher training and found the reporting information and requirements detailed in the curriculum as required by the standard.

(d): The Auditors determined compliance with this subpart of the standard based on review of policy 5.1 that requires, "allegations of sexual abuse in which the alleged victim is under the age of 18 or considered a vulnerable adult under state or local vulnerable persons statute, be reported to the FOD so that ICE can inform state or local services agencies under applicable mandatory reporting laws." The Warden confirmed, juveniles are never placed at SDC and if any vulnerable adult was ever the victim of sexual abuse at SDC, the facility would notify the AFOD as well as the Stewart County Sheriff's Office. The PAQ and interviews with the Warden and PSA Compliance Manager confirmed there weren't any vulnerable adults housed at SDC during the audit period.

§115.62 - Protection duties.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

The Auditors determined compliance with this standard based on review of policy 14-2 that specifies, "when it is learned that a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee". The Auditors questioned 12 security staff, 2 contractors, the PSA Compliance Manager, and the Warden about this type of situation and all the interviewees responded that the detainee's safety and well-being would be their primary concern in any situation. Each indicated their initial response would be removing the detainee from danger by locating him/her and securing them and then immediately notifying their supervisor. The Warden and PSA Compliance Manager confirmed SDC had no known detainees at substantial risk of imminent sexual abuse within the audit period.

§115.63 - Report to other confinement facilities.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that specifies, "if an allegation of sexual abuse involves events that took place while the alleged victim was not in CoreCivic custody (while housed at another provider's facility, or state, or federal facility), the Facility Administrator of the facility that received the allegation shall ensure that the following actions are taken: contact the facility head or appropriate office of the facility where the alleged abuse took place as soon as possible, but no later than 72 hours after receiving the allegation and if the allegation was not reported or not investigated, a copy of the statement of the detainee shall be forwarded to the appropriate official at the location where the incident was reported to have occurred to be investigated." The policy further requires, "the facility document all such contacts and notifications on the 5-1 B Notice to Administration. Any notifications of alleged abuse received by SDC will ensure the allegation is investigated in accordance with PREA standards and reported to the appropriate ICE ERO FOD." The Warden and PSA Compliance Manager indicated the facility received no allegations of sexual abuse that occurred at another facility or allegations from detainees arriving at SDC that occurred at another facility. The PSA Compliance Manager also confirmed SDC received no reported allegations of sexual abuse that occurred at their facility reported back to them by another facility.

§115.64 - Responder duties.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "any employee who discovers or learns of sexual abuse, or an allegation of sexual abuse, shall ensure that the following actions are accomplished: the alleged victim is kept safe, has no contact with the alleged perpetrator, and is immediately escorted to the Health Services Department; if the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall, to the best of their ability, ensure that the victim does not wash, shower, remove clothing without medical supervision, use the restroom facilities, eat, drink or brush his/her teeth; the highest ranking authority on-site is immediately notified and will further ensure to protect the safety of the victim and the integrity of the crime scene and any investigation; and the Health Services Department is responsible for medical stabilization and assessment of the victim until transported to an outside medical provider, if medically indicated, for collection of evidence and any necessary medical treatment." During the review of the nine investigative files, the Auditors determined the responding security staff member(s) followed the protocols as required by the situation and outlined in the policy. The interviews with 12 security staff confirmed their responsibilities as responders to incidents of sexual abuse. All responses covered the subparts and policy protocols.

(b): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that specifies, "if the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence; and notify security staff." During interviews with two non-security staff, each confirmed if a detainee reported sexual abuse to them, they would ensure the victim and perpetrator were separated, not allow either to destroy evidence, and immediately call for a security staff member. During the review of the 13 allegations made, the Auditors confirmed two cases were initially reported to non-security staff who then immediately reported the incident to security staff.

