PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	6/22/2021	**To:**	6/23/2021
AUDITOR INFORMATION			
Name of auditor:	Margaret L. Capel	**Organization:**	Creative Corrections LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	New Orleans		
Field Office Director:	Diane L. Witte		
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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	LaSalle ICE Processing Center		
Physical address:	830 Pinehill Road, Jena, LA 71342		
Mailing address: (if different from above)	P.O. Box 2826, Jena, LA 71342		
Telephone number:	318-992-7800		
Facility type:	D-IGSA		
PREA Incorporation Date:	6/18/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6)	**Telephone number:**	318-992-(b) (6), (b
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Compliance Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(318) 992-(b) (6), (b
ICE HQ USE ONLY			
Form Key:	29		
Revision Date:	02/24/2020		
Notes:	Click or tap here to enter text.		

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the LaSalle ICE Processing Center (LIPC) was conducted June 22 -23, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Margaret Capel and (b) (6), (b) (7)(C) for Creative Corrections, LLC. This is the second DHS Immigration Customs Enforcement (ICE) PREA audit of the facility. The Lead Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (b) (6), (b) (7)(C) and Assistant ICE 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 External Review and Analysis Unit (ERAU) during the audit report review process. The facility's last PREA audit was conducted August 22-24, 2017. LIPC is operated by GEO Corporation.

The ICE PREA audit was originally scheduled for June 2020 and was postponed due to the health pandemic. The audit was changed to a contingency audit. The audit review period became June 2019 to June 22, 2021. ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g., a health pandemic. The process was divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. Approximately four weeks prior to the contingency audit phase, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation was 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 LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program. During the Pre-Audit phase, the Auditors completed a review of submitted documentation to include policies, detainee detention files, and personnel files for staff, contractors, and volunteers, and investigative files. The pre-audit documentation review was completed prior to the Remote Interview Phase. The second phase, Remote Interviews, consists of interviews with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers. Prior to Phase Two of the audit, the facility provided rosters for staff, volunteers, contractors, medical and mental health staff, and detainees, as well as, listing of detainees and staff in specialized categories. From these rosters, the Auditors selected the staff, contractors, volunteers, and detainees to be interviewed. There were several changes to the detainee interview selections due to medical restrictions and detainee transfers.

The PAQ stated the design capacity of the facility is 1,328 with an average daily population of 1,204. At the time of the Remote Interview phase, the facility's count was 445 (males 324; females 121). The average time in custody is 57 days. The top three nationalities of the detainee population at the time of the Remote Interview phase were reported as Mexican, Guatemalan, and Honduran.

The Lead Auditor was responsible for conducting the staff, contractor, and volunteer interviews. The Second Auditor was responsible for conducting the detainee interviews and assisted with interviewing four staff. Interviews were conducted utilizing WebEx technology, and interpretive services (when needed). The Second Auditor completed 27 detainee interviews, which included 14 randomly selected detainees, 9 detainees with limited English proficiency (LEP), one disabled detainee, and 3 detainees who reported a history of prior sexual abuse. There were no detainee victims or transgender or intersex detainees at the facility at the time of the Remote Interviews. The second Auditor also interviewed the Human Resource Manager, a Captain, and Sergeants (2). The Lead Auditor interviewed the Facility Administrator, PSA Compliance Manager, Training Supervisor, Grievance Coordinator, Facility Investigator, classification staff (2), an intake officer, a contract employee, a volunteer, medical/mental health staff (3), first responders (2), first line detention supervisors (4), and detention officers (24). The Remote Interview phase was completed on September 15-17, 2020.

The third phase, the On-site audit visit, was scheduled when it was deemed the environment was 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 was contingent upon the on-site review of observations of facility's operational practices during the facility tour, any additional documentation review, and interviews of staff and detainees to determine all subparts of the standard were appropriately handled per the standard's requirement and upon the Auditors' review of notes and information gathered during the Pre-audit documentation review and the Remote Interview phases of the contingency audit process. Prior to the Phase Three, the On-site audit, the Auditor requested updated facility information and received additional documentation from the ERAU Team Lead and facility staff. The on-site visit was conducted from June 22-23, 2021, and consisted of a facility tour, interviews of staff and detainees, and review of follow-up documentation.

The facility had 12 allegations during the audit period. The Lead Auditor reviewed nine of these investigations, (one open; eight closed) from the audit period of June 2019 to September 17, 2020, during the Pre-Audit documentation review phase and three during the on-site visit (one closed and two open) which occurred between the Pre-Audit phase and the on-site visit. Open cases were reviewed for operational process only. The three open investigations consisted of one staff-on-detainee and two detainee-on-detainee. Of the nine closed investigations reviewed, one staff-on-detainee allegation could not be completed because the facility had received a report from another facility of a possible sexual abuse incident at the LaSalle facility but the only information the reporting facility provided was a first name and no other identifying information; the reporting facility did not have an abuser name or dates of the incident. Due to the limited information, the facility was unable to identify the detainee, so an investigation was not completed, and the case was closed. Of the remaining eight closed investigations, seven allegations involved detainee-on-detainee reported abuse and one allegation of staff-on-detainee reported abuse. The detainee-on detainee investigation outcomes were all unsubstantiated and the staff-on detainee investigation outcome was determined unfounded. The facility conducted administrative investigations for each of the allegations. Nine allegations were referred to the Jena Police Department as the facility deemed them to involve potentially criminal behavior. The Jena Police Department conducted seven investigations and declined to conduct two investigations that did not potentially pose criminal acts.

The Team Lead, (b) (6), (b) (7)(C) with ICE Office of Professional Responsibility (OPR) ERAU, was unable to be at the facility but coordinated and initiated an entrance briefing through a conference call prior to the start of the on-site phase of the audit. Attending the entrance briefing were:

- (b) (6), (b) (7)(C) Team Lead, Inspection and Compliance Specialist, ICE/OPR/ERAU (remote through conference call)
- (b) (6), (b) (7)(C) Assistant Field Office Director (AFOD), ICE
- Margaret L. Capel, Lead PREA Auditor, Creative Corrections LLC
- (b) (6), (b) (7)(C) PREA Auditor, Creative Corrections, LLC
- (b) (6), (b) (7)(C) Facility Administrator, GEO

- (b) (6), (b) (7)(C) Assistant Facility Administrator (AFA), GEO
- (b) (6), (b) (7)(C) Detention Service Compliance Officer (DSCO), ICE
- (b) (6), (b) (7)(C) PSA Compliance Manager, GEO
- (b) (6), (b) (7)(C) Compliance Administrator, GEO
- (b) (6), (b) (7)(C) PREA Investigator, GEO

The Team Lead explained the three phases of the contingency audit process. The Lead Auditor confirmed that no detainees had requested to speak with the Auditors and asked to be notified if a detainee requests to speak to an auditor. She asked if there were any issues that the Auditors needed to be aware of prior to the facility tour. The Facility Administrator explained, there were several housing areas on "cohort" status, which means the detainee was newly received or had possibly been exposed to COVID-19, and although we would not enter these housing areas the Auditors would be able to view most of these housing areas from the large windows. The Lead Auditor explained the audit team would return to the conference room following the tour to discuss their observations and any issues noted from the tour. The Auditor asked to be informed if a new detainee arrives as one of the Auditors will be observing the intake process.

The Auditors toured all areas of the facility accessible to detainees, except for housing areas designated as cohort: Owl Alpha, Owl Charlie, Falcon Bravo, Eagle and Alpha, Eagle Delta. The Auditors were able to view into these housing areas but did not enter. The visitation area had PREA reporting information and PREA posters were displayed. Central control is responsible for monitoring doors and cameras, among other duties. The Auditor viewed camera footage with no PREA concerns noted, except for the suicide precaution cells in the medical area. The facility had blackened a small area at the toilet area for privacy, but it was not wide enough to provide privacy to female detainees. The Facility Administrator had the blackened areas widened and the Auditors determined the cameras provided the needed privacy. The Auditors toured the courtroom, with no issues noted. In two of the housing areas, unannounced rounds by supervisors were conducted at the same time for four days. The Lead Auditor discussed this concern with the Facility Administrator. He was surprised because he has placed such a strong emphasis on the importance of conducting unannounced rounds on an irregular basis. The Auditor and Facility Administrator reinspected logs in several randomly chosen housing areas and found that each area checked had irregular rounds conducted each shift. The Auditor agreed that with two exceptions unannounced rounds were conducted properly. While in intake, the Auditors noted that the camera and monitor for the holding cells in intake were disabled. The Auditor asked to see documentation that security checks are conducted frequently. The facility provided the documentation which reflected security checks were conducted at a minimum every fifteen minutes, which is satisfactory. While visiting one housing unit, a detainee showed the Auditors the tablet provided to detainees. The tablet is available in three languages: Spanish, French, and English. The tablet also provides the PREA video. There were blind spots noted in the barber shops, two storeroom coolers, one freezer, and laundry. The Facility Administrator provided the Lead Auditor with copies of a purchase receipt for security mirrors for those areas. Once installed, facility staff provided the Lead Auditor with photographs of each area showing where each mirror was installed that eliminated the blind spots. Detainee bathroom doors were unlocked in the laundry and kitchen areas. Although not required, it is recommended these doors remain locked and detainees request access. During the tour the Auditor called Wellsprings Alliance through the detainee phone system. Although Wellsprings stated they would talk with a detainee caller, they stated they would not report an allegation if requested. The facility does not have an MOU with Wellsprings Alliance. The Auditor tried to contact RAIN. The call was able to go through without requiring a pin number or other identifying information. The person answering the call told the Auditor to call back at another time and discontinued the call. The Lead Auditor made a second attempt to make an anonymous report to one of the posted sources. All calls went through without requiring the detainee to provide identifying information, but the DRIL operator stated they would not take a report of sexual abuse unless the caller provided their A number. The Auditor tried the OIG and JIC numbers and both operators stated they would take a report of sexual abuse without providing identifying information. The operators for both OIG and JIC were responsive, concerned, and professional. The Auditor then called the line designated by GEO to take anonymous reports and RAIN. Both the GEO number and RAIN referred the Auditor to the same regional/state program. This program stated they would not take calls related to sexual abuse or sexual assault as they only deal with domestic violence. The facility has multiple ways of reporting to include anonymous reporting through OIG and JIC, but the agency requires DRIL to accept anonymous reports, so this is noted in the appropriate standard.

While on-site the Auditors interviewed two detainees (transgender and detainee victim) and conducted several informal discussions with staff to include medical and mental health staff, the PSA Compliance Administrator, Facility Administrator, Assistant Facility Administrator, the new facility PREA investigator, intake staff, maintenance staff, Classification Supervisor, and several security staff. The Auditors also reviewed two detainee files and four investigations.

On Wednesday, June 23, 2021, an exit briefing was conducted at the LaSalle ICE Processing Center. In attendance were:

- (b) (6), (b) (7)(C) Team Lead, Inspection and Compliance Specialist, ICE/OPR/ERAU (remote through conference call)
- (b) (6), (b) (7)(C), AFOD, ICE
- Margaret L. Capel, Lead PREA Auditor, Creative Corrections, LLC
- (b) (6), (b) (7)(C) PREA Auditor, Creative Corrections, LLC
- (b) (6), (b) (7)(C) PREA Manager, GEO Corporate
- (b) (6), (b) (7)(C) Facility Administrator, GEO
- (b) (6), (b) (7)(C) AFA, GEO
- (b) (6), (b) (7)(C) DSCO, ICE
- (b) (6), (b) (7)(C) PSA Compliance Manager, GEO
- (b) (6), (b) (7)(C) Compliance Administrator, GEO
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO)
- (b) (6), (b) (7)(C) SDDO

The Team Lead explained the post audit process and that she would be submitting a final determination report to ICE. She explained the Auditors will be requesting additional information after further review of the facility tour notes, documentation review, and interviews. The Lead Auditor reported all staff were professional and responsive and knowledgeable about their duties. It was clear to the Auditors that the facility is very responsive to any concerns related to PREA and it is apparent PREA is a priority at this facility. Both Auditors thanked the facility staff for their cooperation and hospitality. The Team Lead concluded the exit briefing.

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.

