PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	July 13, 2021	**To:**	July 14, 2021
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:**	202-381-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	New Orleans
Field Office Director:	John Hartnett
ERO PREA Field Coordinator:	(b) (6)
Field Office HQ physical address:	1250 Poydras Street Suite 325, New Orleans, LA 70113
Mailing address: (if different from above)	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Pine Prairie ICE Processing Center		
Physical address:	1133 Hampton Dupre Road, Pine Prairie La. 70576		
Mailing address: (if different from above)	PO Box 650, Pine Prairie, LA 70576		
Telephone number:	337-599-2198		
Facility type:	IGSA		
PREA Incorporation Date:	7/23/20		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	1-337-599-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-446-(b) (6), (b)

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Form Key:	29
Revision Date:	02/24/2020
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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 Pine Prairie ICE Processing Center (PPIPC) was conducted on July 13-14, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt, a contractor with 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 PPIPC is privately owned by GEO Group and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains adult males who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities detained at PPIPC are from Cameroon, Cuban, and Guatemala. This was the second PREA audit for PPIPC. The facility is located in Pine Prairie, Louisiana.

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, 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.

The audit was originally scheduled for September 2020 but was converted to a contingency audit due to the COVID-19 health pandemic. The audit period was expanded to cover the period of September 2019 through July 12, 2021. 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 including the on-site visit. Approximately four weeks prior to the contingency audit, ERAU Team Lead, (b) (6), (b) (7)(C), provided the Auditor with the facility's PAQ, agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation were organized with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form in folders for ease of auditing. The main policy that provides facility direction for PREA is 10.1.1, Sexual Abuse Assault Prevention and Intervention (SAAPI) Program for Immigration Detention Facilities. All the provided documentation, policies, and PAQ were reviewed by the Auditor. A tentative daily time schedule was provided by the Lead Auditor for the interviews with staff and detainees. The Auditor also reviewed the facility's website, www.geogroup.com/PREA.

At the beginning of the Remote Interview audit phase conducted on September 22-23, 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 30 formal detainee interviews (26 during the remote phase and an additional 4 during the on-site visit), randomly selected from the housing units; interviews conducted during the Remote Interview phase were through Cisco WebEx. Eleven 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 42 staff interviews were conducted. Interviews were conducted with GEO staff either randomly chosen or interviewed based on their specific title. Specifically, specialized staff interviewed included the Facility Administrator, PSA Compliance Manager, three medical and mental health staff, the Administration/Human Resources staff, two non-security volunteers/contractors, investigator, Training Administrator, Grievance Officer, the staff responsible for Retaliation Monitoring, the Special Housing Unit (SHU) Supervisor, Classification Officer, Supervisory Detention and Deportation Officer (SDDO), Detention Officer (DO), Contracting Officer's Representative (COR), AFOD, 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 September 23, 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 the environment was deemed 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 July 13-14, 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 374 males. There are four general population living units (A, B, C, D). These general population units consist of multi-occupied detainee (8-20) dormitories. There is one special housing unit (SHU) which is the restricted housing located in building E. There are two single cells and 36 double cells in the E unit.

The facility utilizes trained investigators to complete all allegations of sexual abuse. PPIPC reported six sexual abuse allegations during the audit period, with no open cases. Of the six allegations, four were detainee-on-detainee and two were staff-on-detainee. With regard to the detainee-on-detainee allegations, three were determined to be unsubstantiated and one substantiated. The two allegations against staff were determined to be one unfounded and one substantiated. All six allegations were referred to ICE OPR and none were deemed criminal.

The entry briefing was held in the PPIPC Conference room at 8:15 a.m. on Tuesday, July 13, 2021. In attendance were:

(b) (6), (b) (7)(C) Assistant Facility Administrator, GEO

(b) (6), (b) (7)(C) Assistant Field Office Director (AFOD), ICE

(b) (6), (b) (7)(C) Detention Compliance Officer, ICE

(b) (6), (b) (7)(C) Compliance Administrator, GEO

(b) (6), (b) (7)(C) Prevention of Sexual Assault (PSA) Compliance Manager, GEO

(b) (6), (b) (7)(C) Chief of Security, GEO

Thomas Eisenschmidt, Certified PREA Auditor, Creative Corrections

The Auditor's introduction was made, and then the Auditor provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained that the audit process is designed to assess compliance through written policies and procedures and determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards would be determined based on the review of policy and procedures, observations made at the time of the facility tour, provided documentation review, and the results of interviews with both staff and detainees. The Auditor shared that he received no correspondence from any detainee or staff 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

On July 14, 2021, an exit briefing was held in the facility Conference room. In attendance were:

(b) (6), (b) (7)(C) Assistant Facility Administrator, GEO

(b) (6), (b) (7)(C) AFOD, ICE

(b) (6), (b) (7)(C) Detention Compliance Officer, ICE

(b) (6), (b) (7)(C) Compliance Administrator, GEO

(b) (6), (b) (7)(C) PSA Compliance Manager, GEO

(b) (6), (b) (7)(C) Chief of Security, GEO

Thomas Eisenschmidt, Certified PREA Auditor, Creative Corrections

(b) (6), (b) (7)(C) Assistant Project Manager, Corrective Corrections (via phone)

The Auditor spoke briefly about the staff and detainee knowledge of the PPIPC PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit, and that he would need to discuss their findings and review interview note conducted with (staff and detainee). The Auditor explained the audit report process, timeframes, and thanked all present for their cooperation.

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: 1

§115.31 Staff training

Number of Standards Not Applicable: 1

§115.14 Juvenile and family detainees

Number of Standards Met: 35

§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.18 Upgrades to facilities and technologies
§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
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.41 Assessment for risk of victimization and abusiveness
§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
§115.71 Criminal and Administrative Investigations
§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: 4

§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
§115.17 Hiring and promotion decisions

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.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(c): The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1 (SAAPI) that requires "PPIPC provide guidelines to help prevent sexual assaults on detainees, address the safety and treatment needs of detainees who have been sexually assaulted, and to discipline and prosecute those who sexually assault detainees." The policy describes that to accomplish this goal, it will ensure "employees, contractors and volunteers are informed of GEO's zero-tolerance policy regarding sexual abuse and assault; detainees are informed of PPIPC's zero-tolerance policy regarding sexual abuse and assault; standard procedures are in place to detect and prevent sexual abuse and assault; victims of sexual abuse and assault receive a prompt and effective response to their physical, psychological and security needs; staff allegations of sexual assault or attempted sexual assault are reported immediately to a supervisor and to ERO staff; staff and/or detainee perpetrators of sexual abuse and assault are disciplined and, when appropriate, referred for prosecution in accordance with PPIPC policy and Federal, state or local laws and the facility ensure that each allegation of sexual abuse or assault is investigated by an appropriate criminal or administrative investigative entity." The Facility Administrator confirmed that this policy was reviewed and approved by the agency and provided the Auditor with documentation of the policy review approval dated July 2020. The random staff and detainees interviewed indicated they are aware of the facility's policy on sexual abuse.

(d): The facility has a designated PSA Compliance Manager to oversee the facility's compliance efforts with the implementation of PREA. Policy 10.1.1 states "the PSA Compliance Manager will assist in ensuring facility compliance with sexual abuse and assault prevention and intervention policies and procedures and serve as the facility point of contact for the DHS PSA Coordinator and Corporate PREA Coordinator." The PSA Compliance Manager confirmed he serves as the facility's point of contact for the ICE PSA Coordinator. After interviews with detainees, GEO staff, and ICE staff, the Auditor has determined that the PSA Compliance Manager does not have sufficient time and authority to comply with the facility's sexual abuse and assault prevention and intervention policies and procedures. Random detainee interviews confirmed that they were not aware of whom the PSA Compliance Manager was and did indicate that his name was noted on the DHS posters on each of their housing units but were unable to identify him. Some of the random line staff interviews indicated that the PSA Compliance Manager was not as prominent within the facility population as he used to be.
Prior to the Auditors' on-site arrival, the PSA Compliance Manager was asked specifically for a couple documents. The Auditor was not provided the documents as requested and asked the PSA Compliance Manager about them. He answered, 'he didn't have time" to collect the requested documents. The Auditor spoke with the PSA Compliance Manager, who indicated that since COVID staff reductions at PPIPC and South Louisiana ICE Processing Center, he and other key positions at PPIPC are being shared between both facilities, meaning he is not assigned to PPIPC on a full-time basis.
The PSA Compliance Manager indicated he reports directly to the Facility Administrator on all matters related to PREA. The Facility Administrator also confirmed the PSA Compliance Manager reports directly to him on all PREA related matters. The PPIPC organizational chart indicates the PSA Compliance Manager reports directly to the Facility Administrator.

DOES NOT MEET: The Auditor has determined the PSA Compliance Manager does not have the required time to perform all his PREA related duties at PPIPC. The PSA Compliance Manager must have sufficient time and authority to oversee the facility's efforts to comply with facility sexual abuse prevention and intervention policies and procedures in accordance with subpart (d) of the standard. The facility must develop a plan to ensure the PSA Compliance Manager has sufficient time to perform all the PREA related duties at the facility. The plan must be submitted for compliance review.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy 10.1.1 requires "PPIPC ensure it maintains sufficient supervision of detainees, including through appropriate staffing levels, and where applicable video monitoring to protect detainees against sexual abuse." The Facility Administrator confirmed the staffing levels for the supervision of the detainees are established prior to the contract agreement between ICE and GEO Corporate staff. He stated that staffing levels are based on direct supervision of the detainees taking into account: video monitoring equipment, generally accepted detention/correctional practices, judicial findings of inadequacy, the physical plant; detainee population, findings of incidents of sexual abuse any recommendations of sexual abuse incident reviews; and any other relevant factors. The Facility Administrator and each shift Watch Commander indicated that detainee supervision posts are never closed. The Facility Administrator confirmed supervision posts are always covered and overtime would be used to cover them in the absence of available staff.
During the on-site tour, the Auditor observed detainee supervision by staff as described by the Facility Administrator. The facility supervision guidelines are through post orders and policy. The Auditor requested the supervision guidelines to review. Once this information was provided by the PSA Compliance Manager, the Facility Administrator took the materials prior to the Auditor reviewing and did not make them further available to the Auditor.
During the second day of the on-site visit, the Auditor was approached by the ICE COR, who indicated that he was advised by the ICE Detention Service Manager (DSM), who accompanied the Auditor on the first day of the tour, that extra staff had been placed around the facility during our tour including new recruits. The Auditor then placed a call and spoke with the AFOD who stated that the DSM had on numerous occasions, since COVID, documented staff shortages in his weekly Compliance Reports. The Auditor reviewed 10 copies of these Compliance Reports. In three of these reports (2/5/21, 5/2/21, and 6/25/21) the DSM reported he observed and documented housing units at Pine Prairie without sufficient security staff coverage or cameras to provide the required supervision. One of the reports also documented high security detainees moving about the facility population comingling with low security detainees without the required security escorts.

DOES NOT MEET (a): Based on staff interviews and submitted documentation, the Auditor has determined the facility is not meeting the requirements of subpart (a) of the standard. Each facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The facility must provide a staffing plan to demonstrate the sufficient staffing levels to ensure supervision to protect detainees against sexual abuse. The plan must address how the facility will

maintain sufficient supervision coverage during staff shortages. The plan must be submitted for compliance review along with staffing rosters from dates selected by the Auditor.