§115.65 - Coordinated response.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "the facility to establish a Sexual Abuse Response Team (SART) to include the following positions: PSA Compliance Manager, medical representative, security representative, mental health representative, and Victim Services Coordinator. Policy 14-2 is the SDC developed and written plan to coordinate actions taken by staff in response to an incident of sexual abuse. The SART is comprised of four or more individuals having a primary role in responding to reported incidents of sexual abuse." The PSA Compliance Manager confirmed that the SART's primary duties include responding to reported incidents of sexual abuse; responding to victim assessment and support needs; ensuring policy and procedures are enforced to enhance detainee safety; and participating in the development of practices and/or procedures that encourage prevention of sexual abuse and enhance compliance with PREA standards. The PSA and the facility Investigator confirmed the Investigator, although not specifically mentioned in policy, is part of coordinated response effort in responding to

allegations of sexual abuse.The Auditors reviewed nine closed investigative files and found the content documented the multidisciplinary and coordinated responses taken by staff members at SDC.

(c)(d): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "if a victim of sexual abuse is transferred between any facility, SDC shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." The Warden, PSA Compliance Manager, and PAQ confirmed that SDC had no detainee make an allegation of sexual abuse prior to being transferred to another facility by ICE during the audit period. The Warden also indicated that the information for the need of medical or social services for any victim transferred to any facility from SDC would be provided as permitted by law.

§115.66 - Protection of detainees from contact with alleged abusers.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

The Auditors determined compliance with the standard based on review of policy 14-2 that requires "staff, contractors and civilians [volunteers] suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of an investigation." The Auditors reviewed six allegations of sexual abuse involving staff against a detainee during the audit period. The Auditors found documents from the Facility Administrator in each case prohibiting the staff member from any detainee contact until the investigation was concluded.

§115.67 - Agency protection against retaliation.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that "prohibits staff, contractors, volunteers, and detainees from retaliating against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force." The policy further states "for at least 90 days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation." The PSA Compliance Manager confirmed she has overall responsibility for retaliation monitoring at SDC. She also stated that detainee monitoring is performed by the unit managers and supervised by her. In an instance where a unit manager is the subject of retaliation, the PSA Compliance Manager would monitor for retaliation. A Unit Manager was interviewed, and she confirmed the Unit Manager meets with the detainee and monitors any detainee disciplinary reports, housing change requests, or issue the detainee may be experiencing. The PSA Compliance Manager and Unit Manager stated that staff monitoring for retaliation continues for at least 90 days following a report of sexual abuse and may continue longer if needed. The PSA Compliance Manager confirmed staff monitoring would include negative performance reviews, time off refusals, and change of duties or reassignment. The Auditors observed retaliation monitoring was completed in the nine investigative files that were reviewed. The monitoring continued for 90 days unless the detainee was released. The PSA Compliance Manager confirmed SDC had no cases of retaliation reported by a detainee or staff member within the audit period.

§115.68 - Post-allegation protective custody.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "the facility to take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible." The policy further states "detainee victims shall not be held for longer than five days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment per policy." The Warden informed the Auditors that the use of administrative restriction for detainee victims of sexual abuse would be his last resort and only after every possible alternative including the use of an infirmary bed or transferring the detainee to another facility. He stated that he does not recall segregation ever being used to protect a victim of sexual abuse at SDC. If he were to use the segregation unit, he would notify ICE ERO OIC within 72 hours and follow SDC policy.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(e): The facility's policy 14-2 requires "the Facility Administrator to ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse. All investigations into alleged sexual abuse must be prompt, thorough, and objective……completed by a trained investigator." The interview with the Investigator indicated her investigations are prompt, thorough, and objective and the nine investigative files reviewed appear to have been conducted promptly, thoroughly, and objectively. She also confirmed that the departure of the alleged abuser or victim from the employment or control of the facility or agency would not provide a basis for terminating her investigation. As noted in standard 115.34, the investigator training did not cover "cross agency coordination;" therefore, the requirement of all administrative investigators being completed by a trained investigator was not met.

DOES NOT MEET: (a) Investigations were not completed by a specialized trained investigator. The investigator has not fully completed the specialized investigation training, the training did not include "cross agency coordination." Investigations must be completed by specialized trained investigators. The facility must develop a process to ensure that all investigations are completed by specialized trained investigators and provide the process for compliance review.

(b)(c)(f): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "administrative investigations be completed on all allegations of sexual abuse with procedures to include preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years; and coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation

is not compromised by an internal administrative investigation." The facility investigator confirmed she conducts an administrative investigation on every allegation of sexual abuse regardless of whether a criminal investigation is also conducted. She indicated her investigation, if no criminal investigation by the Stewart County Sheriff's Office or ICE investigation is conducted, would begin within 24 hours of the allegation being made. She also confirmed she is the point of contact for any outside investigative agency and cooperates with them by aiding and providing documentation when needed and would stay in weekly contact with them. The in-depth review of the nine investigation files confirmed the subpart (c) requirements of the policy and standard were followed.