Meets the Standard: 35
§115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 - Detainee supervision and monitoring
§115.15 - Limits to cross-gender viewing and searches
§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 - Hiring and promotion decisions
§115.21 - Evidence protocols and forensic medical examinations
§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 - Staff training
§115.32 - Other training
§115.33 - Detainee education
§115.34 - Specialized training: Investigations
§115.35 - Specialized training: Medical and mental health care
§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 - Report 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
§115.76 - Disciplinary sanctions for staff
§115.77 - Corrective action for contractors and volunteers
§115.78 - Disciplinary sanctions for detainees
§115.81 - Medical and mental health assessment; 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
§115.87 - Data collection
§115.201 Scope of audits

Not Applicable: 2
§115.14 - Juvenile and family detainees
§115.18 - Upgrades to facilities and technologies

Does not meet: 4
§115.41 - Assessment for risk of victimization and abusiveness
§115.42 - Use of assessment information
§115.73 - Reporting to detainees
§115.86 - Sexual abuse incident reviews

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program

(c): LIPC has a written policy mandating zero tolerance toward all forms of sexual abuse, policy 10.1.1 states, "LIPC maintains a zero-tolerance policy for all forms of sexual abuse or assault. Where any requirements of the DHS PREA Standards may conflict with PBNDS 2016, the DHS Sexual Abuse and Assault Prevention and Intervention Standards [SAAPI] shall supersede. The Agency (i.e., ICE ERO Local Field Office) shall review and approve LIPC's written policy and any subsequent changes. It is the policy of the LIPC to provide a safe and secure environment for all detainees, employees, contractors, and volunteers, free from the threat of sexual abuse or assault, by maintaining a Sexual Abuse and Assault Prevention and Intervention Program that ensures effective procedures for preventing, detecting, reporting, responding to, investigating, and tracking incidents or allegations of sexual abuse or assault. LIPC uses a coordinated approach to responding to sexual abuse, which includes security, Immigration Health Service Corp (IHSC) for medical and mental health services, an investigator as well as representatives from outside entities that provide relevant services and expertise." The facility's policy were approved by the agency on July 7, 2020.

(d): Policy 10.1.1 states, "Each Facility Administrator shall designate a local PSA Compliance Manager for each U.S. Corrections and Detention Immigration Facility who shall serve as the facility point of contact for the DHS PSA Coordinator and Corporate PREA Coordinator. The PSA Compliance Manager's duties include gathering facility statistics and reports on incidents of sexual activity, and sexual abuse and assault; assist with development/revision of any site specific SAAPI policies; assist with SAAPI training initiatives; assist with PREA facility assessments; prepare an annual report on findings and corrective actions for the facility; and monitoring for retaliation. The policy also noted that this may be a collateral duty position unless a full-time position is authorized by contract." The facility's PREA responsibilities and ensuring compliance are also coordinated by the GEO Corporate PREA Coordinator. Policy 10.1.1 further states, "GEO shall designate a PREA Coordinator, at the corporate level with sufficient time and authority to develop, implement, and oversee the Company's efforts to comply with the PREA standards and all that is required. The PREA Coordinator duties include PREA oversight for U.S. Corrections and Detention, Reentry Services and Youth; developing the corporate SAAPI policy to comply with standard requirements; work with compliance on the refinement of the SAAPI audit tool; work with facilities if an incident occurs; compile annual reports on findings and corrective actions for the company; and develop and implement best practices in training, identification, treatment, and reporting." The PSA Compliance Manager confirmed she is the facility's point of contact for ICE staff regarding PREA matters and for the Corporate PREA Coordinator. She reports to the Compliance Administrator, who reports to the Facility Administrator. She was recently promoted from Grievance Coordinator/Investigator to PSA Compliance Manager and has temporarily continued the responsibilities of each role, until the Grievance Coordinator/Investigator position is filled. The facility has also hired an additional investigator/grievance officer who now works directly for the Compliance Administrator. The PSA Compliance Manager now reports to the Facility Administrator. The population of the facility has dramatically decreased since the beginning of the pandemic. At this time, she feels she has sufficient time to assume each of these roles.

The facility meets the requirements of this 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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program Exhibit 1 – Roster of ICE Employees
- Exhibit 2 – Post Orders
- Exhibit 3 – Annual Assessment
- Exhibit 4 – Unannounced Supervisory Rounds
- PREA investigations
- Facility Schematic

(a)(b)(c): Policy 10.1.1 states, "LIPC 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 and assault. LIPC shall develop and document comprehensive detainee supervision guidelines to determine and meet the detainee supervision needs; and shall review those guidelines at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, LIPC shall take into consideration generally accepted detention and correctional practices; any judicial findings of inadequacy; the physical layout of each facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the findings and recommendations of sexual abuse incident review reports; any other relevant factors, including but not limited to the length of time detainees spend in facility custody. The Annual PREA Facility Assessment shall be completed and submitted to the local PSA Compliance Manager and Corporate PREA Coordinator annually as determined by GEO's U.S. Corrections and Detention division. GEO's U.S. Corrections and Detention Division, in consultation with the Corporate PREA Coordinator, shall review all LIPC Facility assessments and take appropriate actions necessary to protect Detainees from Sexual Abuse at LIPC. All findings and corrective actions taken shall be documented by the Corporate PREA Coordinator."

The Facility Administrator and PSA Compliance Manager reported during interviews that the facility maintains sufficient supervision of detainees by maintaining the staffing levels required by the contract and utilizing video monitoring. Adequate staffing levels are determined through implementation of generally accepted detention and correctional practices, judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and other relevant factors to

include the length of time the detainee spends in agency custody. This Auditor reviewed the facility schematic and noted, in addition to detention officer assignments to each living area, there is also a control booth officer who oversees four pods per building monitoring cameras, opening doors, and monitoring detainees.

The facility employs 187 security personnel (56 females; 131 males) to provide supervision of detainees. Security staff work 12-hour shifts from 6:00am – 6:00pm and 6:00pm – 6:00am. The facility has a design capacity of 1,328 beds and an average daily population of 1,204. At maximum capacity, this provides an approximate 7:1 ratio for security staff to detainee. The facility ensures proper security coverage by utilizing overtime, when needed. Mandatory posts are not vacated until a relief officer assumes the post.

During the on-site visit, the Facility Administrator explained the facility now employs 75% female detention officers and only 25% male, which has posed difficulty having a male officer available for pat searches. With this staff ratio challenge faced by the facility management, the Facility Administrator and PSA Compliance Administrator explained that the frequency of female detention officers pat searching male detainees had become routine. In response, the Facility Administrator issued a memorandum stating effective immediately, no cross-gender pat-down searches will be conducted on the detainee population.

The facility is equipped with 235 cameras to electronically monitor the facility. (b) (7)(E) [redacted] Cameras provide video but do not record sound. Cameras are monitored by central control officers 24 hours per day. All perimeter cameras are equipped with pan, tilt, and zoom features. During the on-site visit, the Auditor viewed the cameras and found the cameras afford privacy for detainees when showering, performing bodily functions, and changing clothing, except for the suicide precaution cells in the medical area which did not provide privacy for female detainees while using the toilet. Although the monitors were equipped with black out areas, it did not provide enough privacy for female detainees. The Facility Administrator immediately addressed this issue by having additional blackout area placed on the monitor which provided the necessary privacy for the female detainees in this area.

During the tour, the Auditors found several blind spots which prevented supervising staff to have clear view of the area. These areas included: detainee barber shops, two coolers and a freezer in the kitchen, and the laundry. The Facility Administrator provided the Lead Auditor with copies of a purchase receipt for security mirrors for those areas. Once installed, facility staff provided the Lead Auditor with photographs of each area showing where each mirror was installed that eliminated the blind spots.

The Auditor reviewed the last Annual PREA Assessment completed by GEO on September 11, 2019. The assessment revealed there was only one finding for the facility, which was addressed. The finding involved the separation of an employee from detainee contact during a PREA investigation that was not accurately documented within the 24-hour time frame. This was resolved with documentation of staff removal within 24-hours of a PREA allegation. This finding was noted during the GEO Quality Control Plan (QCP) audit. The annual assessment addresses staffing levels, video monitoring, and PREA incidents. The annual assessment indicated there have been no judicial findings of inadequacy and this was confirmed by the PSA Compliance Manager. The Auditors also reviewed the 2020 Annual PREA assessment. Overall allegations decreased from the previous year by two, detainee-on-detainee allegations remained the same, staff -on-detainee allegations decreased by one, substantiated allegations decreased by one.

The comprehensive supervision guidelines were addressed by the facility through post orders and policies. The Auditor reviewed the post orders and policies and found them to be thorough and to reflect good detention practices. The post orders and policies are reviewed annually. The last review by the Facility Administrator was April 21, 2020. The Auditor requested but did not receive copies of the 2021 post order and policy review. The Auditor reviewed the PREA investigations conducted in the audit period, as well as the Sexual Abuse Incident Reviews conducted for each investigation. There were no recommendations by investigators or the Sexual Abuse Incident Review Board.

During the on-site visit, the Auditors reviewed three additional investigation files conducted since the Pre-Audit documentation review process. Two of the three investigations were completed; one remained open. There were no recommendations made including any staff coverage concerns by the investigator or by the completed Sexual Abuse Incident Review Board for the closed cases.

(d): Policy 10.1.1 states, "LIPC 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. Such policy and practice shall be implemented no less than once per week for all shifts. Employees are prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of LIPC."

Security supervisors and detention officers from each shift were interviewed. The detention officers confirmed they make irregular, unannounced security rounds at a minimum every 30 minutes. Security supervisors reported they conducted unannounced security inspections at least once per shift. All staff conducting inspections of the detainee housing areas sign the logbook; supervisors sign the logbook in red ink. The Auditor requested examples of documented unannounced security rounds for all shifts for three days in January 2020 and three days in February 2020. This review showed unannounced security inspections were conducted by the Shift Sergeants for both day and evening shifts, with one exception in which the unannounced round was conducted by the Shift Lieutenant. This documentation also demonstrated three rounds by the facility grievance officer and one round by the Chief of Security during this period. Although the facility policy requires daily rounds be conducted by the Chief of Security, Shift Supervisor, and the Assistant Shift Supervisor, this was not reflected in the documentation provided. During the on-site visit, the Auditors reviewed additional documentation of unannounced security rounds and found unannounced rounds were conducted at irregular times for each shift. Facility administrative staff also conducted frequent unannounced security rounds, primarily during the day shift.

Recommendation: The facility should ensure their policy is adhered for the daily round requirement in all housing units for the Shift Supervisor and Chief of Security and at least once per shift by the Assistant Shift Supervisor and Shift Supervisor. The facility meets the standard through the Shift Sergeants daily rounds on all shifts, however, the facility is not fully complying with the facility's policy directives for rounds.

The facility meets the requirements of this standard.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

Documents Reviewed:

- Exhibit 5 – Memorandum – LaSalle does not house juveniles or families

(a)(b)(c)(d): The facility provided a memorandum stating the facility does not house juveniles or families. The Facility Administer also confirmed juveniles or families are not housed at this facility. While on-site, Auditors reviewed rosters of detainees in which birthdates were provided. None of the detainees were under the age of 18.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 6 – Cross Gender Search Logs
- Exhibit 7 – PREA Training curriculum
- Record of Search forms
- Cross-Gender Pat Search Logs

(b)(c)(d)(e)(f): Policy 10.1.1 states "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 interest at Immigration Detention Facilities. Searches 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 cross-gender pat-down searches of female detainees, absent exigent circumstances are prohibited. All strip searches, visual body cavity searches, and cross-gender pat-down searches shall be documented. 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."

During the pre-audit phase, the Auditor reviewed a completed Cross-Gender Pat-Search log and several completed Record of Search forms. This form meets the requirement for documentation of cross-gender searches. The Cross-Gender Pat-Search log identifies the gender of the detainee and the searching officer. All cross-gender searches reviewed were conducted by female officers searching a male detainee. There were no incidents of a male officer pat searching a female detainee. The Auditor reviewed three Record of Search forms, in which a strip search was conducted while placing a suicidal detainee on suicide precautions. The form had a place for the searching officer and witness to sign. The form does not indicate the gender of the detainee, searching officer or witness. A recommendation was made to the facility during the pre-audit documentation phase that **s**taff should be required to document the gender of the detainee, searching officer and witness on the Record of Search form for all cases of cross-gender searches, including suicide precautions, to ensure the requirement for documentation of searches is met. While on-site, the Auditors reviewed the Record of Search form and found the gender of the detainee, searching officer, and witness was added to the form.

The Auditors interviewed 25 first line supervisors and detention officers (13 females and 12 males). With the exception of two, all male detention officers confirmed they had observed female detention officers pat searching male detainees primarily while assigned to male dormitories or segregation, and also while assisting visitation. All female security staff interviewed confirmed they have conducted pat searches of male detainees. The female officers report they conduct these searches primarily when assigned to work male dormitories but also to assist with mass movement or in other areas such as food service, visitation, or intake. When asked how often female officers work male dormitories, the comments included every day; routinely; daily; and often.

While on-site, the Auditors noted that female officers are routinely placed on posts to supervise male detainees and most often conducted the pat searches of the male detainees. The Auditors spoke with the Facility Administrator and PSA Compliance Administrator and explained that the frequency of female detention officers pat searching male detainees has become routine. In response, the Facility Administrator issued a memorandum while the Auditors were on-site stating effective immediately, no cross-gender pat down searches will be conducted on the detainee population. He stated handheld metal detectors were ordered and will soon be placed on each post and in all instances that a pat search would normally be conducted, staff are to utilize the wand to detect any metal. Detainees returning from recreation or work will still require pat searches, which will be conducted by same gender staff. Following the on-site visit, the PSA Compliance Manager notified the Auditor that the handheld metal detectors were placed on each post. Given the restrictions placed on opposite gender pat-searches through the Facility Administrator's memorandum and the placement of handheld metal detectors for each post, the Auditor's initial concern regarding cross-gender pat-searches has now been addressed.