DOES NOT MEET (b): The facility did not provide documentation of the comprehensive supervision guidelines for the Auditor to review. Each facility must develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and review these guidelines at least annually. The facility must provide the comprehensive supervision guidelines with the annual review for compliance review.

(c): The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.that requires, "PPIPC review their staffing guidelines at least annually utilizing attachment A, Annual PREA Facility Assessment, based on direct supervision of the detainees taking into account: video monitoring equipment, generally accepted detention/correctional practices, judicial findings of inadequacy, the physical plant; detainee population, findings of incidents of sexual abuse any recommendations of sexual abuse incident reviews; and any other relevant factors." The policy also states, "the review be submitted to the local PSA Compliance Manager and Corporate PREA Coordinator annually as determined by GEO's U.S. Corrections and Detention Division." These considerations are the major elements of the annual staffing review conducted by PPIPC annually. The PSA Compliance Manager also detailed these elements during his interview and confirmed he participated in the last review conducted on September 1, 2020. The review of the document by the Auditor confirmed the review was based on the policy and standard requirements.

(d): The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1 that requires, "PPIPC Supervisory staff (intermediate and high-level supervisors) shall conduct and document random unannounced security inspections to identify and deter staff sexual abuse and sexual harassment of detainees. These "PREA Unannounced Security Inspections" may be conducted in conjunction with other daily and weekly rounds as required. PREA Unannounced Security Inspections shall be conducted at least once per shift by the Assistant Shift Supervisor and Shift Supervisor. Daily Unannounced Security Inspections through each housing unit will be conducted by the Chief of Security and the Shift Supervisor documented in the housing unit logbook as PREA Unannounced Security Inspections in red ink. Other members of the executive team shall make less unannounced visits as schedules allow. Such inspections shall be implemented for night as well as day shifts. Employees are prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of PPIPC." Supervisor interviews confirmed rounds are made daily on each shift throughout the day at PPIPC in every area detainees have access to. They also stated that these rounds are made at a different time and locations in order to keep staff from alerting other staff. Random staff indicated that they are prohibited from alerting other staff that the supervisor is conducting rounds. During the tour, the Auditor observed log entries in randomly chosen area's logbooks demonstrating daily supervisory rounds being conducted in accordance with the standard and policy requirements. The Auditor also reviewed post orders and spoke with line staff confirming their requirement to make and document rounds in their areas.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The Pre-Audit Questionnaire (PAQ), the Auditor observations, and interviews conducted with the Facility Administrator and PSA Compliance Manager confirmed PPIPC does not accept juveniles or family detainees; therefore, the Auditor has determined this standard is not applicable.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(d)(i): The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that specifies "searches may be necessary to ensure the safety of officers, civilians, and detainees; to detect and secure evidence of criminal activity, and to promote security, safety, and related interests at immigration detention facilities. Searches at PPIPC shall be performed in the following manner: cross-gender pat-down searches of male detainees 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 and all strip searches, visual body cavity searches and cross-gender pat-down searches shall be documented on attachment N Cross Gender Pat Search Log." This policy further requires "staff shall not search or physically examine a detainee for the sole purposes 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 by learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private by a medical practitioner." The Facility Administrator and PSA Compliance Manager confirmed cross-gender pat-down searches conducted at PPIPC within the audit period were conducted in exigent circumstances when no male officers were available in the Special Housing Unit (SHU). The Auditor reviewed the documentation in the cross-gender logbook and noted the exigent circumstances. The Auditor interviewed both male and female random security staff from each shift, 12 in total. Search training and practices were discussed by each of them indicating search training was provided to them and they described this training, specifically under what conditions a pat-down search and cross-gender pat-search may be performed as outlined in policy and required by the standard. They specifically stated they are prohibited from searching any detainee for the sole purpose of determining their genital status, and if they were required to have that information, the detainee would be brought to medical. Five random staff training files were reviewed and found to detail the search training. The training curriculum was also reviewed by the Auditor and covered all the standard requirements.

(c): PPIPC is an all-male facility; therefore, this subpart provision is not applicable.

(e)(f): The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that states "cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. In cases where strip searches and visual body cavity searches are performed, each shall be documented on the Attachment N – Cross Gender Pat Search Log." The PAQ and interviews with the Facility Administrator and PSA Compliance Manager indicated PPIPC neither authorized nor conducted any body cavity searches during the audit period. Strip searches are permitted as a matter of routine for suicide watch. The Auditors were provided a copy of the log entry and completed attachment N for an authorized strip search. The one authorized strip search was conducted by a male staff member for a medical observation watch as required by their policy. The random interviews with 12 security staff confirmed their knowledge of the restrictions on strip searches and body cavity searches.

(g): Policy 10.1. requires "PPIPC implement policies and procedures which allow detainees to shower, change clothes, and perform bodily functions without employees of the opposite gender viewing them, absent exigent circumstances or instances when the viewing is incidental to routine cell

checks or otherwise appropriate in connection with a medical examination or monitored bowel movement. Employees of the opposite gender shall announce their presence when entering housing units or any areas where detainees are likely to be showering, performing bodily functions, or changing clothes." Signs at the entrance of each housing unit remind cross gender staff to announce themselves prior to entering. PREA announcements are to be documented in the housing unit log. Female staff confirmed the facility's requirement to announce their presence every time they enter an area where detainees may be showering, changing clothes, and performing bodily functions. While touring the facility, the Auditor observed female staff announcing their presence when entering detainee housing units. The Auditor interviewed random detainees and the majority confirmed staff of the opposite gender announce themselves prior to entering their living areas or areas where they may be showering and/or performing bodily functions. However, policy, as written, conflicts with the privacy requirement of the standards as "a monitored bowel movement" is not an acceptable exception for cross-gender viewing and the policy does not detail how supervision of monitored bowel movements are conducted under medical supervision, other facility staff, or same gender staff. The staff interviews could not provide how the supervision of bowel movements were conducted to ensure privacy requirements are met and confirm they were completed by medical staff or the same gender staff.

DOES NOT MEET: The policy as written includes an exception to cross-gender viewing to include monitored bowel movements. During interviews with medical and facility staff they could not provide how privacy requirements are met during the supervision of bowel movements and which staff would conduct the supervision. The Auditor was unable to confirm the supervison of bowel movements are completed by medical staff or a same gender staff member. The facility must clarify the exception of exigent circumstance to include monitored bowel movement to met the privacy requirements. The facility must update the policy and/or provide procedural directive to staff, delineating that a monitored bowel movement is to be conducted under medical supervision in accordance with the standard requirement. The facility must provide the updated policy and/or procedural directive and documented staff training on the updated policy and/or procedural directive for compliance review.

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

(j): The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1 that requires "all security staff be trained to conduct pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees in a professional and respectful manner, and in the least intrusive manner possible, including consideration of officer safety." The Auditor reviewed the training curriculum for searches and found it met the policy and standard requirements. During the 12 random security staff interviews, each confirmed their knowledge of the prohibition of searching detainees to determine their genital status and their responsibility to perform all pat-down searches in a professional and respectful manner. The Auditor reviewed five security staff training files and found completed search training documentation in each of the files. At the time of the audit, there were no transgender or intersex detainees present at the facility to interview.

§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)(c): The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that requires "PPIPC ensure that detainees with disabilities (i.e., those who are deaf, hard of hearing, blind, have low vision, intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from the Company's efforts to prevent, detect, and respond to sexual abuse and assault. PPIPC shall provide written materials to every detainee in formats or through methods that ensure effective communication with detainees with disabilities, including those who have intellectual disabilities, limited reading skills, or who are blind or have low vision. The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their limited English proficiency (LEP). The facility will provide detainees with disabilities with effective communication, which may include the provision of auxiliary aids, such as readers, materials in Braille, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters and note takers, as needed. The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities." The policy further requires in matters relating to sexual abuse, "PPIPC shall provide in-person or telephonic interpretation services that enable effective, accurate and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for a detainee interpreter and the facility determines that such interpretation is appropriate. Any use of these interpreters under these type circumstances shall be justified and fully documented in the written investigative report. Minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of sexual abuse." According to two intake staff, two intake supervisors, the Classification Officer, and the PSA Compliance Manager, each detainee arriving at PPIPC receives the ICE Sexual Abuse and Assault Awareness pamphlet, ICE National Detainee Handbook, and the Pine Prairie handbook. The ICE Sexual Abuse and Assault Awareness pamphlet and Pine Prairie handbook are available at PPIPC in English and Spanish formats only. Staff was not aware that the ICE Sexual Abuse and Assault Awareness pamphlet was currently available in nine languages including French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic. 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 two informational videos (PREA and Know Your Rights) run continuously in the intake area and in each housing unit. The videos are in English and Spanish. The intake staff also indicated when staff encounters a detainee who speaks/understands a language not provided in one of the 11 languages represented in the ICE National Detainee Handbook, staff utilizes the ERO language line interpretive services and read pertinent information from a manuscript. The use of the translated manuscript is documented in the detainees' detention file. Twenty-nine of the 30 detainees interviewed confirmed receiving information in a format that they understood. Eleven of these 30 detainees interviewed were LEP. There was one detainee who indicated he did not receive information in a format he understood, and he was one of the 11 LEP. When the Auditor questioned him, he first acknowledged receiving information and later in the conversation indicated he never received the information in a format he understood. His detention file indicated he had received and signed for receiving this information. The Auditor was also informed by the two intake supervisors that when PPIPC intake staff are confronted with a detainee who may be hearing impaired or deaf, orientation information is provided to them in writing or through use of the facility text telephone (TTY). If staff is confronted with a detainee who is blind or has limited sight, he would be provided individualized service by a staff member to read information to him. The Auditor was also informed by intake staff that if they encounter any detainee with intellectual deficiencies, the staff would try to communicate to them to the best of their abilities. If there was any difficulty, then the detainee would be referred to a supervisor, medical, or mental health staff based on the detainee limitation. The review of the investigative files confirmed that four of the six cases confirmed PPIPC utilized their contracted interpretive services to conduct interviews with LEP detainees.

Recommendation: The Auditor recommends staff who facilitate the intake process be made aware of how to obtain copies of the ICE Sexual Abuse and Assault Awareness Pamphlet from ICE that is currently available in nine languages: English, Spanish, French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(e)(f): The Human Resource staff stated, during the initial hiring, that GEO Corporate uses Career Builder to do a basic review on the candidate; however, they rely on the ICE background check and review for employment eligibility. Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731 and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive, and GEO policy 10.1 require "the facility and agency, to the extent permitted by law, to refuse 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 been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard." The documents require all new hires, staff awaiting promotions, and all staff on an annual basis to complete and submit a self-declaration form indicating he/she has not engaged in any prohibited conduct. The individual will respond directly to questions about previous misconduct, as required per the standard and, as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The Assistant Deputy Division Director of the OPR Personnel Security Unit (PSU), (b) (6), (b) 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 the application. The Human Resources Manager (HRM) at PPIPC confirmed that background checks are conducted on all applicants, staff, contractors, and volunteers. She also stated employees on an annual basis, during their evaluations, acknowledge by signature that they have not engaged in any activity prohibited by policy 10.1.1. She confirmed 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 that this information is provided through GEO Corporate. She stated the facility would request information from prior institutions, where the prospective candidate was previously employed, and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire. The Auditor was provided and reviewed the documentation (self-declaration form indicating he/she has not engaged in any prohibited conduct and a completed background check) completed prior to a promotion. During the 13 employee (ten during the contingency phase and three on-site) and contractor staff file reviews, the Auditor found two contractor files that did not contain the PREA Annual Disclosure form as required by policy and standard. When the PSA Compliance Manager learned that these two individuals had not signed these annual review declarations, the PSA Compliance Manager immediately found these individuals and had them sign the form. He indicated that he would update the policy to ensure that contractors sign the PREA Annual Disclosure document annually at the PREA training.