§115.72 - Evidentiary standard for administrative investigations.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

The Auditors determined compliance with the standard based on review of policy 14-2 that specifies "in any sexual abuse investigation, in which the facility is the primary investigating entity, the facility shall utilize a preponderance of the evidence standard for determining whether sexual abuse has taken place." The facility's Investigator confirmed the evidence standard she uses when determining a sexual abuse investigation is the preponderance of evidence. During the review of the nine investigative files, it appeared to the Auditors that a preponderance of the evidence was the standard used in determining the outcome of the investigations.

§115.73 - Reporting to detainees.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

The Auditors determined compliance with the standard based on review of policy 14-2 that specifies, "when the detainee is still in immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken. If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee. All detainee notifications or attempted notifications shall be documented on the 14-2E Detainee Allegation Status Notification. The detainee shall sign the 14-2E form, verifying that such notification has been received. The signed 14-2E form shall be filed in the detainee's file." During the in-depth review of nine investigative files, the Auditors determined the 14-2E form was used and placed within each folder. Five of these forms were signed by the detainee. Four of them had a notation that the detainee had been released prior to the conclusion of the investigation.

§115.76 - Disciplinary sanctions for staff.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that specifies "employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse." As noted earlier in the report, this policy was reviewed and approved by the ICE ERO OIC. The FOD is notified of the removal and termination of any staff member. There were four allegations of sexual abuse involving staff during audit period. One of the allegations was determined to be substantiated. The facility investigator and PSA Compliance Manager indicated the employee was terminated. The Auditors reviewed the investigative file and confirmed the allegation was substantiated and the employee was terminated.

Recommendation: The policy should be updated to reflect the subpart (a) requirement "removal from Federal Service" even though the staff member is terminated and removed from the facility.

(c)(d): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "all terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, to the extent known." The policy also requires "the facility to report all such incidents of substantiated abuse, removals, or resignations in lieu of removal to the ICE FOD, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known." The Warden confirmed that all allegations of sexual abuse are immediately reported to the Stewart County Sheriff's Office, regardless of if the staff member resigns or not. The Auditors found notifications made to the Stewart County Sheriff's Office in each of the nine investigative files reviewed. The Auditors reviewed the case file of the terminated employee and found the notification of termination to the FOD.

§115.77 - Corrective action for contractors and volunteers.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires "any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees pending the outcome of an investigation. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall also report such incidents to the FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." The Warden stated any contractor or volunteer found to have violated any part of their zero-tolerance policy would face immediate removal from the facility and prohibited from future contact with any detainee. He also confirmed there were no reported incidents requiring the removal of a contractor or volunteer within the audit period and, if there were, they would be reported to the ICE ERO OIC, Stewart County Sheriff's Office, and any licensing body.

§115.78 - Disciplinary sanctions for detainees.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d)(e)(f): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 and policy 15-100, Detainee Discipline, that require "detainees be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault in accordance with the facility disciplinary procedures." These policies further require that

"all sanctions be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, the sanctions imposed for comparable offenses by other detainees with similar histories and intended to encourage the detainee to conform to rules and regulations in the future." Policy 15-100 documents the SDC disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures that considers whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Policy 14-2 requires "the facility not discipline a detainee for sexual contact with staff unless there is a finding the staff member did not consent to such contact." It also requires "a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence enough to substantiate the allegation." During their interviews, the Warden and PSA Compliance Manager confirmed the disciplinary process at SDC allows for progressive levels of reviews, appeals, procedures, and documents all the hearing. The PSA Compliance Manager stated that staff assistance is provided upon detainee request and is provided automatically if the detainee is determined to be cognitively impaired, LEP, or otherwise needs special assistance. Of the 13 reported sexual abuse allegations reported during the audit period, nine were detainee-on-detainee allegations. Five of the allegations were determined to be unsubstantiated, two unfounded, and two substantiated. Of the substantiated allegations, the detainee abusers were removed from the facility prior to the investigative outcome so no disciplinary reports were issued.