(g): Policy 10.1.1 states "LIPC shall 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. PREA announcements are to be documented in the housing unit log."

The detainees reported they are afforded privacy when showering, performing bodily functions and changing clothing and were not seen without their clothing by opposite gender staff. With the exception of observing or conducting a same gender search of a suicidal detainee being placed on suicide precautions, all officers reported they had not conducted or observed another officer conduct a strip search or body cavity search by the same or opposite gender staff. Officers also reported detainees are provided privacy while performing bodily functions, showering, or when changing clothing.

During the on-site visit, Auditors observed staff consistently making cross-gender announcements when opposite gender individuals are entering areas in which detainees may be showering, changing clothing, or performing bodily functions.

While on-site the Auditor informally interviewed medical staff, who reported if a body cavity search was necessary, it would be conducted at the local hospital not on-site. To their knowledge, no body cavity searches have been conducted.

(h): This section of the standard is not applicable as the facility is not a Family Residential Facility.

(i)(j): Policy 10.1.1 also states "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. Security staff shall 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 PowerPoint training utilized to train staff on conducting searches. The search training covered gender requirements for searches, how to conduct same gender and opposite gender searches and searches of transgender or intersex detainees, and the documentation requirements for searches. The Auditor also interviewed the Training Supervisor who confirmed all security staff receive training on how to conduct proper searches during new-hire employee orientation and annually during refresher training. During the interviews, security staff were able to describe proper search techniques for same and opposite gender detainees as well as transgender or intersex detainees. All staff reported they have never witnessed or conducted a search or examination of a detainee to determine the detainee's gender.

During the on-site visit, the Auditors observed a cross-gender search of a detainee and found the staff conducted the search in a professional and thorough manner. During an interview with a transgender detainee, he reported he was routinely searched by female detention officers, although his preference is to be searched by male detention officers. This was discussed with the Facility Administrator and PSA Compliance Administrator. The Facility Administrator stated he will address this with staff. He reported the detainee should not be pat-searched by females but rather should be searched by wand if a male is not available.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program Exhibit 8 – Facility Detainee Handbook
- Exhibit 9 – PREA Posters and Pamphlet
- Exhibit 10 – Language Line Service Agreement

(a)(b): Policy 10.1.1 states "LIPC shall provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP). LIPC 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, interpreters, and note-takers, as needed. LIPC 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."

There were four disabled detainees scheduled for interviews during the Remote Interview phase, but only one was interviewed that met the criteria for having a disability that effected communication. This detainee suffered from a mental illness and offered little information other than to say she "knows nothing" because she speaks Spanish, and no one understands her. Of the 10 LEP detainees, 4 reported they received a handbook (ICE National Detainee Handbook or Facility Handbook, typically not both) in intake and were told to read it. Six reported they did not receive a handbook. All ten detainees reported they did not recall seeing a PREA video while in intake, although a review of each interviewed detainee's files showed each had signed the Intake Department Detainee Orientation Sign-In Sheet acknowledging they had watched the PREA video during intake. There were no disabled detainees at the facility at the time of the on-site visit for additional interviews.

Of the security personnel interviewed, most had never encountered a deaf, hard of hearing, blind or visually impaired detainee. For the deaf detainee, staff reported there are pictures in the officer's area that detainees can point to indicating if they need to see medical, need clothing, and the like. Some officers reported there is a teletypewriter (TTY) phone in medical that can be used for deaf detainees. Most security staff were unsure how to communicate PREA information to a blind detainee. A couple officers reported they would read the information to the detainee. Some reported there was a video in intake that provided this information. When asked about communicating with detainees who had intellectual, psychiatric, or speech disabilities, most reported they had never encountered a detainee with this type of disability. Some reported they would refer the detainee to mental health staff. When asked about communicating with detainees who are LEP, staff reported there are PREA posters the ICE Zero-Tolerance ICE Detention Reporting and Information Line poster (English, Arabic, Simplified Chinese, French, Haitian Creole, Portuguese, Vietnamese, and Spanish) and the OIG Reporting poster (English and Spanish), are posted in the housing areas that provide reporting information. GEO reporting posters (How to Make Anonymous Calls and the Prison Rape Elimination Act of 2003) are posted in English and Spanish. Staff also reported there are language lines available to provide interpretation services for LEP detainees and intake staff provide detainees with handbooks in their language. The Facility Administrator stated sign language is provided through the "purple system," a Video Relay system that communicates with a deaf detainee through sign language. He reported that the medical department has a TTY system as well as volume control on phones in medical and the administration area. He also reported detainees have tablets which provide interpretation of written material in several languages (Spanish, French, and English). The tablet also provides the PREA video (English, French, and Spanish). The facility, including the medical department, have accessibility to language line interpretation services for detainees who are LEP. The facility has the ICE National Detainee Handbooks available in English, Spanish, Chinese, Haitian Creole, Hindi, and Portuguese. Intake staff also confirmed they are able to print the ICE National Detainee Handbook in the other five languages if needed. The ICE National Detainee Handbook is available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). The DHS-prescribed "Sexual Assault Awareness Information" pamphlet is now available through ICE in nine languages (English, Spanish, Arabic, Haitian Creole, French, Hindi, Portuguese, Punjabi, and Chinese); however, the facility only had the DHS-prescribed "Sexual Assault Awareness Information" pamphlet printed in English and Spanish during the on-site

tour. The Auditors informed the facility the pamphlet is available in additional languages; the PSA Compliance Administrator stated she would obtain copies of the pamphlet in these additional languages. Staff and detainees reported there are posters in the housing area instructing detainees about how to report sexual abuse. These posters provide this information in several different languages. Detainees also reported the facility had only English-speaking staff in the intake area. The Auditor reviewed the facility's language line service agreement with Language Line Solutions which provides interpretation and written translation services.

During the on-site visit, the Auditors observed the intake interview of an LEP (Spanish) detainee. The intake officer explained the detainees had viewed the PREA video earlier that morning. The intake officer was fluent in Spanish and interpreted for the Auditor as he conducted the interview. The intake officer then had the detainee's picture taken holding an ICE National Detainee Handbook (English), the DHS-prescribed "Sexual Assault Awareness Information" pamphlet (English), and facility handbook (English), although the detainee was provided this information in his native language, Spanish. When asked about providing PREA information to detainees who spoke a language in which there was no ICE National Detainee Handbook available, the intake officer explained they would read the PREA information contained in the handbook to the detainee, through an interpreter. The intake officer took a picture of the detainee holding an English version of the ICE National Detainee Handbook and PREA pamphlet. The intake officer explained that this is done to verify the detainee was provided PREA orientation material. When asked, he explained that all pictures are taken with the English versions, regardless of the detainee's native language the PREA information was provided in. Of the 14 detainees interviewed, 6 detainees reported they did not receive an ICE National Detainee handbook.

Recommendations: Although the Auditors agree that taking a picture of the materials provided to the detainee is a good practice, the detainee's picture should include the material provided to the detainee in their native language to further support this detainee was provided the PREA information materials in their preferred language. This will ensure consistency with the information provided to detainees.

While on-site, The Auditor asked intake staff to show the Auditor the highlighted PREA information that is read to a detainee through an interpreter. Intake staff reported they did not have highlighted information that is read to the detainee through an interpreter. The Facility Administrator issued a memorandum to intake staff informing them to read the PREA section in the ICE National Detainee Handbook, for those detainees who speak a language not available in the ICE National Detainee Handbook through an interpreter.

(c): LIPC Policy 10.1.1 states that "In matters relating to sexual abuse, LIPC 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." The facility does have the capabilities of providing telephonic interpretation services through the administration and medical areas. Of the security staff interviewed none would allow language interpretation for alleged victims by the abuser, friend of the abuser, or witness; or allow another detainee to provide interpretation assistance to the alleged victim. The Auditor reviewed the investigation files and found that translation of written statements and language interpreters were utilized as necessary.

The facility meets the requirements 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:

Documents Reviewed:

- 5 CFR 731, EO, 10450 Part 731 – Suitability
- ICE Directive 6-7.0 – ICE Personnel Security and Suitability Program
- ICE Directive 6-8.0 – ICE Suitability Screening Requirements for Contractor Personnel
- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program

(a)(b): Policy 10.1.1 states "LIPC is prohibited from hiring or promoting anyone (who will have direct contact with detainees) who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution who has been convicted of engaging 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 who has been civilly or administratively adjudicated to have engaged in such activity. Policy 10.1.1 further states LIPC is prohibited from contracting with anyone (who will have direct contact with detainees) who has engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings or in the community." Policy 10.1.1 states that "the facility, shall also impose upon employees a continuing affirmative duty to disclose any such conduct as part of its hiring and promotional processes, and during annual performance reviews for current employees. Policy 10.1.1 also states that "LIPC shall make its best efforts to contact prior institutional employers to obtain information on substantiated allegations of sexual abuse or any resignation pending investigation of an allegation of sexual abuse, prior to hiring new employees." The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0, requires anyone entering or remaining in government service, employee or contractor undergo a thorough background examination for suitability and retention. The Division Chief of the OPR Personnel Security Unit (PSU) informed Auditors who attended training in Arlington, Virginia in September 2018, that detailed candidate suitability for all 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. The Human Resource Manager confirmed the facility asks applicants on the job application and contractors about previous misconduct and verifies this information through a background check completed through the facility by Career Builders.

The policy does not include enlisting the services of volunteers who may have contact with detainees.

The Auditor reviewed the employment application used by LIPC. Each applicant is asked if they have ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution and the application explains that sexual abuse in this setting includes

sexual acts with the consent of the inmate, detainee, resident, etc. Each applicant is also asked if they have ever been convicted of engaging or attempting to engage in sexual activity in the community 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. The application also asks if the applicant has ever been accused in a civil or administrative hearing of engaging or attempting to engage in sexual activity in the community facilitated by force, or implied threats of force, or coercion or in the victim did not consent or was unable to consent or refuse.

The facility has a contract with Keefe Group to provide commissary services. Keefe provided copies of the questions asked of applicants in the online application. The application asks the applicant if they have ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution and if the applicant has ever been convicted of engaging or attempting to engage in sexual activity in the community 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. The application does not include questions regarding adjudication in a civil or administrative hearing for such activity.

The facility could not provide volunteer applications, interview questions, or the like to determine if a volunteer applicant had worked or volunteered in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or if the volunteer had been civilly or administratively adjudicated for engaging in such activity. Volunteers are not asked questions regarding adjudication in a civil or administrative hearing for such activity. The volunteer information is not captured through an application process or formal interview questions. The facility reported that they do not have a volunteer application form but that they do conduct a criminal background check of each volunteer. It is unclear how the facility determines if the volunteer engaged in such behaviors in another community volunteer setting or correctional setting. During the Pre-Audit documentation phase of the audit, the Auditor requested information as to how the facility determines if a volunteer has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or who has been civilly or administratively adjudicated to have engaged in such activities. The Remote Interview phase responses from the PSA Compliance Manager stated the volunteer is not asked about employers or past volunteer experience. During the on-site visit, the Auditors reviewed the new volunteer application. The new form asks the pertinent PREA questions. The facility is currently not permitting volunteers into the facility due to the health pandemic; therefore, there were no completed volunteer forms to review.

The Human Resource Manager was interviewed and indicated the Human Resource department complies with the requirements of the PREA standards in regard to hiring and promotion practices for employees.

(c)(d): Policy 10.1.1 states that "LIPC shall conduct a background investigation to determine whether the candidate for hire is suitable for employment, including a criminal background records check. Background investigations, including criminal background records checks shall be repeated for all employees at least every five years." Furthermore, Policy 10.1.1 states, "The facility shall conduct a background investigation, including a criminal background check and make its best efforts to contact prior institutional employers to obtain information on substantiated allegations of sexual abuse or any resignation pending investigation of an allegation of sexual abuse, prior to enlisting the services of any contractor. Background investigations, including criminal background checks shall be repeated for all contractors at least every five years. Upon request, LIPC shall submit written documentation showing the detailed elements of the background check for each contractor and the conclusion of the background check." Federal Statute 731.105 requires "background reinvestigations to be conducted on all staff and contractors, having detainee contact with detainees, every five years." The Division Chief of the OPR PSU confirmed that ICE conducts these background checks on contractors and staff. GEO agency/facility conducts initial and five-year background checks on all employee applicants and contractors. These background checks are completed through Career Builders. The Auditor reviewed staff (6), contractor (1), medical/mental health staff (3) and volunteer (1) criminal background checks. There were initial and five-year criminal background checks for all staff, contractors, and volunteers.