DOES NOT MEET (b): The contractor staff in the commissary were not completing the PREA Annual Disclosure form acknowledging by signature they have not engaged in any activity prohibited by policy 10.1.1. PPIPC must develop a process to ensure that the PREA Annual Disclosure form is completed for contractors in accordance with facility policy and the standards requirement. The facility must submit the process for compliance review along with documented training of appropriate staff that will oversee the process.

(c)(d): 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 "the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees prior to being allowed entrance into the facility." It further requires "a background recheck be conducted every five years on all employees and unescorted contractors." The HRM stated ICE completes all background checks for all staff and contractors prior to hiring and then again, every five years. Review of documentation provided by ICE's PSU confirmed that the eight randomly selected employees (six facility staff and two ICE staff) background checks were performed prior to them reporting to work. Documentation also confirmed the due dates for the five-year background rechecks. The Auditor determined the provided background check information was compliant with the standard.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a): This subpart of the standard is not applicable based on the PAQ and the interview with the Facility Administrator confirming PPIPC has not expanded or modified the existing facility.

(b): The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1 that requires," PPIPC consider the effect any (new or upgrade) video monitoring system, electronic surveillance system, or other monitoring system might have on our ability to protect detainees from sexual abuse." (b) (7)(E) The additional need for cameras was noted on the Annual PREA Facility Assessment on September 19, 2019, to address identified blind spots and areas of isolation.

§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 Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1A, Investigating Allegations of Sexual Abuse and Assault and Evidence Collection in Immigration Detention Facilities, that requires "PPIPC follow uniform evidence protocols that maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developmentally appropriate for juveniles where applicable and developed in coordination with the DHS." The Auditor reviewed the facility's uniform evidence protocol and determined it does in fact meet the standard's requirement. The Facility Administrator confirmed the policy outlining the protocol was reviewed and

approved by ICE and provided this documentation to the Auditor. The Facility Investigator confirmed she follows the evidence protocols provided in her training, and as required in policy, to ensure she obtains the physical evidence needed to properly conduct her administrative investigations. 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 assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO 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 AFOD would assign an administrative investigation to be conducted. The Auditor found, after the review of six investigative files, uniform evidence protocols were followed during the administrative investigations.

(b)(d): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that states, "PPIPC shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation and the prosecution of Sexual Abuse perpetrators to most appropriately address victim's needs." The Auditor conducted an interview with a staff member from the St. Landry-Evangeline Sexual Assault Center (SLESAC), a community local advocacy service that provides counseling services and community outreach and educational programs to St. Landry and Evangeline Parishes since 1999, which confirmed these services. This advocate confirmed her agency, the SLESAC, provides short-term crisis intervention to victims and survivors of sexual assault, rape, and molestation. SLESAC provides a 24-hour crisis hotline (1-800-656-4673) services, medical escorts, and criminal justice advocacy to its survivors and their family members. The MOU between PPIPC and SLESAC states SLESAC shall "provide legal advocacy and confidential emotional support services for immigrant victims if requested." The staff member from SLESAC confirmed a qualified staff person from the organization would provide emotional support, crisis intervention, information, and referrals, if needed, and would accompany the victim through any forensics exams and investigative process. She also confirmed the center provides contact information for detainees through the provided telephone number and mailing address. The facility reported six sexual abuse investigations during the audit period. In review of the six closed investigative files, the Auditor determined the alleged victims were offered victim advocacy services as documented in the files. The Facility Investigator confirmed that when the detainee is first taken to medical, they are provided victim advocate information by both the investigator and medical staff after every report of an allegation.

(c): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1A that requires "PPIPC offer to all detainees, who experience sexual abuse, access to forensic medical examinations (whether on-site or at an outside facility) with the victim's consent, and without cost to the detainee and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. PPIPC medical staff shall not participate in sexual assault forensic medical examinations or evidence gathering. Examinations shall be performed by a Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE). An off-site qualified medical practitioner may perform the examination if a SAFE or SANE is not available." The Health Services Administrator (HSA) confirmed forensic examinations are conducted at the St. Francis Cabrini Hospital by a trained SANE practitioner and that her staff, by policy, stabilizes the individual, if necessary, in preparation for transport. PPIPC has tried to establish an MOU with the hospital but has been unable to establish one. The HSA stated and the reviewed documentation indicated that the hospital's legal department was reviewing the MOU but has not entered into any agreement at this time. The Auditor spoke with staff at the hospital who confirmed the hospital provides a SANE to PPIPC victims of sexual assault, at no charge to the detainee. Based on interviews with the PSA Compliance Manager, the HSA, and review of the facility's PAQ and investigations, the facility had no forensic examinations conducted during the audit period.

(e): The facility's policy 10.1.1 states, "PPIPC is required to maintain or attempt to enter into a PREA MOU agreement with law enforcement agency outlining the responsibilities of each entity related to conducting PREA allegation that involve potentially criminal behavior. PPIPC shall maintain copies of agreements or documentation showing unsuccessful attempts to enter into such agreements." The Auditor reviewed the MOU between the facility and Evangeline Parish Sheriff's Department, the agency with the legal authority to conduct criminal investigations within the facility. The facility requested the Department comply with subparts (a) through (d) of the standard. The resulting MOU, established in 2019 with no sunset date, did not include these requirements. None of the six allegations of sexual assault at PPIPC were determined to be criminal.

Recommendation: The facility should attempt to update the MOU with the Evangeline Parish Sheriff's Department to address subparts (a) through (d) of the standard.

§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): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1A that requires "PPIPC have a policy in place to ensure that all allegations of sexual abuse are referred for investigation to a law enforcement agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior." The PPIPC policy requires the facility document all referrals. Criminal investigations are conducted by the Evangeline Parish Sheriff's Department as noted in 115.21. The 10.1.1A policy further requires "an administrative investigation be completed for all allegations of sexual abuse regardless of whether a criminal investigation is completed. Coordination of internal administrative investigations with OPR should be coordinated in a way as to not interfere with the assigned criminal investigative entity criminal investigations. Administrative investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses, and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. The PPIPC investigator shall include an effort to determine whether staff actions or failures to act contributed to the abuse. The investigation shall be documented in a written report format that includes at a minimum the description of the physical and testimonial evidence and the reasoning behind credibility assessments, and investigative facts and findings." The 10.1.1A further states, "PPIPC shall retain all written reports referenced in this section for as long as the alleged abuser is incarcerated or employed by the agency [GEO], plus five years; however, for any circumstance, files shall be retained no less than ten years." The agency's policy 11062.2 outlines the evidence and investigation protocols. All investigations are to be reported to the Joint Intake Center (JIC) who assesses allegations to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination 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, and the AFOD would assign an administrative investigation to be completed. The facility had a total of six allegations: four incidents were detainee-on-detainee allegations and two were staff-on-detainee allegations. All six allegations were referred to ICE OPR and none were deemed criminal. The Auditor reviewed six investigative case files and determined they were completed in accordance with the standard and policy 10.1.1A. The PPIPC investigator was interviewed and found to be very knowledgeable concerning her responsibilities in the investigative process. She also confirmed she assists with outside law enforcement when required.

(c): The protocols for ICE investigations and GEO investigations are found on their respective web pages (www.ICE.gov/prea) and (www.geogroup.com/PREA).

(d)(e)(f): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1A that requires "When a Detainee of the Facility in which an alleged Detainee victim is housed is alleged to be the perpetrator of Detainee Sexual Abuse, PPIPC shall ensure that the incident is promptly reported to the appropriate ICE Field Office Director, and, if it is potentially criminal, referred to an appropriate law enforcement agency having jurisdiction for investigation. When an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, PPIPC ensures the incident is promptly reported to the appropriate ICE FOD. If the allegation is potentially criminal, it must be referred to an appropriate law enforcement agency having jurisdiction for investigation." The Auditor interviewed the AFOD who indicated he is notified by the facility upon every allegation of sexual abuse. He indicated he then would notify the JIC, OPR, and the DHS OIG of the reported allegation. The interviews with the Facility Administrator and the PSA Compliance Manager indicated the AFOD is notified in all allegations of sexual abuse, typically by email and phone call. A copy of the email notification is made part of the investigative paperwork. The documentation observed during the investigative file review confirmed these notifications were completed per policy and the standard's requirement.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "all employees, contractors, and volunteers receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program. PPIPC staff receive upon hiring and during annual refresher PREA training that includes the facility's zero-tolerance policy for sexual abuse and assault. The training fulfills their responsibilities under the agency's sexual abuse and assault prevention, detection, reporting, and response policies and procedures, recognition of situations where sexual abuse may occur, the right of detainees and employees to be free from sexual abuse and retaliation for reporting sexual abuse and assault, definitions and examples of prohibited and illegal sexual behavior, recognition of physical, behavioral, and emotional signs of sexual abuse, methods of preventing and responding to such occurrence; how to detect and respond to signs of threatened and actual sexual abuse, how to avoid inappropriate relationships with detainees, how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, and intersex (LGBTI) or gender non-conforming detainees, and the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. Employees must acknowledge, by signature, they have received and understood this training, on the PREA Basic Training Acknowledgement Form (Attachment F)." This form is used to document pre-service and annual in-service training. The Auditors reviewed 12 random training files and found each file contained a signed training certification form (Attachment F). The random 12 PPIPC staff and 2 ICE staff interviewed by Auditors confirmed each had received PREA pre-service and annual refresher training. They also confirmed the instruction they received included the requirements outlined in subpart (a) of the standard. The interview with the PPIPC Training Administrator and the review of the training curriculum, confirmed the subpart (a) requirements are part of the PREA training. The Training Administrator also confirmed that all staff currently assigned to PPIPC are current with the agency's PREA training requirement. The Auditors indicated the facility exceeds the requirement of the standard as PREA refresher training is provided annually instead of the standard requirement of bi-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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "all Employees, Contractors and Volunteers shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program. 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 Training Administrator confirmed contractors at PPIPC receive and document by signature their understanding of the PREA training that each receives annually. He also stated that regardless of the service they provide all volunteers receive the same ICE Volunteer curriculum. The Auditor interviewed two contracted staff, and each confirmed they had received the agency's sexual abuse training that included their responsibilities on prevention, detection, and response policies and procedures. There were no "other contractors," as delineated in subpart (d) of the standard or volunteers present during the audit to interview. The Auditor reviewed two volunteer training records that demonstrated a signed document acknowledging each received and understood the agency's sexual abuse training.