§115.81 - Medical and mental health assessment; history of sexual abuse.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "if the screening (sexual abuse screening) indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate." The policy further states, "that when a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment and when a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." The classification officer confirmed that the referral for medical or mental health follow-up is typically accomplished on the same day but always within the standard and policy time requirements. The HSA confirmed during her interview that medical does their own vulnerability assessment asking about prior victimization during their intake meeting with the detainee and if a detainee discloses prior sexual victimization, they are referred to mental health. If the situation requires immediate attention the detainee is seen immediately, otherwise the detainee is seen in accordance with policy and procedures. The Auditors interviewed one detainee who reported prior victimization and indicated he was offered medical and mental health services but declined. The Auditor also interviewed a detainee who had never disclosed prior victimization but informed the Auditors of prior victimization during her interview. The PSA was immediately contacted at the conclusion of the interview and the detainee was seen by medical and mental health staff.

§115.82 - Access to emergency medical and mental health services.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." The policy further requires, "all treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The Auditors reviewed nine detainee investigative files and their medical files. The review of these files confirmed each of the nine alleged victims of sexual assault were immediately brought to the medical unit and evaluated by medical staff. The HSA confirmed during her interview that alleged victims of sexual assault would have access to medical examinations and treatment, with their consent and at no cost to the detainee regardless of whether the alleged victim names the abuser or cooperates with any investigation arising out of the incident. The Auditors were unable to interview any detainee who alleged sexual abuse while at SDC or during the Remote Interview phase as none were present in the facility.

§115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(f): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "the facility to offer a medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention consistent with the community level of care." The policy further requires "the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody." SDC is also required by this policy, "to provide these services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The HSA stated the facility provides medical and mental health services consistent with the community level of care and continued treatment without cost to all detainee victims regardless, if he/she names the abuser or cooperates with any investigation arising out of the incident. The Auditors were unable to interview any detainee who alleged sexual abuse while at SDC or during the Remote Interview phase as none were present at the facility. The Auditors reviewed nine detainee investigative files and their medical files which documented each were seen by medical and mental health staff on the day the allegation became known to the facility.

(d)(e): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires, "Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services." This policy also requires, "Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate." The HSA confirmed that her medical and mental health departments provide on-site crisis intervention services to include emergency contraception, pregnancy testing, sexually transmitted infections and other infectious diseases testing, and prophylactic treatment to victims, if necessary. There were no allegations made at SDC within the audit period requiring any of the services outlined in the standard or policy.

(g): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires, "the facility attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within sixty (60) days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." The Mental Health Practitioner confirmed that in the two cases that were determined to be

substantiated within the last 12 months, both detainee abusers were seen by mental health and both refused treatment. The mental health contact with each detainee was noted in their medical records.

§115.86 - Sexual abuse incident reviews.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires, "a sexual abuse incident review to be conducted within 30 days of the conclusion of every sexual abuse investigation by the facility incident review team, utilizing the 14-2F DHS Sexual Abuse Incident Review Report form." The policy also requires "the review team consist of the Warden, PSA Compliance Manager, upper-level facility management, with input from line supervisors, investigators, and medical or mental health practitioners." The PSA Compliance Manager also confirmed all findings and recommendations for improvement will be documented on the 14-2F form and provided to the Facility Administrator, the PSA Compliance Manager, agency PREA Coordinator, and the FSC PREA Coordinator. The Auditors reviewed nine investigative files and found a completed incident review in each of the files conducted within 30 days of the investigation being completed. There were no recommendations for improvement made in any of these completed incident reviews.

(b): The Auditors determined compliance with this subpart of the standard based on review of the 14-2F Sexual Abuse Incident Review Report form that indicates the team is required to look at: race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification; status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, while conducting their incident review. The incident reviews completed on this form included a review of each of the elements within the subpart of this standard and were included in the nine investigative files the Auditors reviewed.

(c): The Auditors determined compliance with this subpart of the standard based on review of policy 14-2 that requires, "SDC to conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the Facility Administrator, FSC PREA Coordinator, and the ICE Agency PSA Coordinator." The PSA Compliance Manager provided the Auditors with the annual review conducted by the facility, completed in November 2019 which addressed the requirement that the facility assess and improve their sexual abuse intervention, prevention, and response efforts.