(e)(f): Policy 10.1.1 states, "Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate." The Auditor confirmed this through an interview with the Human Resource Manager. Furthermore, Policy 10.1.1 states that "Unless prohibited by law, LIPC shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." The Human Resource Manager confirmed the facility would provide information regarding substantiated allegations of sexual abuse to an institutional employer upon request.

The facility meets the requirements of this standard.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 SAAPI Program
- Exhibit 11 - Memorandum – No expansions or modifications

(a)(b): Policy 10.1.1 states, "LIPC shall consider the effect any (new or upgrade) design, acquisition, substantial expansion or modification of the physical plant might have on our ability to protect detainees from sexual abuse. LIPC shall also 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."

The facility provided a memorandum during the pre-audit documentation review phase stating LIPC has not made any substantial expansions or modifications to the existing facility, since the last audit. The Facility Administrator also confirmed there had been no expansions or modifications to the facility or upgrades to the video monitoring system. During the on-site visit, the Facility Administrator confirmed there have been no expansions or modifications to the facility or upgrades to the video monitoring system.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection

- Exhibit 12 – Announcement of Sheriff's Victim Advocate Program
- Exhibit 13 – Memorandum – Facility utilizes Christus St. Francis Cabrini Health System for SANE/SAFE exams
- Exhibit 14 – Mutual Assistance Agreement (MAA) between LIPC and LaSalle Parish Sheriff's Office
- DHS Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention

(a): Policy 10.1.1-A states, "LIPC is responsible for investigating allegations of sexual abuse and is required to 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." PREA allegations may also be investigated through OPR or DHS. The agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. OPR will coordinate with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS OIG, OPR, or the local law enforcement agency, the Assistant FOD would assign an administrative investigation to be conducted. The PSA Compliance Manager confirmed there are uniform evidence protocols that were developed in coordination with DHS and address evidence collection as it relates to a review of facility documentation, written and verbal statements, reviewing video footage, and phone monitoring. A review of the sexual abuse investigations completed during the audit period confirmed staff followed the uniform evidence protocol established by the facility. The uniform evidence protocol was approved by the AFOD on July 7, 2020. The facility does not house juveniles, so this requirement of the standard is not applicable.

(b): The facility provided information about the new Victim Advocate Program provided through the LaSalle Parish Sheriff's office and stated they were unable to secure an MOU or Mutual Aid Agreement (MAA) with the program. The facility provided documentation of their attempts to secure victim advocacy services through the rape crisis centers with no success. When the Auditor contacted the LaSalle Parish Sheriff's Office Victim Advocacy program, the advocate explained the services provided were primarily for sexual abuse or domestic abuse victims in the community. She stated they would not provide a victim advocate during Sexual Assault Forensic Examiner (SAFE)/Sexual Assault Nurse Examiner (SANE) examines, investigatory interviews, or other PREA related services to the facility. The PSA Compliance Manager explained the measures the facility has taken to secure community services for alleged victims with no success. The facility does not have a trained advocate on staff.

During the on-site visit, the Auditors also met informally with the PREA Compliance Manager, Facility Administrator, and Assistant Facility Administrator to discuss their efforts to secure a rape crisis center to provide crisis intervention and counseling services to no avail. The facility does utilize the services of a local hospital, where forensic examinations are provided at no cost to the detainee and a victim advocate is provided through the hospital during the forensic exam if requested by the victim, as further discussed in the following paragraphs. The Auditors also met with facility mental health staff. The Auditors are satisfied that the facility mental health staff possess the skills and time to provide crisis intervention and counseling services to detainee victims. There was one detainee victim available for interview during the on-site visit. He reported he was evaluated by mental health staff when he reported the incident and offered follow-up counseling services at no cost to the detainee. The facility has attempted to the fullest extent possible to secure community resources to provide crisis intervention and counseling services. The facility has the resources to provide these services through the facility's mental health staff.

(c)(d): Policy 10.1.1 states, "If the alleged sexual abuse is reported or discovered within 96 hours of the incident, and if determined appropriate by the medical provider and/or investigator, the alleged victim shall be either transported to the designated off-site facility or a SANE or SAFE shall be called to the facility for the collection of forensic evidence and medical treatment." Policy 10.1.1-A states, "LIPC shall 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." Policy 10.1.1 also states, "As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting the forensic exam, shall be allowed for support during a forensic exam and investigatory interviews."

The facility provided a memorandum (MOU) stating Christus St. Frances Cabrini Health System provides SANE/SAFE exams. The PSA Compliance Manager stated the hospital provides a victim advocate during the forensic examinations. The Auditor confirmed through Christus St. Frances Cabrini Health System Emergency Room, SAFE/SANE examiners are employed by the hospital and available to provide these services to the alleged victim. The hospital staff also reported they will provide a victim advocate during the forensic examination, if requested by the alleged victim. Facility medical staff confirmed detainees are seen by medical staff when a PREA allegation is made but that medical staff are not trained, nor do they conduct SAFE/SANE examinations. The medical staff will stabilize the detainee for transportation to the hospital. Medical staff confirmed there is no cost to the detainee for the forensic examinations. The Auditor reviewed 12 sexual abuse investigations (open and closed), one of which required a forensic examination.

(e): The facility provided a copy of the Mutual Aid Agreement (MAA) between the facility and the LaSalle Parish Sheriff's Office. This agreement requires investigations by the Sheriff's office to comply with the requirements of the PREA standards. The facility also provided a statement explaining the LaSalle Parish Sheriff's Office does not have jurisdiction over the facility since the facility is located within the town of Jena, Louisiana. The Jena Police Department has jurisdiction and investigates those allegations referred by the facility. As initially indicated during the Remote Interview phase, the facility had made several attempts to obtain an MOU with the Jena Police Department, with no success; however, since the Remote Interview phase, the facility has entered into an MAA with the Jena Police Department, which the Auditor reviewed while on-site. The PSA Compliance Manager/Investigator explained the facility has a very good working relationship with the Jena Police and she is able to stay informed about the progress of any investigation being conducted by the Jena Police Department. Nine allegations were referred to the Jena Police Department as the facility deemed them to involve potentially criminal behavior. The Jena Police Department conducted seven investigations and declined to conduct two investigations that did not potentially involve criminal acts.

The facility meets the requirements of this 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:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection
- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 14 – MAA Between LIPC and LaSalle Parish Sheriff's Office (LPSO)
- Exhibit 15 – GEO Website Posting of Protocols
- Exhibit 16 – Referral of Investigation to Jena Police Department

(a): Policy 10.1.1-A states, "LIPC shall have a policy in place to ensure that all allegations of sexual abuse are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. LIPC shall document all referrals." The Agency's policy 11062.2 outlines the evidence and investigative protocols. The JIC assesses all sexual abuse allegations reported to them to determine whether the allegation is referred to the DHS OIG or OPR. The DHS OIG has the first right of refusal on all staff, volunteer, or contractor-on-detainee sexual abuse allegations and the OPR reviews and assesses all detainee-on-detainee sexual abuse allegations. Once the allegation referred to the DHS OIG is reviewed and accepted, OPR would not investigate. If refused by the DHS OIG, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR, the investigation is conducted in accordance with OPR policies and procedures and coordinated with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation. The ERO would assign an administrative investigation to be completed. All investigations are closed with a report of investigation. The Jena Police Department has jurisdiction over the facility and conducts the criminal investigations for the facility. Administrative investigations are completed by the facility's PREA-trained investigator. The PSA Compliance Manager and Facility Administrator stated all investigations are immediately referred to ICE officials and/or the local sheriff for investigation.

During the on-site visit, the Auditors interviewed the new facility PREA investigator. He reports to the Compliance Administrator. He was knowledgeable about conducting sexual abuse investigations through training and experience. He was aware the standard of evidence should not be higher than a preponderance of the evidence for administrative investigations. The facility had 12 allegations during the audit period. During the pre-audit documentation phase, the Lead Auditor reviewed eight closed investigations and one open investigation; during the on-site phase, the Lead Auditor reviewed one closed and two open investigations. Of the three open investigations, two were detainee-on-detainee allegations and one staff-on-detainee allegation. Each investigation that may have rose to the level of criminal charges was appropriately referred to the Jena Police Department and the Jena Police Department responded to each referral. Specifically, nine allegations were referred to the Jena Police Department. The Jena Police Department conducted seven investigations (two are still open) and declined to conduct two investigations that did not potentially pose criminal acts.

(b): Policy 10.1.1-A states, "GEO shall retain all written reports referenced [in] this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years; however, for any circumstance, files shall be retained no less than ten years."

(c): Policy 10.1.1-A states, "GEO Corporate shall publish such corporate policy on its website." The Auditor reviewed the agency website as well as the facility/corporate website and found the agency and facility had posted their protocols to ensure all allegations of sexual abuse are investigated. 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): Policy 10.1.1 states, "When a detainee of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, LIPC shall ensure that the incident is promptly reported to the appropriate ICE FOD, 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, LIPC shall ensure the incident is promptly reported to the appropriate ICE FOD. If the allegation is potentially criminal, also referred to an appropriate law enforcement agency having jurisdiction for investigation. The corporate PREA Coordinator shall also be notified of all detainee sexual abuse allegations." There were no substantiated or unsubstantiated allegations against staff, volunteers, or contractors during the audit period.

The PSA Compliance Manager/Facility Investigator and Facility Administrator confirmed that all allegations of sexual abuse are referred for investigation and reported to the JIC, the corporate PREA Coordinator, and the Jena Police Department. Of the 12 reviewed allegations in the investigative files, each was referred for investigation within 24 hours of receipt of the allegation. If the allegation was potentially criminal in nature, the investigation was referred to the Jena Police Department. There were nine investigations referred to the Jena Police Department. The Jena Police Department conducted seven investigations and declined to pursue two of the investigations that did not meet the standard for a criminal charge. In addition, the facility conducted a thorough administrative investigation for each allegation. All allegations were reported to the JIC the same day the allegation was received.

The facility meets the requirements of this standard.

§115.31 - Staff training.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 17 – PowerPoint – SAAPI Refresher training
- 2019 Employee Training Records

(a): Policy 10.1.1 states, "All employees, contractors and volunteers shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program (SAAPI). LIPC shall train all employees who may have contact with detainees on: its zero tolerance policy for sexual abuse and assault; how to fulfill their responsibilities under agency Sexual Abuse and Assault prevention, detection, reporting and response policies and

procedures, to include procedures for reporting knowledge or suspicions of sexual abuse; recognition of situations where sexual abuse may occur; the right of detainees and employees to be free from sexual abuse, and from retaliation for reporting sexual abuse and assault; instruction that sexual abuse and/or assault is never an acceptable consequence for detention; definitions and examples of prohibited and illegal sexual behavior; recognition of physical, behavioral and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; how to detect and respond to signs of threatened and actual sexual abuse; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; how to communicate effectively and professionally with detainees, including LGBTI or gender non-conforming detainees; 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; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; instruction on reporting knowledge or suspicion of sexual abuse and/or assault; and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault."

The facility policy covers each element of this standard subsection. In addition, the facility also provides pre-service training to explain the investigation process; responding to detainees with mental or physical disabilities; documentation and referral of allegations/suspicions of sexual abuse; evidence preservation; and working with vulnerable populations. These additional topics exceed the requirements of this portion of the standard.

The Auditor reviewed the SAPPI training curriculum and verified each element of the standard was addressed. The Training Supervisor also verified that each element of the standard is addressed through training. The Auditor verified this training was provided through the review of 8 employee training records, interviews with employees, and the Training Supervisor.

Each employee is also provided a Sexual Abuse First Responder Duties card. The card details the first responder duties, the employee hotline, and the GEO website for reporting, including the ability to report anonymously.

(b)(c): The facility's policy 10.1.1 further states, "PREA refresher training shall be conducted each year thereafter for all employees. Refresher training shall include updates to sexual abuse and assault policies. Employees shall document training through signature on the PREA Basic Training Acknowledgement Form and that they understand the training they have received. This form shall be used to document Pre-Service and Annual In- Service SAAPI Training."

The Auditor reviewed the PowerPoint titled SAAPI 2019 In-Service. The Training Supervisor explained employees are provided a week-long refresher training titled American Correctional Association (ACA) training. The required refresher PREA training is included in this training. This is an excellent training program, and it covers each of the components required by the standard. A review of employee training records and interviews with the Training Supervisor and employees verified this in-service training is provided annually.

While on-site, the Auditors reviewed the documentation of PREA training provided to ICE personnel who have contact with facility detainees. Of the four employees reviewed, all had received the initial PREA training but only one of the staff had received refresher PREA training within the past two years. The agency meets substantial compliance with three of the four staff training files in compliance.

Recommendation: The agency must ensure all agency employees who may have contact with immigration detention facility detainees complete refresher information every two years. One of the four ICE personnel training files reviewed for staff who have contact with detainees had not received PREA refresher training every two years as required per subpart (b) of the standard.