§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)(e)(f): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "during the intake process PPIPC ensure that the detainee orientation program notifies and informs detainees about the zero-tolerance policy regarding all forms of sexual abuse and assault and includes instruction on prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, employee-on-detainee sexual abuse and coercive sexual activity, explanation of methods for reporting sexual abuse or assault, including to any employee, including an employee other than immediate point-of contact line officer (i.e. the PSA Compliance Manager or mental health staff), the Detention and Reporting Information Line (DRIL), the DHS OIG, and JIC and the ICE/OPR investigation process, information about self-protection and indicators of sexual abuse, prohibition against retaliation, including an explanation that reporting sexual abuse 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." This policy further requires "education/notification be provided in formats accessible to all detainees, including those [who] are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. PPIPC shall maintain documentation of detainee participation in the intake process orientation which shall be retained in their individual files." As noted in 115.16, detainees arriving at PPIPC are provided an ICE National Detainee

Handbook, the Pine Prairie handbook, the DHS-prescribed SAAPI pamphlet, and are shown a PREA video (PREA and Know Your Rights) available in English or Spanish. The ICE National Detainee Handbook is available in 11 languages. The PPIPC detainee handbook is available in Spanish and English only. Although the DHS-prescribed Sexual Assault Awareness pamphlet is now provided in nine languages, PPIPC only has it available in English and Spanish. The intake staff confirmed that orientation information is provided to all detainees regardless of the detainee's language or disability. During interviews with two intake staff and the intake supervisors, the staff explained the intake process and confirmed the materials noted above being provided to each detainee upon arrival, either through written formats, staff assistance and/or interpretive services. During the 30 detainee interviews, all but one confirmed they had received copies of these documents in a format they understood. The Auditor reviewed the detention file of the one detainee who alleged not receiving these documents and found the detainees' signature indicating he did receive this information in a format he understood. The Auditor randomly selected eight detainee files and reviewed signed documentation indicating the detainees received both the ICE National Detainee Handbook and the Pine Prairie handbook and viewed the PREA video.

Recommendation: Subpart (e) states, "The facility shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet." The Auditor recommends that staff who facilitate the intake/orientation program be made aware of how to obtain copies of the ICE Sexual Abuse and Assault Awareness Pamphlet that is currently available in nine languages: English, Spanish, French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic.

(d): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "PPIPC post on all housing unit bulletin boards the following notices: the DHS-prescribed sexual assault awareness notice, the name of the PSA Compliance Manager, and the name of local organizations that can assist detainees who have been victims of sexual abuse." During the on-site visit, the Auditor observed the required DHS poster with the name of the PSA Compliance Manager in each area of PPIPC that detainees have access to, including in all housing units. These areas also contained the victim advocate contact information. The 30 random detainee interviews also confirmed their knowledge of these posters and the required information.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "in addition to the general training provided to all facility employees, the facility shall 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. This training must cover, at a minimum, 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. The facility must maintain written documentation verifying specialized training provided to investigators pursuant to this paragraph." The primary Facility Investigator confirmed she received specialized training through GEO, as documented in her training record. The secondary investigator's training record was also checked, and the Auditor found documented investigator training in his file as well. The Auditor reviewed the GEO Investigator Training and found the curriculum provided the standard subpart (a) requirements. The Auditor confirmed, after the investigative file reviews, all investigations that were conducted at PPIPC during the audit period were conducted by the two trained investigators.

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 agency has provided training records for agency investigators on the ICE SharePoint to document compliance with the 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 PPIPC as the facility medical department is operated by the GEO group.

(c): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "PPIPC shall train all full-time and part-time Medical and Mental Health Care Practitioners who work regularly in its Facilities on certain topic areas, including detecting signs of Sexual Abuse and Assault, preserving physical evidence of Sexual Abuse, responding professionally to victims of Sexual Abuse and proper reporting of allegations or suspicions of Sexual Abuse and Assault." The HSA confirmed that the facility medical staff do not participate in sexual assault forensic medical examinations or evidence gathering and that all forensic examinations are performed at St. Frances Cabrini Hospital by a SAFE or SANE practitioner. The HSA also confirmed that all current medical and mental health practitioners have been provided this training. The Auditor randomly chose two medical files and found this required training documented in their files. The policy was approved by the AFOD. There were no forensic examinations conducted at PPIPC during the audit period as confirmed by interviews with the HSA and PSA Compliance Manager. The HSA indicated that medical staff are trained in procedures for examining and treating victims of sexual abuse and would prepare the detainee for transport to the outside hospital for a forensic examination.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "all detainees be assessed during intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. Each new arrival at PPIPC shall be kept separate from the general population until he/she is classified and may be housed accordingly." The policy requires "PPIPC shall also consider, to the extent that the information is available, the following criteria to assess Detainees for risk of sexual 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 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 detainees' own concerns about his or her physical safety." The two intake officers interviewed stated that, by policy, they consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to them and the facility through documents provided through ICE (e.g., medical files or 213/216 records, etc.) in assessing their risk of being sexually abusive. Policy 10.1.1 further requires "this assessment be completed upon arrival and the initial classification be completed within 12-hours after arrival at PPIPC. Detainees are to be kept separate from general population until the assessment and classification processes are completed. The PSA Compliance Manager shall maintain an "at risk log" of potential victims and potential abusers determined from this PREA Risk Screening Assessment. The "at risk log" will be kept current and include current housing locations. Following any reported allegation of sexual abuse, the PREA Compliance Manager will ensure victims are placed on the "at risk log" as soon as possible and tracked as a potential victim and housed separate from potential abusers pending the outcome of the investigation. If the investigation is determined "unfounded," the victim may be removed from the "at risk log." The PSA Compliance Manager will also maintain a tracking log of those individuals who self-identify as LGBTI with their housing location as a result of information obtained during the risk screening." The Auditor reviewed 10 detainee detention files and found completed risk assessments conducted, utilizing the GEO PREA Risk Assessment Tool, on the day of the detainee's arrival. The detention file review also confirmed each detainee received their initial classification assessment on their day of arrival. The random detainees' interviews indicated that the classification and risk assessment were completed within the first couple hours of the detainee's arrival. The Intake Supervisor stated PPIPC detainees remain in the intake area until the risk assessment and classification process are completed. He stated that he did not recall a situation where the intake process, risk assessment and classification, was not competed within the first three hours of arrival.

(e): Policy 10.1.1 requires "PPIPC ensure that between 60 and 90 days from the initial assessment at the facility, staff reassess each detainee's risk for victimization or abusiveness using the GEO PREA Vulnerability Reassessment Questionnaire, Attachment C, to conduct the reassessment by the classification staff. At any point after the initial intake screening, a detainee shall be reassessed for risk of victimization or abusiveness when warranted based upon the receipt of additional, relevant information, or following an incident of abuse or victimization." The interview with the PSA Compliance Manager and Classification Officer confirmed PPIPC conducts reassessments on all detainees at the facility between the 60-90-day requirement but was not conducting reassessments on alleged victims nor alleged abusers of sexual assault, as required by the standard. During the review of 10 detainee detention files, 9 of the files required a 60–90-day reassessment; these reassessments were completed as required by policy and standard. However, the facility could not demonstrate special reassessments completed at any other time when warranted based on the receipt of additional, relevant information or following an incident of abuse or victimization during the Pre-audit documentation review. Interviews conducted with PSA Compliance Manager and Classification Officer indicated reassessments are not being completed for alleged victims/abusers upon report of a sexual abuse allegation. Although through interviews the Auditor was told special reassessments were not occurring, during the review of the six investigative files, the Auditor found three instances where the reassessment was completed within 24 hours and one instance of a reassessment conducted as a result of a PREA allegation completed 6 days after the reported incident and not within the Performance-Based National Detention Standards (PBNDS -2011) requirement of 24 hours. The facility meets substantial compliance with the subpart of the standard with the completion of four reassessments from the six reported PREA allegations, although one reassessment was outside the 24-hour requirement.

Recommendation: Facility staff should receive refresher training on the standard requirement that a reassessment of each detainee's risk of victimization or abusiveness at any time warranted based on additional information or following an incident of abuse or victimization. The reassessments need to be completed on the alleged victim and alleged abuser within 24 hours of the allegation report.

(f): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that "prohibits detainees from being punished 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, two Intake Supervisors, and the two intake officers confirmed detainees are not disciplined for refusing to answer any of the questions asked during the risk assessment.

(g): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires "PPIPC implement appropriate controls on dissemination of responses to questions asked related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees." The policy further requires "sensitive information to be limited to staff on a need-to-know basis only for treatment, programming, housing, security, and management decisions." The classification officer confirmed appropriate controls are placed on all detainee records and information, including reassessments, which are maintained in the detainee detention file and secured in the records room file cabinet, under lock and key. PPIPC staff receive upon hiring and during annual refresher PREA training that includes the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. Employees acknowledge, by signature, they have received and understood this training. The 12 random staff interviews confirmed their responsibility of remaining confidential with all information they become knowledgeable about during incidents of sexual abuse, discussing it only with their supervisor or investigator.

§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 Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires "screening information from the vulnerability assessment shall be used to assign detainees to housing, recreation and other activities, and voluntary work and shall make individualized determinations about how to ensure the safety of each detainee." The Classification Officer confirmed all housing, voluntary work, and activities are based on each detainee's interview and their individual responses to the GEO PREA Risk Assessment Tool, and other pertinent information she receives from ICE about the detainee, to make determinations for the safety of each detainee. The Auditor reviewed 13 detention files, and each appeared to have an individualized determination regarding housing and programming.

(b)(c): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that states "transgender and intersex detainees may be housed in medical for up to 72 hours (excluding weekends, holidays and emergencies) until the appropriate housing determination is made by the Transgender Care Committee (TCC). TCC members shall consist of the Facility Administrator or Assistant Facility Administrator, Security Chief, Classification or Case Management Supervisor, medical and/or mental health staff and PSA Compliance Manager. The Corporate PREA Coordinator may