§115.87 - Data collection.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a): The Auditors determined compliance with the standard based on review of policy 14-2 that requires, "all claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling be retained in accordance with CoreCivic Policy 1-15 Retention of Records." The PSA Compliance Manager confirmed all investigative files and related abuse data is securely maintained in her office under double lock and key, with access restricted to only staff with a need to review. She indicated the records are retained for at least five years after release of the staff or detainee from SDC control unless federal, state, or local law requires otherwise. The Auditors verified record storage while on-site.

§115.201 - Scope of audits.

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(d): The Auditors were allowed access to the entire facility and able to interview staff and detainees about sexual safety during the on-site visit.
(e:) The Auditors were able to revisit areas of the facility and to view all relevant documentation as requested.
(i): Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j): Audit notices were posted and observed throughout the facility in English and Spanish. The Auditors received no staff or detainee correspondence.

AUDITOR CERTIFICATION

Update Audit Findings Outcome Counts by Clicking Button: **Update Outcome Summary**

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	34
Number of standards not met:	3
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

I certify that the contents of the report are accurate to the best of my knowledge and no conflict of interest exists with respect to my ability to conduct an audit of the agency under review. I have not included any personally identified information (PII) about any detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.

Thomas Eisenschmidt 8/2/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 8/2/2021

PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 8/2/2021

PREA Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Corrective Action Plan Final Determination

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Atlanta Field Office		
Field Office Director:	Thomas P. Giles		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C) OIC		
Field Office HQ physical address:	180 Ted Turner Drive, SW; Atlanta, GA 30303		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Stewart Detention Center (SDC)		
Physical address:	146 CCA Rd Lumpkin, GA 31815		
Mailing address: *(if different from above)*	P.O. Box 248 Lumpkin, GA 31815		
Telephone number:	229-838-5000		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	229-838-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Assistant Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	229-838-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

Directions: Please provide summary of audit findings to include the number of provisions with which the facility has achieved compliance at each level after implementation of corrective actions: Exceeds Standard, Meets Standard, and Does Not Meet Standard.

The Prison Rape Elimination Act (PREA) audit of the Stewart Detention Center (SDC) was conducted on May 25-27, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Thomas Eisenschmidt and [redacted], contractors employed by Creative Corrections, LLC. The Auditors were provided guidance and review during the audit report writing and review process by the Immigration and Customs Enforcement (ICE) PREA Program Manager, [redacted] and Assistant Program Manager, [redacted], both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The SDC is privately owned by CoreCivic and operates under contact with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains adult male and female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at SDC are from Mexico, Guatemala, and Cuba. SDC is located in Lumpkin, Georgia.

During the audit, the Auditor found the SDC met 34 standards, had two standards (115.17,115.31) that exceeded, had two standards (115.14, 115.18) that were non-applicable, and three non-compliant standards (115.34, 115.41 and 115.71). As a result, the facility was placed under a Corrective Action Period to address the non-compliant standards which has now been completed and the facility is found compliant with all standards.

On September 16, 2021, and January 6, 2022, the Auditor was provided the ICE PREA Corrective Action Plan (CAP) from the External Reviews and Analysis Unit (ERAU). These submissions were then reviewed and approved by the auditor to determine compliance with the three standards that did not meet compliance during the PREA audit site visit and documentation review. The final supplied documentation was reviewed by the Auditor on January 8, 2022, and it was determined that all three standards are compliant in all material ways.

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence replied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable.

§115. 34 - Specialized training: Investigations

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b): The Auditors determined compliance with these subparts of the standard based on review of policy 14-2 that requires the facility "to provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. The provided training is to cover interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process." SDC has a primary investigator and a backup investigator in her absence. During the interview with the primary investigator, she indicated she had received her training through the National Institute of Correction (NIC). The Auditor verified the training "Investigating Sexual Abuse in Confinement Setting." The curriculum does not meet the ICE PREA standard requirements for the cross-agency coordination requirement. The cross-agency coordination was not documented through any other training curriculum. The Investigators must provide documentation that they have received this cross-agency coordination training.