The facility meets the requirements of this standard.

§115.32 - Other training.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 SAAPI Program
- Exhibit 18 – Documentation of Contractor and Volunteer Training
- PowerPoint – Volunteer and Contractor Training

(a)(b)(c): LIPC Policy 10.1.1 states, "All employees, contractors, and volunteers shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program (SAAPI). LIPC shall ensure that all volunteers who have contact with detainees are trained on their responsibilities under GEO's Sexual Abuse and Assault prevention, detection, and response policies and procedures. The level and type of training provided to volunteers shall be based on the services they provide and the level of contact they have with detainees, but all volunteers who have contact with detainees shall be notified of GEO's and the facility's zero tolerance policies regarding sexual abuse and informed how to report such incidents. Volunteers who have contact with detainees shall receive annual SAAPI refresher training. Volunteers shall document through signature on the PREA Basic Training Acknowledgement Form that they understand the training they have received. This form shall be used to document Pre-Service and Annual In-Service SAAPI Training."

Policy 10.1.1 also states, "LIPC shall ensure that all contractors who have contact with detainees are trained on their responsibilities under GEO's sexual abuse and assault prevention, detection, and response policies and procedures. The level and type of training provided to contractors shall be based on the services they provide and the level of contact they have with detainees, but all contractors who have contact with detainees shall be notified of GEO's and the facility's zero tolerance policies regarding sexual abuse and informed how to report such incidents. Contractors who have contact with detainees shall receive annual SAAPI refresher training. Contractors shall document through signature on the PREA Basic Training Acknowledgement Form (See Attachment E) that they understand the training they have received. This form shall be used to document Pre-Service and Annual In-Service SAAPI Training."

The facility contracts with Keefe to provide commissary services to the facility. These are the only contract staff. The Auditor reviewed the training PowerPoint used for training contractors and volunteers and found it covered each element of the standard and provides information pertinent to their role at the facility. The Auditor verified this training was provided through a review of one contractor's and one volunteer's training records

and interviews with the training supervisor, contract employees, and volunteers. Interviews with the contract employee and volunteer confirmed these individuals had received initial and annual PREA training and understood their responsibilities under PREA.

The facility meets the requirements of this standard.

§115.33 - Detainee education.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 8 – Detainee Handbook

(a)(f): Policy 10.1.1 states, "During the intake process, LIPC shall ensure that the detainee orientation program notifies and informs detainees about the company's 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, 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 Office of Inspector General (OIG), the ICE/OPR investigation processes; and the JIC; 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."

The Auditor reviewed the detainee PREA education video which is available in English and Spanish. The orientation video addresses each element of this subpart of the standard and is presented in a manner that is easy to understand. The ICE National Detainee Handbook and the DHS PREA "Sexual Assault Awareness Information" pamphlet informs detainees of methods to report sexual abuse and reporting sexual abuse will not negatively impact their immigration status and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The Auditor reviewed the facility detainee handbook which is available in English and Spanish.

(b): Policy 10.1.1 also states, "At LIPC, education shall be provided in formats accessible to all detainees, including those are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. LIPC shall provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP). LIPC 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. LIPC 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 ICE Zero-Tolerance ICE DRIL poster is available in multiple languages (English, Arabic, Simplified Chinese, French, Haitian Creole, Portuguese, Vietnamese, and Spanish) in the housing areas that provide reporting information. GEO reporting posters (How to Make Anonymous Calls and the Prison Rape Elimination Act of 2003) are posted in English and Spanish. Staff also reported there are language lines available to provide interpretation services for LEP detainees and intake staff provide detainees with handbooks in their language. The ICE National Detainee Handbook is available 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 Facility has the ICE National Detainee Handbook readily available in English, Spanish, Chinese, Haitian Creole, Hindi, and Portuguese. Intake staff also confirmed they are able to print the ICE National Detainee Handbook in multiple languages. The Facility Administrator stated sign language is provided through the "purple system," a Video Relay system that communicates with a deaf detainee through sign language. He reported that the medical department has a TTY system as well as volume control on phones in medical and the administration area. He also reported detainees have tablets which provide interpretation of written material in several languages (Spanish, French, and English). The tablet also provides the PREA video. The intake staff reported they print the ICE National Detainee Handbooks in a language the detainee can understand. They explained if the material is not available in their language, an interpreter is used, and important PREA information in the ICE National Detention handbook is read to the detainee through use of a language interpretation service. Intake staff also reported that deaf or hard of hearing detainees receive orientation information through a TTY phone and written material. While on-site, the Auditors interviewed intake staff and medical staff. Intake staff were knowledgeable about how to educate disabled detainees utilizing the available resources i.e., reading material to the blind and ensuring the detainee hears the PREA video in its entirety; utilizing the mental health staff to assist with communicating with the mentally ill and intellectually disabled; and utilization of written material and the TTY or video relay system (purple system) for sign language for the deaf.

During the on-site visit, the Auditors observed the processing of an incoming, Spanish speaking, male detainee. Intake staff advised the Auditor that the PREA video had been shown to the detainees prior to the Auditor's arrival in intake. The intake officer was fluent in Spanish and conducted the interview in Spanish, providing interpretation for the Auditor. The detainee was provided a Spanish ICE National Detainee Handbook and the PREA DHS-prescribed Sexual Assault and Awareness Information pamphlet. There was one disabled detainee interviewed who kept yelling loudly that they tell her nothing and no one speaks Spanish, so she knows nothing. The Auditor advised facility staff of the detainee's actions during the interview and was advised by staff that the detainee is currently under mental health care.

(c): Policy 10.1.1 states, "LIPC shall maintain documentation of detainee participation in the intake process orientation which shall be retained in their individual files." The Auditor reviewed the Orientation Sign-In Sheet which serves as an acknowledgement by the detainee that they reviewed the orientation video and received the facility Detention handbook and PREA pamphlet. The form is presented in English with Spanish translation on the same form. The Auditor also reviewed a completed Detainee Property Sheet which documents the detainee's receipt of the ICE National Detainee Handbook. Neither the Orientation Sign-In Sheet nor the Detainee Property Sheet indicated the language of the information provided to the detainee. The facility also photographs detainees holding PREA information materials to document the issuing of the information. The Auditor observed an LEP Spanish detainee was provided a Spanish ICE National Detainee Handbook and PREA pamphlet. The intake officer took a picture of the detainee holding an English version of the ICE National Detainee Handbook and PREA pamphlet. The intake officer explained that this is done to verify the detainee was provided PREA orientation material. When asked, he explained that all pictures are taken with the English versions, regardless of the detainee's native language the PREA information is provided in to the detainee.

Of the 29 detainees interviewed, most reported they were handed a facility and/or an ICE National Detainee Handbook and instructed to read it. None of the detainees recalled seeing a PREA video during orientation, although a review of detainee files showed each detainee had signed a form

acknowledging they had watched the PREA video during intake. Some detainees reported seeing a video played in their housing area but were unclear if the video provided PREA information. Most of the detainees were aware of the reporting options available to them and learned of this information through the posters posted in the housing areas. Several detainees reported, to their knowledge, intake staff were only English speaking.

Recommendation: The Auditor agrees that photographs provide verification of the materials provided to the detainee, but this process is not effective if the detainee is not photographed with the actual material they are provided. The facility should revise this practice to photograph detainees holding the actual PREA educational material provided to the detainee in the language they understand.

(d): Policy 10.1.1 states, "LIPC shall 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 Auditors toured each area of the facility accessible to detainees, with the exception of the cohort and isolation pods. The Auditor reviewed the posters available to detainees throughout the facility and confirmed the reporting information on these posters are available in several different languages. The Auditors found the following PREA postings in each living unit: the ICE Zero-Tolerance ICE DRIL poster is available in the following languages: English, Arabic, Simplified Chinese, French, Haitian Creole, Portuguese, Vietnamese, and Spanish; and GEO reporting posters, How to Make Anonymous Calls and the Prison Rape Elimination Act of 2003 (English and Spanish), with the name of the PREA Compliance Administrator and the number for the National Rape Hotline with information about reporting anonymously.

(e) Policy 10.1.1 states, "Facilities shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet." The DHS-prescribed "Sexual Assault Awareness Information" pamphlet is available through ICE in nine languages (English, Spanish, Arabic, Haitian Creole, French, Hindi, Portuguese, Punjab, and Chinese). The facility has the DHS-prescribed "Sexual Assault Awareness Information" pamphlet in English and Spanish. The Auditor informed the facility how to access the pamphlet in the additional languages and the PSA Compliance Manager stated she will obtain copies of these pamphlets in all available languages. The facility provides the DHS-prescribed Sexual Assault Awareness pamphlet at intake to the detainee and the pamphlet is also posted in the housing units as observed by the Auditors.

The facility meets the requirements of this standard.

§115.34 - Specialized training: Investigations.

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

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention SAAPI) Program
- ICE HQ Training on website
- Exhibit 23 – Investigator training certificates

(a)(b): Policy 10.1.1 states, "LIPC investigators shall be trained in conducting investigations on sexual abuse and effective cross-agency coordination. All investigations into alleged sexual abuse must be conducted by qualified investigators. Investigators shall receive this specialized training in addition to the general training mandated for employees. Facilities shall maintain documentation of this specialized training."

During the remote interview phase, the PSA Compliance Manager confirmed she was also serving as the Facility Investigator until the Investigator position is filled. The facility provided verification of the Investigator's PREA orientation and annual refresher training as well as specialized investigator training. The Auditors interviewed the Facility Investigator and found her to be knowledgeable about how to conduct a PREA investigation in a confinement setting and effective cross-agency coordination. The facility provided a training certificate verifying the Facility Investigator had completed a PREA investigator training titled, "Special Training: Investigating Sexual Abuse in a Correctional Settings." This training addresses the standard provisions, including cross-agency coordination. While on-site, the Auditors interviewed the newly hired Investigator and reviewed his training and experience. He has extensive investigation experience through his work with law enforcement. He has completed the required PREA and investigator training. During the interview, the Investigator stated he also has previous experience completing PREA investigations for the Federal Bureau of Prisons. The Training Supervisor verified the specialized training is provided to the 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 Investigations Incidents of Sexual Abuse and Assault training curriculum and found the curriculum covers in-depth investigative techniques, evidence collection, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency also offers a 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 provides rosters of trained investigators on ERAU SharePoint site for Auditors' review; this documentation is in accordance with the standard.

The facility meets the requirements of this standard.

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

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

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- IHSC Directive: 03-01 Sexual or Physical Assault, Abuse and/or Neglect
- ICE HQ Training on website

(a)(b)(c): Medical and mental health services is provided to detainees through IHSC medical staff. IHSC Directive 03-01 requires all IHSC staff to receive training on the agency directive SAAPI, PREA standards, and response protocol. The training is required during initial orientation and annually thereafter. The training includes how to detect and assess signs of sexual abuse, professional and effective response to victims of sexual abuse, reporting procedures, evidence preservation, and effective communication with Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) or gender

nonconforming detainees. Policy 10.1.1 states, "Each facility 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. Medical and mental health practitioners shall receive this specialized training in addition to the general training mandated for employees. Facility medical staff shall not participate in sexual assault forensic medical examinations or evidence gathering. Forensic examinations shall be performed by a SANE or SAFE. An offsite qualified medical practitioner may perform the examination if a SAFE or SANE is not available. LIPC shall maintain documentation of this specialized training."

During the Remote Interview phase, the Training Supervisor explained the specialized training provided to medical and mental health staff is provided by IHSC staff. The Auditor reviewed the IHSC SAAPI Training PowerPoint. The training covered each of the required elements of the standard. The Auditor interviewed medical and mental health staff who acknowledged receiving orientation and refresher training and specialized training annually. While on-site, the Auditors reviewed medical and mental health staff files which verified the PREA-specialized training provided to medical and mental health staff and the files verified that all health care staff have received specialized training related to PREA.

The facility meets the requirements of this standard.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 25 – Risk Assessment
- Exhibit 26 – Custody Classification and Reassessment

(a)(b): Policy 10.1.1 states, "All detainees shall 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 shall be kept separate from the general population until he/she is classified and may be housed accordingly. The initial classification and initial housing assignment shall be completed within 12-hours of admission to the facility. Facilities shall use the GEO PREA Risk Assessment Tool to conduct the initial risk screening assessment. In addition to the screening instrument, persons tasked with screening shall conduct a thorough review of any available records (e.g., medical information indicated on the detainee's criminal history, or, 213/216 remand (criminal history/record of persons transferred, etc.) that can assist them with risk assessment."