also be consulted." The policy further states "the TCC shall consider the detainee's documented criminal history and past/present behavior; the detainee's physical, mental, medical and special needs; the detainee's self-assessment of his/her safety needs (do they feel threatened or at risk of harm); privacy issues, including showers, available beds and or housing and all records and prior assessments of the effects of any housing placement on the detainee's health and safety that has been conducted by a medical or mental health professional." The policy further states, "The TCC is required to attempt to reach consensus on all decisions made regarding the detainees assessment. Summary notes shall be documented on the Transgender Care Committee Summary, Attachment D, for each TCC meeting to include persons attending and conclusions reached. A copy of the notes shall be retained in the detainee's institutional file and a copy forwarded to the Corporate PREA Coordinator upon completion. Transgender and intersex detainees are to be reassessed for vulnerability at least twice a year, and when operationally feasible, transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." The PSA Compliance Manager indicated there are several options available for accommodating a transgender or intersex detainee who wishes to shower alone. The detainee could shower during count times, when other detainees are locked down, or allowing the detainee to shower in the medical area. The facility had no transgender or intersex detainees at the time of the interviews. The PSA Compliance Manager confirmed their placement and program assignments would be assessed twice a year. He also provided the Auditor for review, two detainee files of previously housed detainees indicating they were transgender and the completed attachment D demonstrating review of the detainee by the TCC. Neither of these detainees were at PPIPC long enough to be seen again within six months.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "PPIPC develop and follow written procedures governing the management of its administrative restriction unit. These procedures should be developed in consultation with the ICE ERO FOD having jurisdiction for the facility. PPIPC must document detailed reasons for placement of an individual in administrative restriction on the basis of a vulnerability to sexual abuse or assault. The use of administrative restriction to protect detainees vulnerable to sexual abuse or assault shall 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 option exists, as a last resort." The policy further requires that "if PPIPC should assign detainees vulnerable to sexual abuse or assault to administrative restriction for their protection 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 during which time they shall have access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable." The interview with the Facility Administrator confirmed the above mentioned would take place if a detainee would need to be placed in administrative SHU. Interview with the Facility Administrator also confirmed the facility's written procedures governing the management of the administrative SHU were developed in consultation with the AFOD. The Facility Administrator indicated that segregation would not be used to protect any vulnerable detainee or sexual abuse victim and that alternative housing, including the use of medical beds would be utilized. The Facility Administrator also confirmed the facility has not needed to house any detainee at risk of victimization in the SHU during the audit period. However, he informed the Auditor that if the SHU was to be utilized for that purpose, it would not exceed 30 days. He also confirmed he would notify the appropriate ICE FOD no later than 72 hours after the initial placement if it was ever used for this purpose. From the Auditor's review of the investigative files, there was one allegation of sexual abuse made by a detainee while he was housed in the SHU. The Auditor interviewed this detainee who was housed in general population during the on-site audit. From the detainee's interview and review of the investigative files, the detainee was placed in SHU on March 26,2021 during an active investigation that was a non-PREA incident (improper communication with a staff member and security concerns). The facility was monitoring phone calls going to a staff member's phone from different detainee PIN accounts. An investigation found that this inmate was utilizing other PIN numbers to contact this employee. The detainee was placed in SHU for security concerns. He was questioned on his relationship with this employee, and he refused to answer any questions including if he was a victim of sexual assault. While in segregation on April 13, 2021, he made a PREA allegation. When initially questioned by the facility PREA investigator, the detainee gave no specifics about the alleged sexual abuse. Days later, he informed the Investigator that "you have the tapes" as his allegation. During that investigation, the staff member resigned. The detainee's housing in the SHU continued for investigation and disciplinary sanctions that were not PREA-related, as well as, the clinical psychologist's review which determined the detainee was not appropriate for general housing based on security risk. The detainee was returned to general housing two weeks after the allegation was made.

(d): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that states "a supervisory staff member conduct a review within 72 hours of the detainee's placement in administrative restriction to determine whether the restriction is still warranted. A supervisor must conduct, at a minimum, an identical review after the detainee has spent 7 days in administrative restriction, and every week thereafter for the first 30 days, and every 10 days thereafter. PPIPC utilizes the "DHS Sexual Assault/Abuse Available Alternatives Assessment" form Attachment G to document these assessments." The interview with the Administrative Restriction Unit Supervisor confirmed administrative restriction has not been utilized in the audit period for the purpose of protecting a vulnerable detainee. However, if it was ever used for that purpose, the reviews would be documented on the DHS Sexual Assault/Abuse Available Alternatives Assessment. The Auditor reviewed the SHU reviews for the detainee mentioned above, who was placed in SHU during an investigation unrelated to PREA, but then who made an allegation of sexual abuse while in the SHU. The detainee received his first SHU review for placement with the first 72 hours after his placement in SHU and then weekly until his release. His weekly status review was completed by a facility team comprised of medical, mental health, PSA Compliance Manager, security, classification staff and a final review by the Facility Administrator. The team reviews the reason for his placement and any effects of his placement while confined in SHU. The detainee was present for all of his reviews. There was also a weekly review completed on his status by the SDDO and that was documented as well. The Auditor reviewed the status documents for the day prior to his PREA allegation and his final conducted on 4-21-2021.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 which requires "PPIPC provide multiple ways for detainees to privately report sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. PPIPC provides contact information to detainees for relevant consular officials, the DHS OIG, and the JIC, to confidentially and if desired, anonymously, report these incidents." The Pine Prairie handbook also provides and outlines reporting options which includes for detainees to report to any staff member, any case manager, chaplain, nurse, PREA Compliance Manager, lieutenant, officer, calling the facility's 24-hour toll-free notification telephone numbers, through their family members, and the Detainee Reporting Information Line (DRIL). The PSA Compliance Manager and random staff informed the Auditor that consular office information and reporting information is provided to detainees in the orientation materials at intake and on posters throughout the facility. The Auditor observed these reporting notices throughout the facility that

detainees have access to. The 30 random detainees interviewed confirmed their knowledge of how to report sexual abuse and indicated that this information is provided upon arrival and posted in the detainee living areas. The Auditor checked the reporting line DRIL in two different housing locations and a hold room and found them operational with no need for a detainee PIN to make the call. The DRIL individual receiving the call indicated calls may be made anonymously.

(c): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires "employees accept reports made verbally, in writing, anonymously and from third parties and shall promptly document any verbal reports." The PSA Compliance Manager, Facility Investigator, and the facility's PAQ confirmed that of the six allegations reported during the audit period, one was reported through the DRIL, one was reported verbally to medical staff, one was reported verbally to mental health staff, and three were reported verbally to security staff. The Facility Investigator informed the Auditor that, in each case where the incident was reported verbally to staff, the incident was documented in writing. The PSA Compliance Manager and the facility Investigator confirmed that at PPIPC all verbal allegations are put into writing by staff. Those staff who are bilingual and speak and understand the language of the detainee making the allegation, document what the detainee has alleged. In instances where staff utilize the language line for interpretation, the staff documents the allegation through the interpreter, who is usually the PSA Compliance Manager or Investigator. During the investigative file reviews, the Auditor found written staff reports of the allegations in each of the files. The Auditor interviewed random staff who confirmed the PPIPC policy requirement and that they are to accept and immediately report all 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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 "PPIPC shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after or in lieu of lodging an informal grievance or complaint, not impose a time limit on when a detainee may submit a grievance regarding allegation of sexual abuse, implement written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. Staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment and allow a detainee to obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. The facility shall issue a decision on the grievance within 5 days of receipt and shall respond to an appeal of the grievance decision within 30 days." The Auditor interviewed the Acting Grievance Officer who confirmed the PSA Compliance Manager and Facility Administrator are immediately notified of all allegations of sexual abuse made through the grievance office. He also stated allegations of sexual abuse made in a grievance are handled through the grievance process as an emergency grievance. He further stated that any grievance alleging sexual abuse, requires the alleging detainee be taken immediately to the proper medical personnel for assessment. He also indicated all emergency grievances are responded to within 5 days of receipt and responses to an appeal of the grievance decision are responded to within 30 days. The interview with the PSA Compliance Manager confirmed that, once notified of a sexual abuse allegation through the grievance process, he notifies the AFOD of the allegation, who then notifies the FOD. The interview with the AFOD also confirmed the notification process. None of the six allegations within the audit period were made through the grievance process.

(f) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "To prepare a grievance, a Detainee may obtain assistance from another Detainee, the housing officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties." Interviews conducted with 12 random security staff confirmed their knowledge of the grievance process on reporting allegations of sexual abuse by detainees and their responsibility to take reasonable steps to expedite requests for assistance from these other parties if needed. Most of the 30 random detainee interviews confirmed their knowledge of the grievance process, and it could be used to address sexual abuse/assault. The random staff interviews confirmed their knowledge of the policy allowing the housing officer or other facility staff, family members, another detainee, or legal representatives to assist the detainee with the grievance.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "PPIPC utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to most appropriately address victim's needs." The policy further requires "PPIPC make available to detainees, information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers." PPIPC entered into a MOU with St. Landry-Evangeline Sexual Assault Center in 2019 with no sunset date. This local community victim advocacy organization provides emotional support and crisis intervention services to victims of abuse regardless of when the abuse occurred. The Auditor spoke with a representative of this center who confirmed the MOU and services the center provides. The Pine Prairie handbook details for detainees the extent to which regular mail and the regular use of the telephones are monitored. The PSA Compliance Manager confirmed that all contact with the rape crisis center as well, as the reporting of allegations to the DRIL or OIG, is confidential and unmonitored at PPIPC and does not require the use of a PIN. The Auditor verified that detainees may contact this advocate agency without entering their PIN and the line is not monitored. The Auditor interviewed one detainee who alleged sexual abuse at the facility; he indicated he was provided information about St. Landry-Evangeline. The facility reported six sexual abuse investigations during the audit period. In review of the six investigative files, the Auditor determined the alleged victims were offered victim advocacy services. The Facility Investigator confirmed that when the detainee is first taken to medical, they are provided information for the Sexual Abuse Center, by both the investigator and medical staff. The PSA Compliance Manager and Investigator interviews confirmed this as well.

§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 Auditor determined compliance with this standard based on policy 10.1.1 that requires "PPIPC post publicly GEO's third-party reporting procedures. In addition, GEO shall post on its public website its methods of receiving third-party reports of sexual abuse or assault on behalf of detainees. In all facilities, third party reporting posters shall be posted in all public areas, in English and Spanish, to include lobby, visitation, and staff break areas within the facility." The review of the ICE National Detainee handbook and the Pine Prairie handbook provide information for the reporting of sexual abuse by third parties. The Auditor's review of the ICE website, https://www.ice.gov/prea, and GEO website, https://www.geogroup.com/PREA, confirmed the websites have third-party reporting information available to the public on behalf of detainees as well. These resources are available to the public. The PSA Compliance Manager and Facility Investigator confirmed PPIPC received one allegation of sexual misconduct reported through the DRIL during the audit period. The review of investigative files also demonstrated the allegation was received from one of the third-party sources (DRIL). The random interviews with detainees indicated they were aware that reports of sexual abuse could be made on their behalf from third parties.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "all PPIPC staff to immediately report, in accordance with GEO policy, any of the following: knowledge, suspicion, or information regarding an incident of sexual abuse or assault that occurred in a facility whether or not it is a GEO facility; retaliation against detainees or employees who reported such an incident or participated in an investigation about such incident, and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation." The policy also prohibits "employees from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions." This policy was reviewed and approved by the AFOD. The 12 random security staff interviews confirmed their knowledge of the reporting requirements as outlined in policy and required by the standard. The Auditor reviewed the training curriculum for PREA pre-service and annual refresher training and found the reporting information requirements detailed as outlined by the standard. Staff interviews also confirmed their understanding of their ability to report sexual abuse incidents outside their chain of command to the Chief of Security, upper-level executives privately, the employee hotline, or the Corporate PREA Coordinator. Of the six allegations reported during the audit period, five were reported to staff: one was reported verbally to medical staff, one was reported verbally to mental health staff, and three were reported verbally to security staff. The Facility Investigator informed the Auditor that, in each case where the incident was reported verbally to staff, the incident was documented in writing. During the investigative file reviews, the Auditor found written staff reports in each of the files.

(d): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 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 person's statute shall be report[ed] to the designated State or local services agencies under applicable mandatory reporting laws." The Facility Administrator and PSA Compliance Manager confirmed that juveniles are never placed at PPIPC. They also stated within the audit period. the facility has not had a vulnerable adult placement at PPIPC. If a vulnerable adult was ever the victim of sexual abuse at PPIPC, the facility would notify the Evangeline Parish Sheriff's Department and the AFOD.