DOES NOT MEET (a)(b): The cross-agency coordination training element was not documented through any training curriculum or certificates. The facility must provide documentation, i.e., updated training curriculum, certificates of training, sign-in sheets indicating they have received the cross-agency coordination training.

CORRECTIVE ACTION: The Auditor was provided the PowerPoint presentation, "Effective Cross-Agency Coordination to Agency or Facility Investigators," outlining training provided to the SDC Investigator, who conducts investigations into allegations of sexual abuse at the facility. The PowerPoint is inclusive in that it covers the requirement of cross-agency coordination, thus meeting the requirement of standard 115.34(a). The Auditor was also provided the documentation for the staff member's completion of the training to include the course sign-in sheet for the Investigator and the curriculum which satisfies compliance with subpart (b). The facility complies in all material ways with the standard.

§115. 41 - Assessment or risk of victimization and abusiveness

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(e): Policy 14-2 requires SDC "reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The reassessment of the detainee's risk level of victimization or abusiveness will be conducted by the appropriate case manager or a staff member utilizing the 14-2B-DHS Sexual Abuse Screening Tool." The 2011 PBNDS requires that the reassessment on detainees alleging sexual abuse be conducted within 24 hours of the allegation. A review of four random investigative and detention files confirmed in three cases the reassessment was conducted after three days and the fourth was conducted two weeks after the allegation. The facility needs to conduct these reassessments within the 24-hour PBNDS-2011 requirement. The Auditors did review a detention detainee file who was at SDC over 90 days and his reassessment was conducted as required by policy and the standard on the 61st day.

DOES NOT MEET (e): The reassessments of detainees that reported sexual abuse were not completed in a timely manner. The facility must complete reassessments of detainees that reported sexual abuse within 24-hours. The facility must provide updated training with staff on the policy and standard requirement and provide documentation of the staff training. The facility must provide reassessments of five detainees that reported sexual abuse within the appropriate timeframe, if applicable, to demonstrate compliance.

CORRECTIVE ACTION: Based on new guidance from ERO, the 24-hour requirement in the PBNDS-2011 does not apply to the reassessment required following an incident of abuse or victimization. Based on this new guidance and previous misinterpretation, this provision is no longer a deficiency. The facility is compliant with Standard 115.41 in all material ways.

§115. 71 - Criminal and administrative investigations

Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a): The facility's policy 14-2 requires "the Facility Administrator to ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse. All investigations into alleged sexual abuse must be prompt, thorough, and objective……completed by a trained investigator." The interview with the Investigator indicated her investigations are prompt, thorough, and objective and the nine investigative files reviewed appear to have been conducted promptly, thoroughly, and objectively. She also confirmed that the departure of the alleged abuser or victim from the employment or control of the facility or agency would not provide a basis for terminating her investigation. As noted in standard 115.34, the investigator training did not cover "cross agency coordination; "therefore, the requirement of all administrative investigators being completed by a trained investigator was not met.

DOES NOT MEET (a): Investigations were not completed by a specialized trained investigator. The investigator has not fully completed the specialized investigation training as the training did not include "cross agency coordination." Investigations must be completed by specialized trained investigators. The facility must develop a process to ensure that all investigations are completed by specialized trained investigators and provide the process for compliance review.

CORRECTIVE ACTION: The Auditor was provided the PowerPoint presentation, "Effective Cross-Agency Coordination to Agency or Facility Investigators," outlining training provided to the SDC Investigator, who conducts investigations into allegations of sexual abuse at the facility. The Auditor has reviewed the PowerPoint presentation and found it inclusive in that it covers all the requirements relating to cross-agency coordination, thus meeting the requirement of standard 115.71(a). The Auditor was provided the documentation for staff completion of the training to include the course sign in for the Investigator and the curriculum. The facility complies in all material ways with the standard.

§115. Choose an item.
Outcome: Choose an item.
Notes:

§115. Choose an item.
Outcome: Choose an item.
Notes:

§115. Choose an item.
Outcome: Choose an item.
Notes:

AUDITOR CERTIFICATION:
I certify that the contents of the report are accurate to the best of my knowledge and no conflict of interest exists with respect to my ability to conduct an audit of the agency under review. I have not included any personally identified information (PII) about any detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.

Thomas Eisenschmidt January 18, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) January 25, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) October 27, 2017
Program Manager's Signature & Date