Interviews with intake staff and detainees verified the risk assessment is completed during intake. The Classification Supervisor explained the facility reviews detainee information prior to their arrival. This information includes, as available to the agency, the detainee's criminal history to include crimes involving sexual abuse, prior incarcerations, problems encountered during incarceration, and other pertinent information. This information allows staff to begin the custody assessment and provides information for use on the risk screening prior to the arrival of the detainee. The Auditors reviewed 10 detainee files and confirmed risk assessments were completed for each detainee upon admission to the facility. Detainees and intake staff confirmed that the intake process is completed within 12 hours of admission. Information as to how long the detainee spent in intake was not available. Due to a global pandemic, the facility has adopted measures to quarantine incoming detainees for 14 days before assignment to the general population. This is a necessary measure to address risk of exposure to other detainees.

(c)(d): Policy 10.1.1 states, "LIPC shall also consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: mental, physical or developmental disability; age; physical build and appearance; previous incarceration or detained; nature of criminal history; prior convictions for sex offenses against an adult or child; whether detainee self-identified as LGBTI or gender non-conforming; whether detainee self-identified as having previously experienced sexual victimization; own concerns about his/her physical safety. The intake screening shall also consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing the risk of being sexually abusive."

The Auditor reviewed the risk assessment provided by the facility. The risk assessment addresses each required element of the standard. The form provides clear instructions to screening staff for completing the form properly and utilizes an objective scoring system for determining a detainee's risk of sexual victimization or sexual abusiveness. During the Pre-audit documentation review, although there is a language line available to staff, there was not an area on the form, or elsewhere, to indicate if the assessment was done through an interpreter, TTY phone, or other communication alternatives. The facility had revised the PREA Risk Screening to include an area to enter the Language Solution line code when an interpreter is used to complete the PREA risk screening. The Classification Supervisor stated age was listed on the risk assessment, but he was unclear how to assess age as a risk factor.

While on-site, the Auditor observed the intake processing of a new LEP detainee. The Intake Officer utilized an interpreter through a conference call to complete the risk assessment. The detainee was asked if he was LGBTI, but he did not understand the question. The Intake Officer stated through the interpreter that she was basically asking if he was straight or gay. The Intake Officer did not explain the question thoroughly.

Recommendation: The facility should provide additional training for Intake Officers in completing the risk assessment, especially for LEP detainees, how to assess age as a risk factor, and how to ask questions regarding sexual orientation and gender identity. The PSA Compliance Administrator should consider observing the intake process periodically to ensure intake officers are completing the intake process appropriately.

During the on-site visit, the Auditor interviewed a transgender detainee. The detainee said he was asked if he was transgender at intake, but no further actions were taken by the facility. He stated he also told mental health staff he was transgender but again nothing happened. Approximately two months later, he submitted a request for hormone therapy. After this request, staff met with him to determine necessary accommodations and he was allowed to shower separately from other detainees. The Auditors met with medical and mental health staff and reviewed the detainee's medical and mental health files. Healthcare staff stated they were not aware the detainee was transgender until he submitted a request for hormone therapy. The Auditor's also reviewed the PREA risk assessment. The risk assessment includes one question, in two parts, related to sexual orientation and gender identity. The detainees are asked, "Do you wish to identify as gay, bisexual, transgender, intersex or gender non-conforming." The interviewer then answers the question, "Is the detainee perceived to be gender non-conforming?" If the

detainee answers in the affirmative and/or if the interviewer determines the detainee is gender non-conforming, the detainee is given one point on the risk assessment. The risk assessment does not specify the detainee's sexual orientation or gender identity. The interviewer is given instruction on the form to refer all detainees to medical if they answer affirmative to questions related to past sexual abuse or abusiveness but no instructions to refer a detainee to medical and mental health staff if the detainee identifies as transgender or intersex. The risk assessment does not identify transgender detainees or provide instructions to staff to refer the detainee to medical and mental health for evaluation.

Recommendation: The risk assessment asks the question if the detainee identifies as LGBTI. If the detainee answers yes, the interviewer does not ask, specifically if the detainee is lesbian, gay, bisexual, transgender, or intersex and the form does not instruct intake staff to refer transgender or intersex detainees to medical and mental health. The risk assessment should identify if a detainee identifies as transgender and an instruction to the intake officer for processing the transgender individual appropriately.

(e)(g) The policy 10.1.1 continues to state, "LIPC shall ensure that between 60 and 90 days from the initial assessment at the facility, staff shall reassess each detainee's risk for victimization or abusiveness using the PREA Vulnerability Reassessment Questionnaire which is to be completed by case managers. Facilities shall use the GEO PREA Vulnerability Reassessment Questionnaire to conduct the reassessment. 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 or abuse or victimization." During the on-site visit, the Auditors reviewed 10 detainee files and found reassessments were completed within 60-90 days of admission for all detainees except one. Access to this information is restricted to those individuals with a need to know.

The Classification Supervisor stated the facility completes reassessments within 60-90 days of the initial assessment but that the facility does not complete a risk assessment following an incident of sexual abuse. He confirmed transgender detainees are reassessed every six months. While on-site, the Auditor reviewed the transgender detainee's initial risk assessment and the detainee's mental health file. The transgender detainee had only recently been identified as transgender. The initial risk assessment did not indicate the detainee was transgender, although the detainee reports giving this information to the intake officer. The transgender detainee stated he also reported this information to mental health staff. This was confirmed through a review of the mental health file, but the mental health staff failed to inform medical staff or the facility. The mental health staff member is no longer employed by the facility. The PSA Complliance Manager stated she would ensure the 6-month reassessment of trqansgender detainees would be completed. An interview with the PSA Compliance Manager indicated the facility does not complete a reassessment of the victim or abuser immediately following an incident of sexual abuse.

Does Not Meet: (e): The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The facility must develop a process to ensure reassessments are completed on all victims and abusers after an allegation of sexual abuse, within 24 hours of the incident. The facility must provide training to staff on the reassessment process, provide this reassessment process in writing, and the documented staff training for compliance review.

(f): The policy 10.1.1 states, "Disciplining detainees for refusing to answer or not providing complete information in response to certain screening questions is prohibited." Intake staff and the Classification Supervisor confirmed detainees are not disciplined for not divulging disabilities, self-identification as LGBTI, having previously experienced sexual victimization, or the detainee's own concerns about their safety.

(g): The policy 10.1.1 states, "LIPC shall 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. Sensitive information shall be limited to need-to-know employees only for the purpose of treatment, programming, housing, and security management decisions."

The Classification Supervisor explained sensitive information related to sexual victimization or abusiveness is maintained in the detainee file and on the facility's computer database with restricted access only to those staff with a need to know the information.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 27 – Risk Assessment (transgender); Memorandum – No transgender detainees past 60 days PREA At Risk Log

(a): Policy 10.1.1 states, "Screening information shall be used to inform assignment of detainees to housing, recreation and other activities, and voluntary work. LIPC shall make individualized determinations about how to ensure the safety of each detainee. The PSA Compliance Manager will maintain an "at risk log" of potential victims and potential abusers determined from the PREA Intake Risk Screening Assessment. The "at risk log" will be kept current and include current housing locations. The PSA Compliance Manager will also maintain a tracking log of those individuals who self- identify as LGBTI with their housing location…Following a 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 intake and classification staff explained a custody (security) classification scoring system is utilized to determine the housing, work, and program placement. Information from the risk assessment could affect the placement of detainees to increase or decrease the security level of their housing and placement with victims/abusers. The PREA At-Risk logs demonstrated the facility's monitoring of individual detainees who are potential victims or abusers which includes their housing assignment. The information in the detainee files does not indicate where the detainee was housed following the intake risk assessment, but a risk assessment was included as well as a custody classification assessment.

The Auditors reviewed ten detainee files and found initial risk assessments were completed for nine of these detainees.

(b): Policy 10.1.1 states, "When making assessments and housing decisions for transgender and intersex detainees, LIPC shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. A medical or mental health practitioner shall be consulted as soon as practicable on these assessments and placement decisions which shall not be based solely on the identity

documents or physical anatomy of the detainee. Unless client written mandates differ, the following guidelines will be adhered to if for security reasons general population housing is not assigned after intake processing, and involuntary segregation is used, the guidelines for Protective Custody of this policy must be followed. Serious consideration shall be given to the individual's own views with respect to his/her own safety. 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 AFA, 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. Placement into administrative segregation due to a detainee's identification as transgender or intersex should be used only as a last resort and when no other viable housing options exist. The detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. Housing and programming assignments for each transgender and intersex detainee shall be reassessed at least twice each year to determine any threats to safety experienced by the detainee. This assessment is completed by the PREA PSA Compliance Manager. Serious consideration shall be given to the individual's own views with respect to his/her own safety. LIPC shall use the Transgender Care Committee Summary form to conduct the six-month reassessment."

Interviews with the Classification Supervisor and security staff confirmed transgender detainees were housed in Special Housing Unit (SHU). Several security staff reported that most transgender detainees are housed in the segregation area. Although the information received during the interviews does not support compliance, the facility policy and practice supported compliance. The transgender detainee interviewed onsite was not placed in SHU, but rather was allowed to remain in general population, as he requested.

The Auditor reviewed a risk assessment of a transgender detainee provided by the facility during the pre-audit phase. The facility also provided a memorandum stating there have been no transgender detainees who have remained in the facility past 60 days, so an example of a reassessment of a transgender detainee was not available. During the on-site audit, the facility shared there had been no transgender detainees housed longer than 60 days; therefore, there were not files to review.

During the on-site visit, the Auditor interviewed a transgender detainee. The detainee said he was asked if he was transgender at intake, but no further actions were taken by the facility. He stated he also told mental health staff he was transgender but again nothing happened. Approximately two months later, he submitted a request for hormone therapy. After this request, staff met with him to determine necessary accommodations and he was allowed to shower separately from other detainees. The Auditors met with medical and mental health staff and reviewed the detainee's medical and mental health files. The mental health file confirmed the detainee informed the mental health worker that he was transgender, but the mental health worker did not share this information with medical or facility staff. The mental health worker is no longer on staff. Healthcare staff stated they were not aware the detainee was transgender until he submitted a request for hormone therapy. The Auditors also reviewed the PREA risk assessment. The risk assessment includes one question, in two parts, related to sexual orientation and gender identity. The detainees are asked, "Do you wish to identify as gay, bisexual, transgender, intersex or gender non-conforming." The interviewer then answers the question, "Is the detainee perceived to be gender non-conforming?" If the detainee answers in the affirmative and/or if the interviewer determines the detainee is gender non-conforming, the detainee is given one point on the risk assessment. The risk assessment does not specify the detainee's sexual orientation or gender identity. The interviewer is given instruction on the form to refer all detainees to medical if they answer in the affirmative to questions related to past sexual abuse or abusiveness but no instructions to refer a detainee to medical and mental health staff if the detainee identifies as transgender or intersex (as per facility policy).

Does Not Meet (b): An initial risk assessment did not specify the detainee was transgender, and the detainee was not referred to medical and mental health, also housing and showering accommodations were not made until two months following his admission to the facility. Mental health staff were informed the detainee was transgender but did not ensure the information was passed on to medical or facility staff. The risk assessment should specify if the detainee answered in the affirmative to being gay, lesbian, bisexual, transgender, or intersex. The risk assessment should direct the intake officer to refer transgender or intersex detainees to medical and mental health to ensure their specific needs are addressed, as outlined in the facility's policy and the standard. The facility must develop a process to ensure that medical and mental health staff are consulted as soon as possible on the detainee's assessment and housing placement for the detainee's health and safety or complete a Transgender Care Committee as required by policy within the appropriate time frame which includes medical and mental health staff. The facility must provide the process that will be used to making assessments for transgender detainees and provide documented training of staff on the process as well as an example of an initial risk assessment and the housing placement determination for a transgender detainee made based on TCC or another process for compliance review.

(c): Policy 10.1.1 states, "When operationally feasible, transgender and intersex detainees shall be given an opportunity to shower separately from other detainees." All security staff, medical staff and the Facility Administrator interviewed reported that transgender detainees are given the opportunity to shower separately from the general population. The transgender detainee interviewed on-site stated he was given the opportunity to shower separately, and he is satisfied with his showering situation.

§115.43 - Protective custody.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 28 – Documentation of Protective Custody Order and review
- PREA Policy approval

(a)(b): Policy 10.1.1 states, "LIPC shall develop and follow written procedures governing the management of its administrative special management unit. These procedures should be developed in consultation with the ICE Enforcement and Removal Operations (ERO) FOD having jurisdiction for the facility, must document detailed reasons for placement of an individual in administrative special management on the basis of a vulnerability to sexual abuse or assault. Use of administrative special management 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. LIPC should assign detainees vulnerable to sexual abuse or assault to administrative special management for their protection 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."

The Facility Administrator explained that the facility strives to avoid placing detainees vulnerable to sexual abuse in administrative segregation. He explained they would not remain in administrative segregation longer than 24 hours, allowing staff to secure alternative housing. The exception would be if a detainee requested and was approved for placement in protective custody.

The Auditor confirmed the facility policies were approved by the AFOD on July 7, 2020.