§115.62 - Protection duties.

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

Notes:

The Auditor determined compliance with the standard based on policy 10.1.1 that requires "when an employee or facility staff member has reasonable belief that a detainee is subject to substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." Random staff, the PSA Compliance Manager, and the Facility Administrator were specifically asked by the Auditor about their handling of any detainee they believed to be at substantial risk of imminent sexual abuse. All indicated the detainee's safety would be their primary concern and their initial response would be to immediately remove the detainee from the perceived danger. The Facility Administrator, PSA Compliance Manager, and the facility's PAQ confirmed PPIPC had no detainees at substantial risk of imminent sexual abuse during the audit period. In review of the six completed sexual abuse reports and investigations in the audit period, the Auditor determined the facility took immediate action to protect the detainee victims.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "in the event that a detainee alleges that sexual abuse occurred while confined at another facility, PPIPC shall document those allegations and the Facility Administrator or Assistant Facility Administrator (in the absence of the Facility Administrator) shall contact the Facility Administrator or designee where the abuse is alleged to have occurred and notify the ICE Field Office as soon as possible, but no later than 72 hours after receiving the notification. PPIPC shall maintain documentation that it has provided such notification and all actions taken regarding the incident. Copies of this documentation shall be forwarded to the PSA Compliance Manager. PPIPC is that receives notification of alleged abuse is required to ensure that the allegation is investigated in accordance with PREA standards and reported to the appropriate ICE Field Office Director." The Facility Administrator and PSA Compliance Manager indicated the facility received one allegation of sexual abuse that occurred at another facility from a detainee arriving at PPIPC. The Auditor was provided the notification sent to the Facility Administrator at the other facility, which indicated the notification was made within 72 hours of being informed of the incident. The Facility Administrator and PSA Compliance Manager also stated that PPIPC received no reports from other facilities/agencies of allegations of sexual abuse that occurred at PPIPC. They indicated that if such report was received, the allegation would be investigated as per policy.

§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 Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires "upon learning of an allegation that a detainee was sexually abused, or if the employee sees abuse, the first security staff member to respond to the incident shall separate the alleged victim

and abuser, immediately notify the on-duty security supervisor and remain on the scene until relieved by responding personnel, preserve and protect to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence, and if the sexual abuse occurred within 96 hours; and the alleged victim and abuser shall be separated to ensure that the alleged victim and abuser do not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating until the forensic examination can be performed." This policy further requires "a security staff member of the same sex shall be placed outside the area where the detainee is secured for direct observation to ensure these actions are not performed." During the review of investigative files, the Auditor confirmed that the security staff members responding to the incident appeared to have followed these required protocols. The 12 security staff interviewed detailed their first responder obligations, as outlined in policy and per the standard requirement, when responding to incidents of sexual abuse. In each of six cases where the alleged victim was responded to initially by a security staff member or immediately turned over to a security staff member, it appeared the security staff member followed policy and standard responder requirements.

(b): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "if the first 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, remain with the alleged victim, and notify security staff." Two non-security staff confirmed that if a detainee reported to them that they had been sexually abused, 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 interview with the Facility Investigator, concerning the six allegations made during the audit period, she indicated that two of the allegations were reported to two non-security staff (mental health and medical). The Auditor confirmed during the investigative file review that both staff immediately contacted the shift supervisor upon being informed of the allegation.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "PPIPC develop written facility plans to coordinate the actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to incidents of sexual abuse and assault. PPIPC shall use a coordinated, multidisciplinary team approach to responding to sexual abuse and assault to include addressing any safety, medical, or mental health needs." The PSA Compliance Manager confirmed that the 10.1.1 policy outlines the primary duties of each participant in response to any sexual abuse allegation to 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. The Auditor reviewed six closed investigative files and found that each file documented the multidisciplinary and coordinated responses taken by staff members at PPIPC in response to allegations of sexual abuse.

(c)(d) Policy 10.1.1 requires "whenever the victim of sexual abuse is transferred between DHS Immigration Detention Facilities, the sending facility shall, as permitted by law, shall inform the receiving facility of the incident and the victim's potential need for medical or social services. If the victim of sexual abuse is transferred to a non-DHS Facility, the sending facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The Facility Administrator and PSA Compliance Manager confirmed that no detainee victim has been transferred from PPIPC and if a detainee were to be transferred under these conditions, a Notification of Transfer by email would be completed to include the information of potential services needed and forwarded to the AFOD.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "when an employee, contractor and volunteer is suspected of perpetrating sexual abuse he/she shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Separation orders requiring "no contact" will be documented by facility management via email or memorandum within 24 hours of the reported allegation. The email or memorandum shall be printed and maintained as part of the related investigation file." The PSA Compliance Manager and Facility Administrator both confirmed that any employee, contractor, or volunteer who was an alleged perpetrator of sexual abuse of a detainee would be removed from any further contact with detainees pending the investigation outcome. PPIPC had two allegations of sexual abuse made against staff during the audit period. The facility provided the Auditor with documentation, signed, and dated by the Facility Administrator, indicating the staff members removal from detainee contact pending the outcome of the investigations.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that "prohibits employees, contractors and 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 activity as a result of force, coercion, threats, or fear of force." This policy further requires "PPIPC employ multiple protection measures, such as housing changes, removal of alleged staff abusers from contact with victims, and emotional support services for detainees and employees who fear retaliation for reporting sexual abuse or for cooperating with investigations." At PPIPC, the PSA Compliance Manager is the designated staff person responsible for monitoring staff and detainee retaliation. During his interview, he confirmed retaliation monitoring starts the day the allegation is made and continues for at least 90 days or longer, if needed. He indicated that he personally meets with the detainee weekly, and documents the meeting on the Protection from Retaliation Log, Attachment B. He stated that detainee monitoring includes a review of the detainee's disciplinary reports and/or housing changes or program changes. He stated that staff monitoring is done for 90 days or more, if needed. He confirmed that monitoring includes a monthly in-person meeting with staff and includes monitoring negative performance reviews, time off refusals, and change of duties or reassignment requests. The Auditor was provided documentation of retaliation monitoring and also found examples of retaliation monitoring in the six completed investigative files reviewed. In each case, retaliation monitoring was conducted for at least 90 days, except in the cases where the detainee was released from PPIPC custody, or the investigation was determined to be unfounded. The PSA Compliance Manager confirmed PPIPC has had no cases requiring staff retaliation monitoring nor any allegations of retaliation by a detainee or staff member during the audit period. Of the two allegations involving staff, one staff member resigned before the allegation was made and the other allegation was unfounded. The facility has met substantial

compliance with the documented retaliation monitoring in all six cases although the staff member (alleged abuser) was not monitored in the unfounded case.

Recommedation: The facility must conduct retailiation monitoring on staff, contractors, volunteers, and detainees who report, complains about, or participates in an investigation into an allegation of sexual abuse on all cases including unfounded cases.

§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)(d): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "PPIPC take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible subject to the requirements of 115.43. Such detainees should 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. Detainee victims shall not be held for longer than five days in any type of administrative restriction, except in unusual circumstances or at the request of the detainee." The Auditor interviewed the Administrative Restriction Unit Supervisor who indicated that segregation is never used for victims or potential victims of sexual assault unless the detainee requests it. The Facility Administrator indicated that segregation would not be used to protect any vulnerable detainee or sexual abuse victim and that alternative housing, including the use of medical beds would be utilized. He also stated that if segregation was ever used for that purpose, he would notify the FOD within 72 hours. This policy was approved by the AFOD. The PSA Compliance Manager confirmed no detainee alleging sexual abuse at PPIPC was placed in segregation during the audit period through the review of the investigative files. . From the Auditor's review of the investigative files, there was one allegation of sexual abuse made by a detainee while he was housed in the SHU. The Auditor interviewed this detainee who was housed in general population during the on-site audit. From the detainee's interview and review of the investigative files, the detainee was placed in SHU on March 26,2021 during an active investigation that was a non-PREA incident (improper communication with a staff member and security concerns). The facility was monitoring phone calls going to a staff members phone from different detainee PIN accounts. An investigation found that this inmate was utilizing other PIN numbers to contact this employee. The detainee was placed in SHU for security concerns. He was questioned on his relationship with this employee, and he refused to answer any questions including if he was a victim of sexual assault. While in segregation April 13, 2021, he made a PREA allegation. When initially questioned by the facility PREA investigator he gave no specifics about the alleged sexual abuse. Days later he informed the Investigator that "you have the tapes" as his allegation. During that investigation, the staff member resigned. After the staff member's resignation, the detainee made a PREA allegation that involved that staff member. However, the detainee's housing in the SHU continued as the assignment was for an investigation and disciplinary sanctions not PREA-related. The detainee was returned to general housing two weeks after the allegation was made.

(c): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires "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 reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." The PSA Compliance Manager confirmed if a detainee had been placed in segregation a vulnerability assessment would be completed prior to the detainee being released from restrictive housing.

§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)(b): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires "when PPIPC conducts its own investigations into allegations of sexual abuse, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. PPIPC shall use investigators who have received specialized training in these sexual abuse investigations. This policy further requires "an administrative investigation be completed for all allegations of sexual abuse at PPIPC regardless of whether a criminal investigation is completed. Coordination of the administrative investigations with the ICE Office of Professional Responsibility (OPR) should be coordinated in a way as to not interfere with the assigned criminal investigative entity criminal investigations." This policy was approved by the AFOD. The Facility Investigator stated, during her interview, that she conducts an administrative investigation on every allegation of sexual abuse, regardless of if a criminal investigation is conducted. Policy also states, "In allegations where a criminal investigation is initiated by ICE OPR, DHS OIG, or outside law enforcement, the facility shall begin an administrative investigation as soon as the criminal investigation has concluded or at such time as outside investigative entity indicates the facility may begin their administrative investigation." None of the allegations of sexual assault at PPIPC were determined to be criminal. The review of the six investigative files appeared to be completed promptly, thoroughly, and objectively and as required in subpart (a) of this standard.

(c): The Auditor determined compliance with this subpart of the standard based on the review of Policy 10.1.1-A, the Facility Investigator's interview, and the investigative files reviews. The Facility Investigator stated that her investigative protocols for administrative investigations, as stated in policy, include gathering direct and circumstantial evidence; gathering available electronic monitoring data; gathering interview notes from the alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse or assault, involving the suspected perpetrator. She confirmed that she assesses the credibility of the alleged victim, suspect, or witness based on evidence and not on the individual's status as a detainee, employee, or contractor, and never requires any detainee, who alleged sexual abuse or assault, to submit to a polygraph as a condition of the investigation. The PPIPC Investigator and the PSA Compliance Manager confirmed all investigative files are maintained for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. The review of the six investigative files appeared to follow the subpart (c) requirements.

(e): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1-A that requires, "the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation." The Facility Investigator confirmed that the departure of the alleged abuser or victim from employment or control of the facility does not affect the investigation from being completed. One investigative case reviewed confirmed the investigation continued and was completed after the staff member resigned.

(f): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1-A that requires, "when outside agencies investigate Sexual Abuse, PPIPC shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." The Facility Administrator stated that she is the point of contact for any outside investigative agency if a criminal investigation is conducted. She stated that she cooperates with the outside investigative agency by providing assistance when needed.

§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 Auditor determined compliance with the standard based on Policy 10.1.1-A that requires "facilities impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated." The interview with the Facility Investigator confirmed the standard she uses when determining a sexual abuse investigation is the preponderance of evidence. The Auditor reviewed six investigative case files. Based on the review, the Auditor determined 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 Auditor determined compliance with the standard based on Policy 10.1.1-A. that requires "at the conclusion of all investigations conducted by the facility's Investigator, the facility's Investigator or staff member designated by the Facility Administrator shall inform the detainee victim of sexual abuse in writing, whether the allegation has been substantiated, unsubstantiated, or unfounded." The policy also requires "the detainee receive the original completed Notification of Outcome of Allegation, Attachment D in a timely manner and a copy of the form shall be retained as part of the investigative file." The policy further states "the detainee be provided an updated notification at the conclusion of a criminal proceeding, if the detainee is still in custody at the facility." During the six investigative file reviews, the Auditor found these notification forms (attachment D) signed by the detainee unless the detainee had left the custody of the facility prior to the investigation being completed.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "The Agency shall review and approve facility policies and procedures regarding disciplinary or adverse actions for staff and shall ensure that the facility policy and procedures specify disciplinary or adverse actions for staff, up to and including removal from their position and from the Federal service for staff, when there is a substantiated allegation of Sexual Abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Removal from their position and from the Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in Sexual Abuse." The interviews with the Facility Administrator, HR staff person, and the PSA Compliance Manager confirmed staff removal from their position and from federal service would be the presumptive disciplinary sanction for staff having engaged in or attempted or threatened to engage in sexual abuse. There were two allegations of sexual abuse involving a staff member during the audit period. One allegation was determined to be substantiated and the second one was unsubstantiated. The staff member resigned at the onset of the investigation for the case which was determined to be substantiated.

(c)(d): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "PPIPC shall report all removals or resignations in lieu of removal for violations of Agency or facility Sexual Abuse policies to appropriate law enforcement agencies,
unless the activity was clearly not criminal. The facility shall also report all such incidents of substantiated abuse, removals or resignations in lieu of removal to the Field Office Director, 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 Facility Administrator confirmed that he is responsible for making these notifications if and when it becomes necessary. He also confirmed all allegations of sexual abuse are immediately reported to the Evangeline Parish Sheriff's Department, regardless of if the staff member resigns or not. The Auditors found notifications made to the Evangeline Parish Sheriff's Department in each of the six investigative files reviewed. There were no reported terminations of a PPIPC employee for violation of the facility's zero-tolerance policy. One staff member resigned during a non-PREA related investigation, which turned into a PREA investigation after the detainee reported a PREA allegation following the staff member's resignation. At that the time of the resignation, the case was not referred to the local Sheriff's department as the facility believed it was just a staff interaction that exceeded what was professional, and that it was non-PREA related. After the detainee's allegation of sexual abuse, the case was referred to the Sheriff's department. This case was one of the six notifications made to the Sheriff's department following allegations.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "Any contractor or volunteer who has engaged in Sexual Abuse shall be prohibited from contact with Detainees. PPIPC shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated Sexual Abuse by a Contractor or Volunteer. Such incidents shall also be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall also report all such incidents of substantiated abuse by a contractor or volunteer to the Field Office Director, 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. PPIPC 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 but have violated other provisions within these standards." The Facility Administrator confirmed that any contractor and volunteer suspected of perpetrating sexual abuse would be removed from all duties requiring detainee contact pending the outcome of the investigation. He also stated he would take appropriate remedial measures and consider whether to prohibit further contact with detainees by any contractor or volunteer who has not engaged in sexual abuse but has violated other provisions within these standards. He also confirmed there were no reported incidents requiring the removal of a contractor or volunteer during the audit period, however, if there were, the incidents would be reported to law enforcement, the FOD, 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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "the facility subject a detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse. At all steps in the disciplinary process any sanctions imposed shall be commensurate with the severity of the committed prohibited act

and intended to encourage the detainee to conform with rules and regulations in the future. This policy further requires, "the facility have a detainee 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. The facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, 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 sufficient to substantiate the allegation." The interviews with the Facility Administrator and PSA Compliance Manager confirmed that the disciplinary process at PPIPC allows for progressive levels of reviews, appeals, procedures, and that the entire hearing is documented. They also confirmed that staff assistance is provided upon any detainee request. There were four allegations of detainee-on-detainee sexual abuse, with three determined to be unsubstantiated and one substantiated during the audit period. According to the PSA Compliance Manager, the one PPIPC detainee was disciplined for violating the facility's zero-tolerance policy after being evaluated by mental health. The interview with one of the hearing officers indicated he reviews any PREA cases with the PSA Compliance Manager and Mental Health staff prior to any hearing.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "if during the intake assessment, persons tasked with screening determine that a detainee is at risk for either sexual victimization or abusiveness, or if the detainee has experienced prior victimization or perpetrated sexual abuse, the detainee shall be referred to a qualified medical and/or mental health practitioner for medical and/or mental health follow-up as appropriate." This policy further requires "when a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than 2 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 interviews with the HSA and Mental Health Administrator confirmed that any detainee disclosing prior victimization, during the intake assessment, would be seen by medical staff within 24 hours and a mental health practitioner within 72 hours. The Auditors interviewed two detainees who reported prior victimization, and each detainee indicated that they were offered medical/mental health services during their intake at PPIPC but declined the service.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "victims of sexual abuse in custody shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by medical and mental health practitioners. This access includes offering timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The Auditor reviewed six investigative files completed during the audit period. The review of the investigative files confirmed that each of the six alleged victims was immediately brought to the medical unit and evaluated by medical staff and/or mental health. The interview with the HSA confirmed that all detainees alleging sexual abuse are seen by medical and/or mental health staff and provided with services that are consistent with community standards, and at no cost to the detainee regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor also reviewed each of the alleged victim's medical files and found medical entries made the day of the allegation. The Auditor had the opportunity to interview a detainee who alleged sexual abuse during the on-site visit. He indicated that he was seen by medical on the day he made the allegation. His was one of the six investigative files and medical records that were reviewed by the Auditor.

§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 Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "PPIPC offer medical and mental health evaluations (and treatment where appropriate) to all victims of sexual abuse while in immigration detention. The evaluation and treatment should include 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." This policy further states these "services shall be provided in a manner that is consistent with the level of care the individual would receive in the community." Another section of the policy states, "Victims of Sexual Abuse in custody shall receive timely, unimpeded, access to emergency medical treatment and crisis intervention services as directed by Medical and Mental Health Practitioners. This access includes offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The interview with the HSA confirmed PPIPC medical and mental health services are consistent with the community level of care and the treatment provided to the victim would be at no cost, regardless of if the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor reviewed six investigative files which reflected that detainee's alleging sexual abuse were seen by medical and mental health staff upon reporting the allegation. Of the six files reviewed there were some detainees, who alleged sexual abuse that were already on the mental health review and services. The services continued after the investigation closed. The Auditor interviewed a detainee during the on-site visit, who had reported sexual abuse. He indicated he was never charged for any services provided related to the allegation.

(d): The PAQ and interview with the Facility Administrator indicated there are no females at PPIPC. Therefore, this subpart is not applicable.

(e): The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "victims of sexual abuse shall be offered tests for sexually transmitted infections as medically appropriate." The interview with the HSA confirmed that victims of sexual abuse requiring medication would normally have it administered at St. Francis Cabrini Hospital, with continuation at the facility. He indicated that the facility has had no need for this type of medication or the need to offer tests for sexually transmitted infections during the audit period. The review of the investigative files confirmed that none of the allegations were such that required the need for tests for sexually transmitted infections or medications.

(g): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "PPIPC attempt to conduct a mental health evaluation on all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by mental health practitioners". This same policy defines "Known abusers as those abusers in which SAAPI investigation determined either administratively substantiated or substantiated by outside law enforcement." The facility had one detainee-on-detainee substantiated allegation during the audit period requiring this type of evaluation. The HSA confirmed all known abusers would be offered evaluation and treatment. The one substantiated detainee-on-detainee allegation resulted in the offering of mental health services to the abuser according to the HSA and review of the file.

§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)(b): The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "PPIPC conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation. Such review shall occur within 30 days of the conclusion of the investigation and the review team shall consist of upper-level management officials, the local PSA Compliance Manager, medical and mental health practitioners and the Corporate PREA Coordinator, if available." The interview with the PSA Compliance Manager indicated the review team considers race; ethnicity; gender identity; LGBTI 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. He also stated that this incident review has to be completed on the DHS Sexual Abuse or Assault Incident Review form, Attachment J, after examining the elements of subpart (b) of this standard. The PSA Compliance Manager advised the Auditor the completed incident review reports and responses are forwarded to the FOD for distribution to the agency PREA Coordinator per the standards requirement. The Auditor reviewed six investigative files and found an incident review form in each file, conducted within 30 days of the investigation being completed. There were no recommendations for improvement made in any of these completed incident reviews.

(c) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "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 documented utilizing the DHS Annual Review of Sexual Abuse Incidents, Attachment K, and provided to the Facility Administrator, FOD or his/her designee, and Corporate PREA Coordinator upon completion." The PSA Compliance Manager provided the Auditor with the annual review completed in October 2020 and indicated that it was distributed to the Facility Administrator, FOD, and Corporate PREA Coordinator. The annual review was addressed to the ICE FOD.

§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 Auditor determined compliance with the standard based on policy 10.1.1 that requires, "PPIPC maintain in a secure area, all case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary, and/or counseling in accordance with the PREA standards and applicable agency policies and established schedules." The PSA Compliance Manager confirmed that data collected for any investigation of sexual abuse is securely maintained in his office under double lock and key, with access restricted to only staff with a need to review. He indicated the records are retained for at least ten years, after the date of the initial collection, unless federal, state, or local law requires otherwise. The Auditor viewed this secure location during the site visit.

§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 Auditor was allowed access to the entire facility and able to interview staff and detainees about sexual safety during the on-site visit.
(e) The Auditor was 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 Auditor 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:	1
Number of standards met:	35
Number of standards not met:	4
Number of standards N/A:	1
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 9/8/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/8/2021

PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/8/2021

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:**	772-201-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	New Orleans
Field Office Director:	John Hartnett
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1250 Poydras Street Suite 325 New Orleans, Louisiana 70113
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Pine Prairie ICE Processing Center (PPIPC)		
Physical address:	1133 Hampton Dupre Road, Pine Prairie La. 70576		
Mailing address: *(if different from above)*	PO Box 650 Pine Prairie, LA 70576		
Telephone number:	337-599-2198		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	1-337-599-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-446-(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 Pine Prairie ICE Processing Center (PPIPC) was conducted on July 13-14, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt, a contractor with 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 PPIPC is privately owned by GEO Group and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains adult males who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities detained at PPIPC are from Cameroon, Cuban, and Guatemala. This was the second PREA audit for PPIPC. The facility is located in Pine Prairie, Louisiana.

During the audit, the Auditor found PPIPC met 35 standards, had one standard (115.31) that exceeded, one standard (115.14) that was non-applicable, and four non-compliant standards (115.11, 115.13, 115.15, and 115.17). 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.

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.