(c): Policy 10.1.1 states, "If special management housing is used to protect vulnerable detainees, they shall have access to programs, visitation, counsel and other services available to the general population to the maximum extent practicable." There was one case in which a detainee was placed on protective custody at his request but shortly thereafter requested removal from protective custody. The detainee had access to programs, visitation, and other services available to the general population as noted in the detainee's file. The detainee was removed from protective custody.

(d)(e): Policy 10.1.1 also states, "Facilities shall implement written procedures for the regular reviews of all detainees held in administrative special management for their protection as follows: a supervisory staff member shall conduct a review within 72 hours of the detainee's placement in administrative special management to determine whether special management unit (SMU) is still warranted; a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in administrative special management and every week thereafter for the first 30 days, and every 10 days thereafter. Facilities shall utilize the "DHS Sexual Assault/Abuse Available Alternatives Assessment" form to document the assessments. All completed forms shall be reviewed and signed by the Facility Administrator or AFA upon completion. The facility shall notify the appropriate ICE FOD no later than 72 hours after the initial placement in administrative special management on the basis of a vulnerability to sexual abuse or assault for review and approval of the placement." The Auditors received conflicting information regarding the placement of at-risk detainees in protective custody. Interviews with the Classifiction Supervisor and several security officers indicated protective custody was routinely used for housing of transgender detainees and victims, but the practice and facility policy did not support these statements. The Auditors found only one case in which a detainee victim requested and was approved for assignment to protective custody. Shortly after assignment, the detainee did not feel he needed protective custody and asked to be removed. He was removed from protective custody and returned to general population.

While on-site, the Auditors toured the administrative special management unit. The Auditors were informed there were no detainees in protective custody following a PREA allegation.

The facility meets the requirements of this standard.

§115.51 - Detainee reporting.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 29 – Posting of consular, DHS Inspector General free numbers
- Exhibit 30 – Posting of DHS OIG hotline info for complaints

(a): Policy 10.1.1 states, "LIPC shall 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. Facilities shall provide contact information to detainees for relevant consular officials and the DHS OIG or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents."

The Auditor reviewed three postings provided by the facility. The first posting, a document tilted "Jena/LaSalle ICE Processing Center (71432)" provides instructions and a listing of free calls available to detainees, to include the designated consular officials and various free legal services. These calls are not anonymous as the detainee must enter their pin number. The second posting is the ICE Zero-Tolerance poster which provides information, in seven different languages, for reporting sexual abuse or assault to the DHS OIG, which is anonymous, and to the facility's PSA Compliance Manager/Investigator. The third posting is the DHS-prescribed Sexual Assault Awareness Information pamphlet in English and Spanish, which provides instructions to detainees for making free, anonymous reports of sexual abuse or assault. The DHS-prescribed Sexual Assault Awareness Information pamphlet is available through ICE in nine languages (English, Spanish, Arabic, Haitian Creole, French, Hindi, Portuguese, Punjab, and Chinese). The pamphlet provides numbers for reporting sexual abuse to the DRIL, OIG, JIC, PREA Information Hotline, National Rape Hotline, and the state sexual abuse hotline. The facility handbook informs detainees that correspondence to or from private attorneys and other legal representatives; embassies and consulates; the Department of Justice (including the DOJ Office of the Inspector General); DHS, ICE, ICE Health Services Corps, ERO, the DHS Office for Civil Rights and Civil Liberties, and the DHS OIG will only be treated as special correspondence if the title and office of the sender (for incoming correspondence) or addressee (for outgoing correspondence) is unambiguously identified on the envelope, clearly indicating that the correspondence is special.

During the on-site visit, the Auditors toured every area accessible to detainees, with the exception of housing areas designated as cohort or isolation. Each housing area had the ICE Zero-Tolerance DRIL poster, and the DHS-prescribed Sexual Assault Awareness Information posted. The facility also posts how to contact their consulate. The PSA Compliance Manager confirmed this information is posted in the housing and common areas of the facility.

(b): Policy 10.1.1 states, "Facilities shall provide detainees contact information on how to report sexual abuse or assault to a public or private entity or office that is not part of GEO (i.e., contracting agency ICE) and that is able to receive and immediately forward detainee reports of sexual abuse to facility or GEO officials, allowing the detainee to remain anonymous upon request. Facilities shall provide detainees contact information on how to report sexual abuse or assault to the facility PSA Compliance Manager."

As noted above, the Auditor reviewed the postings provided by the facility, which includes information for reporting to an agency that receives and immediately forwards detainee reports of sexual abuse or assault to the agency or facility. The posting indicates these calls can be made anonymously. While on-site the Auditor checked the DRIL, OIG, JIC and the phone number for reporting sexual abuse outside of GEO, and the National Rape Hotline. The Auditor called Wellsprings Alliance through the detainee phone system. Although Wellsprings stated they would talk with a

detainee caller, they stated they would not report an allegation if requested. The Auditor tried to contact RAINN. The call was able to go through without requiring a pin number or other identifying information. The person answering the call told the Auditor to call back at another time and discontinued the call. The Lead Auditor made a second attempt to make an anonymous report to one of the posted sources. All calls went through without requiring the detainee to provide identifying information, but the DRIL operator stated they would not take a report of sexual abuse unless the caller provided their A number. The Auditor tried the OIG and JIC numbers and both operators stated they would take a report of sexual abuse without providing identifying information. The operators for both OIG and JIC were responsive, concerned, and professional. The Auditor then called the line designated by GEO to take anonymous reports and RAIN. Both the GEO number and RAIN referred the Auditor to the same regional/state program. This program stated they would not take calls related to sexual abuse or sexual assault as they only deal with domestic violence. The facility has multiple ways of reporting to include anonymous reporting through OIG and JIC, but the agency requires DRIL to accept anonymous reports. Most detainees reported they would report any PREA concerns to the supervising officer or would call the phone numbers listed on the posters. Of the nine closed investigation files reviewed from the audit period, five allegations were reported verbally to staff, two through grievances, one through a digital request to the Captain, and one from another facility.

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

(c): Policy 10.1.1 states, "Employees shall accept reports made verbally, in writing, anonymously and from third parties and shall promptly document any verbal reports." All security staff interviewed reported they would accept reports of sexual abuse made verbally, in writing, anonymously, and from third parties. All staff reported they would immediately separate the victim and contact their supervisor. The security staff also reported any sexual abuse or assault reported to them would only be shared with those with a "need to know." The reporting requirements are also outlined on the Sexual Abuse First Responder Duties card for staff. Through the review of the investigative files, staff members have accepted verbally reported allegations and promptly documented the verbal report.

The facility meets the requirements of this standard.

§115.52 - Grievances.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 8 – Detainee Handbook
- Exhibit 31 – Memorandum – No grievances for sexual abuse

(a)(b)(c)(d)(f): Policy 10.1.1 states, "LIPC grievance policies shall include the following procedures regarding sexual abuse grievances: LIPC 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; LIPC shall not impose a time limit on when a detainee may submit a grievance regarding allegation of sexual abuse; LIPC shall 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; LIPC staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment; 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."

The facility's detainee handbook explains the grievance procedure as it relates to sexual abuse reports and notifies detainees that there are no time restrictions as to when a grievance related to sexual abuse can be submitted.

The PSA Compliance Manager/Grievance Officer reported she would accept a report of sexual abuse made through the grievance system. She also stated there are no time limits imposed for reporting sexual abuse grievances. She stated upon receipt of a grievance related to sexual abuse, she would notify the PSA Compliance Manager and her supervisor. She added an investigation would begin immediately, and staff would have the alleged victim separated from the alleged abuser and the alleged victim taken to medical.

The security staff reported they would accept a report of sexual abuse made through the grievance system. They reported they would immediately separate the victim and alleged abuser and notify their supervisor, who in turn would notify medical staff. Approximately half of the detainees interviewed were aware that they could file a report of sexual abuse through the grievance system. Largely, the English-speaking detainees had a much better understanding of the grievance system and how to report using the grievance system.

The facility provided a memorandum stating there were no grievances reported, related to sexual abuse, during this audit period. However, the Auditor's review of sexual abuse investigations revealed there were three grievances related to allegations of sexual abuse. Two of the grievances were submitted at the same time and named the same alleged abuser, and the third grievance was an allegation against staff. Each of these instances were handled in accordance with the facility policy and this standard. There were two allegations reported through the grievance process. Both grievances were accepted by the housing unit officer and forwarded for further action. The facility started investigations on the same day as the allegations were made through the grievance process. One case was determined unfounded and the other one was unsubstantiated.

(e): LIPC Policy 10.1.1 further states, "LIPC 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. LIPC shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE FOD at the end of the grievance process. The PSA Compliance Manager shall receive copies of all grievances related to sexual abuse or sexual activity for monitoring purposes."

The Grievance Officer reported she would respond to the grievance within 24 hours, notifying the detainee that an investigation had been initiated, and would adhere to all other time limits for handling sexual abuse grievances. This was documented in the review of the investigative file and the grievance response to the detainees. She added the case manager would expedite a detainee's request for assistance from another person to complete the grievance. Most security staff were unsure how to expedite a detainee's request for assistance from another person to file the grievance, while others reported they would contact the case manager who is able to expedite the detainee's request for assistance.

Recommendation: The facility should provide refresher training to staff on the grievance process including that when preparing a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives and on the process for staff to take reasonable steps to expedite requests for assistance from other parties.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 8 – Detainee Handbook
- Exhibit 9 – ICE Zero Tolerance Poster; ICE PREA Pamphlet; How to Make Anonymous Calls; GEO PREA Reporting info Exhibit 12 – Announcement for Sheriff's Victim Advocate Program

(a)(b)(c): Policy 10.1.1 states, "LIPC 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. LIPC shall 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 (including toll-free hotline numbers where available). If local providers are not available, LIPC shall make available the same information about national organizations".

The PSA Compliance Manager explained the facility has attempted to obtain services for detainees through community resources, with no success. During the on-site visit, the Auditors also met informally with the PREA Compliance Manager, Facility Administrator, and Assistant Facility Administrator to discuss their efforts to secure victim advocacy services to provide crisis intervention and counseling services to no avail. The Auditor reviewed attempts by the facility to secure community resource services.

The facility has attempted to the fullest extent possible to secure community resources to provide crisis intervention and counseling services. The facility has the resources to provide these services through the facility's mental health staff. The facility's mental health staff are available to provide victim advocacy services to victims of sexual abuse and to the abuser. The Auditors met with facility mental health staff to discuss the availability of the victim advocacy services. The Auditors are satisfied that the facility mental health staff possess the skills and time to provide crisis intervention and counseling services to detainee victims. There was one detainee victim available for interview during the on-site visit. He reported he was evaluated by mental health staff when he reported the incident and offered follow-up counseling services at no cost to the detainee. The facility also provides a listing of national organizations that can provide support services.

The Auditors determined the facility has exhausted every effort to locate community resources and has posted the National Rape Hotline, which will not accept calls related to sexual abuse. The Auditors also determined the mental health staff have the time, and skills to provide these services to detainee victims of sexual abuse.

Recommendation: The facility should contact the National Rape Hotline and notify them of the problems encountered when referred to the state/regional program.

(d): Policy 10.1.1 states, "LIPC shall enable reasonable communication between detainees and these organizations as well as inform detainees (prior to giving them access) of the extent to which GEO policy governs monitoring of their communications and when reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." The facility cannot obtain outside confidential support services for detainees and has made considerable efforts to try and obtain these outside services for detainees; therefore the facility has not had to inform detainees about reasonable communication governing the monitoring of communications with outside confidential support services. The National Rape Hotline is posted but, as noted earlier, refers the detainee to the regional organization. Through a phone call with the regional organization, the Auditor was told the regional organization only works with domestic violence victims and does not address sexual abuse compliants and only provides support services to domestic violence victims. These support services are provided to the detainee through the facility's mental health staff as confirmed with interviews with the mental health staff and the PSA Compliance Manager.

The facility meets the requirements of this standard.

§115.54 - Third-party reporting.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 30 - Posting of DHS OIG hotline info for complaints
- Exhibit 32 – ICE Detention and Reporting and Information Line Public Posting

Policy 10.1.1 states, "LIPC shall 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."

GEO posts information for third party reporting on their website at: https://www.geogroup.com/prea.

During the on-site visit, the Auditors confirmed that third party reporting information is posted in the lobby, visitation, and staff break areas.

The facility meets the requirements of this standard.

§115.61 - Staff reporting duties.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program

(a)(b): Policy 10.1.1 states, "Employees are required to immediately report, in accordance with agency 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; any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation."

The PSA Compliance Manager confirmed that staff are trained to immediately report any of the above information directly to the Facility Administrator, Human Resource Manager, or to her office. The security staff interviewed were aware of their responsibility to immediately report this information and were aware that they could contact upper administration directly. The Auditor confirmed the facility policies were approved by the AFOD on July 7, 2020.