§115.11 - 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:

(d): The facility has a designated PSA Compliance Manager to oversee the facility's compliance efforts with the implementation of PREA. Policy 10.1.1 states "the PSA Compliance Manager will assist in ensuring facility compliance with sexual abuse and assault prevention and intervention policies and procedures and serve as the facility point of contact for the DHS PSA Coordinator and Corporate PREA Coordinator." The PSA Compliance Manager confirmed he serves as the facility's point of contact for the ICE PSA Coordinator. After interviews with detainees, GEO staff, and ICE staff, the Auditor has determined that the PSA Compliance Manager does not have sufficient time and authority to comply with the facility's sexual abuse and assault prevention and intervention policies and procedures. Random detainee interviews confirmed that they were not aware of whom the PSA Compliance Manager was and did indicate that his name was noted on the DHS posters on each of their housing units but were unable to identify him. Some of the random line staff interviews indicated that the PSA Compliance Manager was not as prominent within the facility population as he used to be. Prior to the Auditors' on-site arrival, the PSA Compliance Manager was asked specifically for a couple documents. The Auditor was not provided the documents as requested and asked the PSA Compliance Manager about them. He answered, 'he didn't have time" to collect the requested documents. The Auditor spoke with the PSA Compliance Manager, who indicated that since COVID staff reductions at PPIPC and South Louisiana ICE Processing Center, he and other key positions at PPIPC are being shared between both facilities, meaning he is not assigned to PPIPC on a full-time basis. The PSA Compliance Manager indicated he reports directly to the Facility Administrator on all matters related to PREA. The Facility Administrator also confirmed the PSA Compliance Manager reports directly to him on all PREA related matters. The PPIPC organizational chart indicates the PSA Compliance Manager reports directly to the Facility Administrator.

DOES NOT MEET: The Auditor has determined the PSA Compliance Manager does not have the required time to perform all his PREA related duties at PPIPC. The PSA Compliance Manager must have sufficient time and authority to oversee the facility's efforts to comply with facility sexual abuse prevention and intervention policies and procedures in accordance with subpart (d) of the standard. The facility must develop a plan to ensure the PSA Compliance Manager has sufficient time to perform all the PREA related duties at the facility. The plan must be submitted for compliance review.

CORRECTIVE ACTION TAKEN: During the CAP period, the facility provided documentation, including the staffing plan, demonstrating the PREA PSA Compliance Manager position. The Auditor again interviewed the PSA Manager. He indicated that during his original interview, he was providing PREA service at PPIPC and another close facility, as well as unrelated PREA duties at both locations. He stated that at that time of his initial interview, he felt he did not have enough time to appropriately handle his PREA responsibilities. He further stated that although he was still performing PREA related duties at both facilities, the Warden had removed some of the additional unrelated PREA responsibilities, allowing him enough time to effectively oversee PREA. He also stated if the population increased at the other facility, that facility would hire their own PSA Compliance Manager. Based on the documentation provided as part of the staffing plan, should the ADP at the other facility rise above 700, a PSA Compliance Manager and PSA Investigator will be hired as full-time employees at the facility. Based on the supplied documentation and interview the Auditor believes PPIPC complies in all material ways with subpart (d) of the standard.

§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) During the second day of the on-site visit, the Auditor was approached by the ICE Contracting Officer Representative (COR), who indicated that he was advised by the ICE Detention Standards Monitor Service Manager (DSM), who accompanied the Auditor on the first day of the tour, that extra staff had been placed around the facility during the tour to include new recruits. The Auditor then placed a call and spoke with the AFOD who stated that the DSM had on numerous occasions, since COVID, documented staff shortages in his weekly Compliance Reports. The Auditor reviewed 10 copies of these Compliance Reports. In three of these reports (2/5/21, 5/2/21, and 6/25/21), the DSM reported he observed and documented housing units at Pine Prairie without sufficient security staff coverage or cameras to provide the required supervision. One of the reports also documented high security detainees moving about the facility population comingling with low security detainees without the required security escorts. Based on staff interviews and submitted documentation, the Auditor has determined the facility did not meet the requirements of subpart (a) of the standard, requiring each facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. They also failed to comply with subpart (b) by failing to provide to the Auditor documentation of the comprehensive supervision guidelines for the Auditor to review. Each facility must develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs. The facility must provide a staffing plan to demonstrate the sufficient staffing levels to ensure supervision to protect detainees against sexual abuse. The plan must address how the facility will maintain sufficient supervision coverage during staff shortages. The plan must be submitted for compliance review along with staffing rosters from dates selected by the Auditor.

DOES NOT MEET (a): Based on staff interviews and submitted documentation, the Auditor has determined the facility is not meeting the requirements of subpart (a) of the standard. Each facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The facility must provide a staffing plan to demonstrate the sufficient staffing levels to ensure supervision to protect detainees against sexual abuse. The plan must address how the facility will maintain sufficient supervision coverage during staff shortages. The plan must be submitted for compliance review along with staffing rosters from dates selected by the Auditor.

DOES NOT MEET (b): The facility did not provide documentation of the comprehensive supervision guidelines for the Auditor to review. Each facility must develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and review these guidelines at least annually. The facility must provide the comprehensive supervision guidelines with the annual review for compliance review.

CORRECTIVE ACTION TAKEN: During the CAP, the Auditor was provided and reviewed the current contract/extension for staff between the facility and ICE; the staffing plan for PPIPC; the collective bargaining agreement between the Corporation and the Security Police and Fire Professionals of America (SPFPA) (Union representing staff at PPIPC); post orders and randomly selected rosters. The collective bargaining agreement outlines the staffing requirements of the facility and is approved by ICE. Random staffing rosters chosen demonstrated appropriate post coverage. Based on review of the documentation provided, the Auditor believes the facility is providing sufficient supervision of detainees to protect detainees against sexual abuse, through appropriate staffing levels and, where applicable, video monitoring. Exhibit three provided to the Auditor prior to the site visit included an annual staffing review conducted at PPIPC for 2019 and not 2020. The Auditor was provided a copy of the 2020 completed annual review dated September 2020 demonstrating the facility reviewed each of the subpart (c) requirements in determining adequate levels of detainee supervision. PPIPC complies in all material ways with the subparts (a)(b) and the standard.

§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:

(g): Policy 10.1. requires "PPIPC implement policies and procedures which allow detainees to shower, change clothes, and perform bodily functions without employees of the opposite gender viewing them, absent exigent circumstances or instances when the viewing is incidental to routine cell checks or otherwise appropriate in connection with a medical examination or monitored bowel movement. Employees of the opposite gender shall announce their presence when entering housing units or any areas where detainees are likely to be showering, performing bodily functions, or changing clothes." Signs at the entrance of each housing unit remind cross gender staff to announce themselves prior to entering. PREA announcements are to be documented in the housing unit log. Female staff confirmed the facility's requirement to announce their presence every time they enter an area where detainees may be showering, changing clothes, and performing bodily functions. While touring the facility, the Auditor observed female staff announcing their presence when entering detainee housing units. The Auditor interviewed random detainees and the majority confirmed staff of the opposite gender announce themselves prior to entering their living areas or areas where they may be showering and/or performing bodily functions. However, policy, as written, conflicts with the privacy requirement of the standards as "a monitored bowel movement" is not an acceptable exception for cross-gender viewing and the policy does not detail how supervision of monitored bowel movements are conducted under medical supervision, other facility staff, or same gender staff. The staff interviews could not provide how the supervision of bowel movements were conducted to ensure privacy requirements are met and confirm they were completed by medical staff or the same gender staff.

DOES NOT MEET (g): The policy as written includes an exception to cross-gender viewing to include monitored bowel movements. During interviews with medical and facility staff they could not provide how privacy requirements are met during the supervision of bowel movements and which staff would conduct the supervision. The Auditor was unable to confirm the supervision of bowel movements are completed by medical staff or a same gender staff member. The facility must clarify the exception of exigent circumstance to include monitored bowel movement to meet the privacy requirements. The facility must update the policy and/or provide procedural directive to staff, delineating that a monitored bowel movement is to be conducted under medical supervision in accordance with the standard requirement. The facility must provide the updated policy and/or procedural directive and documented staff training on the updated policy and/or procedural directive for compliance review.

CORRECTIVE ACTION TAKEN: During the CAP, the Auditor was provided the updated and approved PPIPC Policy 10.1.1 (effective 09/17/2001) indicating "a monitored bowel movement is to be conducted under medical supervision." The Auditor was also provided random training certification documenting staff had been trained on the policy change. Based on the provided documentation, the Auditor believes PPIPC complies in all material ways with the subpart (g) of this standard.

§115.17 - Hiring and promotion decisions
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(e)(f): The Human Resource staff stated, during the initial hiring, that GEO Corporate uses Career Builder to do a basic review on the candidate; however, they rely on the ICE background check and review for employment eligibility. Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731 and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive, and GEO policy 10.1 require "the facility and agency, to the extent permitted by law, to refuse 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 been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard." The documents require all new hires, staff awaiting promotions, and all staff on an annual basis to complete and submit a self-declaration form indicating he/she has not engaged in any prohibited conduct. The individual will respond directly to questions about previous misconduct, as required per the standard and, as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The Assistant Deputy Division Director 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 the application. The Human Resources Manager (HRM) at PPIPC confirmed that background checks are conducted on all applicants, staff, contractors, and volunteers. She also stated employees on an annual basis, during their evaluations, acknowledge by signature that they have not engaged in any activity prohibited by policy 10.1.1. She confirmed 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 that this information is provided through GEO Corporate. She stated the facility would request information from prior institutions, where the prospective candidate was previously employed, and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire. The Auditor was provided and reviewed the documentation (self-declaration form indicating he/she has not engaged in any prohibited conduct and a completed background check) completed prior to a promotion. During the 13 employee (ten during the contingency phase and three on-site) and contractor staff file reviews, the Auditor found two contractor files that did not contain the PREA Annual Disclosure form as required by policy and standard. When the PSA Compliance Manager learned that these two individuals had not signed these annual review declarations, the PSA Compliance Manager immediately found these individuals and had them sign the form. He indicated that he would update the policy to ensure that contractors sign the PREA Annual Disclosure document annually at the PREA training.

DOES NOT MEET (b): The contractor staff in the commissary were not completing the PREA Annual Disclosure form acknowledging by signature they have not engaged in any activity prohibited by policy 10.1.1. PPIPC must develop a process to ensure that the PREA Annual Disclosure form is completed for contractors in accordance with facility policy and the standards requirement. The facility must submit the process for compliance review along with documented training of appropriate staff that will oversee the process.

CORRECTIVE ACTION TAKEN: During the CAP, the Auditor was informed that staff in the commissary are contractors and not PPIPC employees. After the Auditor's follow-up interview with the PSACM, and further research into the commissary employees' status, it was determined that the commissary employees are not employed by the facility and are employees of the entity providing contract commissary services to the facility and do not have contact with ICE detainees. Based on this information and advisement by the Creative Corrections PM, APM, ICE Agency PSAC and the ERAU Unit Chief, the Auditor agrees that the requirement for annual disclosure in §115.17 (b) does not extend to these Keefe contract employees. The facility complies in all material ways with subpart (b) of this standard.

§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 3, 2022*
Auditor's Signature & Date

(b) (6), (b) (7)(C) *January 4, 2022*
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) *January 4, 2022*
Program Manager's Signature & Date