The reporting requirements are also outlined on the Sexual Abuse First Responder Duties card for staff. Through the review of the investigative files, all reports made to staff were immediately reported and responded to appropriately.

(c): Policy 10.1.1 states, "Apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary 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. Employees reporting sexual abuse shall be afforded the opportunity to report such information to the Chief of Security or upper- level executive privately if requested and may also utilize the employee hotline or contact the Corporate PREA Coordinator directly to privately report these type incidents."

The security staff were also aware that information regarding sexual abuse or assault is only provided to those staff with a "need to know."

(d): The facility does not house juveniles. The Facility Administrator and PSA Compliance Administrator were unsure about state reporting requirements for vulnerable adults but they stated they would verify if there were local or state requirements for reporting sexual abuse of a vulnerable adult. There were no reports of sexual abuse by a vulnerable adult during this audit period.

The facility meets the requirements of this standard.

§115.62 - Protection duties.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program

Policy 10.1.1 states, "When an employee or LIPC 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. Employees shall report and respond to all allegations of sexually abusive behavior. Employees should assume that all reports of sexual victimization, regardless of the source of the report (i.e., "third party") are credible and respond accordingly."

Each staff member is provided a Sexual Abuse First Responder Duties card outlining staff are to separate the alleged victim and abuser and immediately notify the on-duty call supervisor. All security staff interviewed reported that upon receiving a report of sexual abuse or knowledge that a detainee was at risk of sexual abuse, they would take immediate action to protect the detainee by separating the alleged victim and contact their supervisor. A review of the investigative files revealed staff took immediate action to protect the detainee and to immediately report the report of sexual abuse.

The PSA Compliance Manager explained sexual abuse victims who express a concern for their safety or if the facility has concerns for the sexual abuse victim's safety would be placed in SHU for protective custody. The facility will utilize protective custody in SHU, as a last resort.

The Auditors reviewed 11 allegations of sexual abuse, in each case, the alleged victim was immediately separated from the alleged abuser.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 33 – Memorandum – No incidents of reporting to another facility

(a)(b)(c): Policy 10.1.1 states, "In the event a detainee alleges that sexual abuse occurred while confined at another facility, LIPC shall document those allegations and the Facility Administrator or AFA (in the absence of the facility administrator) where the allegation was made shall contact the

Facility Administrator or designee where the abuse allegedly occurred and notify the ICE Field Office as soon as possible but no later than 72 hours after receiving the notification. LIPC 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."

The Facility Administrator and PSA Compliance Manager confirmed that notification would be made to the Facility Administrator of the facility in which the sexual abuse allegedly occurred and that they would report the information to the ICE Field Office. The facility also provided a memorandum stating they have not received any reports of sexual abuse or assault at another facility during the Pre-audit documentation review. While on-site, the Auditors were informed there were no reports of sexual abuse while a detainee was confined at another facility during the audit period.

(d): LIPC Policy 10.1.1 also states, "If the facility receives notification that an abuse occurred at the facility, the facility is responsible for notifying the ICE Field Office Director and to investigate the allegation in accordance with the PREA standards. This was also confirmed by the Facility Administrator." LIPC received notification from another facility of a reported allegation of sexual abuse that occurred at LIPC. The report only provided the first name of the alleged victim and did not have the date of the incident, the names of anyone else involved, or any other identifying information about the victim. LIPC attempted to identify the alleged victim but was unable to do so. Due to the limited information, the facility was unable to identify the detainee, so an investigation was not completed, and the case was closed.

The facility meets the requirements of this standard.

§115.64 - Responder duties.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 34 – Report of sexual abuse made by a 1st responder
- Sexual Abuse First Responder Duties card

(a)(b): Policy 10.1.1 states, "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 report 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; if the sexual abuse occurred within 96 hours, ensure that the alleged victim and abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. The alleged victim and abuser should be placed (separately) in a dry cell or area, where they cannot perform the following: washing, brushing teeth, changing clothes, urinating, defecating, and smoking, drinking, or eating; until the forensic examination can be performed. A security staff member of the same sex shall be placed outside the cell or area for direct observation to ensure these actions are not performed. 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."

The facility provides staff with a Sexual Abuse First Responder card that outlines the first responder duties. The card directs the staff to 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 any crime scene until appropriate steps can be taken to collect any evidence; do not let the alleged victim or abuser take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating; 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; and apart from reporting to designated supervisors, employees shall not reveal any information related to the incident to anyone other than to staff involved with investigating the alleged incident. The card also provides the employee hotline and GEO website as reporting methods, including anonymous reporting.

The security and non-security staff interviewed were aware of their responsibility to immediately separate the alleged victim from the abuser, notify their supervisor, preserve any evidence in the area, and inform alleged victims and abusers not to take any action, (eating, drinking, using the restroom, etc.) which may destroy physical evidence. It is clear to the Auditor that the security staff are well trained in how to respond appropriately to allegations of sexual abuse or assault.

The facility provided an example of a sexual abuse report made by a first responder (the Case Manager) in which the first responder immediately made notification to the PSA Compliance Manager of the abuse. During the audit period, the Auditors reviewed 12 investigations (nine closed; three open). Of these allegations, nine were reported to staff, two through the grievance process, one report from another facility and one report to staff through a formal request for interview.

The facility meets the requirements of this standard.

§115.65 - Coordinated response.

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

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 35 – Memorandum – No incident of transferring victim to another facility
- Exhibit 35 – LIPC #23 PREA Coordinated Response

(a)(b): Policy 10.1.1 states, "LIPC shall 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. LIPC shall use a coordinated, multidisciplinary team approach to effectively respond to all incidents of sexual abuse or assault and address any safety, medical, or mental health needs. The PSA Compliance Manager shall be a required participant and the Corporate PREA Coordinator may be consulted as part of this coordinated response."

The facility's institutional response plan is detailed in LIPC Emergency Plan #23 PREA Coordinated Response. The plan outlines the duties of first responders, shift supervisors, medical staff, mental health staff, investigators, and facility leadership. The plan includes a comprehensive checklist to be completed for all PREA incidents and clearly outlines a multidisciplinary approach to responding to allegations of sexual abuse or harassment. The Auditors reviewed 12 allegations of sexual abuse. Each of these investigations followed the coordinated response plan.

(c)(d): Policy 10.1.1 also states, "If the victim of sexual abuse is transferred between DHS Immigration Detention Facilities, 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. 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. Facilities shall utilize the "Notification of PREA Incident" form."

The Facility Administrator confirmed the facility would provide information of a victim's need for services, as permitted by law. He explained that the transfer, including any information provided, would be coordinated through ICE. The facility provided a memorandum stating there had been no sexual abuse victims transferred to another facility. The Auditors reviewed four investigations while on-site and nine investigations during the pre-audit phase. None of the alleged victims were transferred to another facility.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program

Policy 10.1.1 states, "Employees, contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Separation orders requiring "no contact" shall 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 Facility Administrator confirmed that any employee, contractor, or volunteer suspected of perpetrating sexual abuse are removed from any contact with detainees. Contractor and employees may be assigned other duties which do not allow detainee contact or are placed on leave pending the outcome of the investigation. Volunteers are not allowed to return to the facility until the investigation is completed.

The facility provided the first page of an allegation by a detainee of voyeurism by a staff member. The detainee signed and dated the allegation, but the receiving officer did not receive the report until two days later with no explanation provided. The PSA Compliance Manager was notified, and an investigation was initiated. There was no information provided regarding the separation of the detainee from the staff member in the investigation file. The allegation was investigated and determined to be unfounded.

Of the 12 allegations, three investigations involved a staff-on-detainee allegation. Two investigations were closed, and one investigation was open. One staff-on-detainee allegation came from another facility. This report did not identify the abuser. From the limited information provided the facility was unable to identify the victim. The investigation could not be conducted due to the limited information available, and the case was closed. For the remaining investigations, the staff member was removed from detainee contact pending the outcome of the investigation. None of the investigations involved a volunteer or contractor.

The facility meets substantial compliance with the separation of the staff member from detainee contact after a reported allegation from two of the three staff-on-detainee reported allegations.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 36 – Protection from Retaliation Logs

(a)(b)(c): Policy 10.1.1 states, "Employees, contractors, and volunteers, and detainees shall not retaliate 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. LIPC shall 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. LIPC's PSA Compliance Manager or mental health personnel shall be responsible for monitoring detainee retaliation. Facilities shall have multiple protection measures, such as housing changes or transfers for victims or abusers, removal of alleged staff or abusers from contact with victims who fear retaliation for reporting sexual abuse or for cooperating with investigations. A mental health staff member or the PSA Compliance Manager shall meet weekly (beginning the week following the incident) with the alleged victim in private to ensure that sensitive information is not exploited by staff or others and to see if any issues exist. Any issues discussed shall be noted on the "Protection from Retaliation Log", to include corrective actions taken to address the issue. For at least 90 days following a report of sexual abuse, LIPC shall monitor the conduct and treatment of detainees who reported the sexual abuse to see if there are changes that may suggest possible retaliation by detainees or staff; and shall act promptly to remedy such retaliation. Items to be monitored for detainees include disciplinary reports and housing or program changes. For at least 90 days following a report of staff sexual misconduct (abuse or harassment) by another employee, the facility human resources staff or facility investigator as designated by the Facility Administrator shall monitor the conduct and treatment of the employee who reported the staff sexual misconduct (abuse or harassment) or employee witnesses who cooperate with these investigations to see if there are changes that may suggest possible retaliation by others, and shall act promptly to remedy such retaliation. Monitoring shall terminate if the

allegation is determined to be unfounded. Designated staff shall meet every 30 days for 90 days with employees in private to ensure that sensitive information is not exploited by staff or others and to see if any issues exist. The Employee Assistance Program (EAP) may also be offered for emotional support services for employees who fear retaliation. Any issues discussed shall be noted on the "Employee Protection from Retaliation Log", to include corrective actions taken to address the issue. Items to be monitored for employees include negative performance reviews and employee reassignments. If any other individual expresses a fear of retaliation, the LIPC shall take appropriate measures to protect that individual as well. Completed monitoring logs shall be retained in the investigative file of the corresponding SAAPI incident."

The PSA Compliance Manager and Facility Administrator confirmed that the facility begins retaliation monitoring within one week of the report of the allegation. The PSA Compliance Manager explained that the monitoring would continue for a minimum of 90 days for staff, contractors, volunteers, and detainees, or until the detainee's release (if released prior to 90 days). She stated when monitoring detainees for retaliation, she reviews incident reports, disciplinary reports, and housing changes, as well as maintaining contact with the alleged victim. When monitoring staff for retaliation, she reviews disciplinary reports, shift changes, and post assignments. She added that she will extend the monitoring period if needed.

The Auditor reviewed nine closed sexual abuse investigations. With the exception of three cases, all alleged victims were monitored for retaliation until their release. One detainee was released before retaliation monitoring had been initiated. In another case, the alleged victim could not be identified due to lack of information and a full investigation could not be completed. The third allegation was unfounded and retaliation monitoring was not completed.

Recommedation: The facility must conduct retailiation monitoring on all cases including unfounded cases.

The facility meets substantial compliance with the standard by completing retaliation monitoring on six of the nine closed sexual abuse allegations.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 28 – Protective Custody Order
- Exhibit 37 – Administrative Segregation Order

(a)(b)(c)(d): Policy 10.1.1 states, "LIPC shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible (e.g., protective custody), subject to the requirements of 115.43. Detainee victims shall not be held for longer than five days in any type of administrative special management, except in unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. LIPC shall notify the appropriate ICE ERO FOD whenever a detainee victim has been held in administrative special management for 72 hours."

The PSA Compliance Manager explained that the alleged victim and alleged abuser are immediately separated when the allegation is received. The alleged victim can request protective custody but typically the alleged victim remains in general population in housing separate from the alleged abuser. The PSA Compliance Manager said detainees are reviewed after 72 hours to determine if alternative housing can be secured or if protective custody needs to continue. The facility will also notify the appropriate ICE FOD whenever a detainee victim has been held in administrative segregation for 72 hours. At the time of the Remote Interview phase, there were no detainees in protective custody due to concerns about sexual safety.

During the pre-audit phase, the facility provided documentation of one incident in which an alleged victim was placed in protective custody following a report of sexual abuse during the audit period. The alleged victim specifically requested placement in the SHU. The facility completed a DHS Sexual Abuse/Assault Available Alternative Assessment on the detainee, and he was subsequently placed in protective custody. The proper notifications were made to the FOD. The facility completed a 72-hour review of the detainee's placement to determine if alternative housing could be provided, and at the detainee's request, he was moved from protective custody. An administrative segregation review was conducted the same day and the detainee was removed from protective custody. The detainee had received sanctions which were unrelated to the sexual abuse allegation and was assigned to segregation as a result of this infraction. The detainee victim was interviewed and denied requesting protective custody. He reports he was housed in segregation for 55 days. After he completed his sentence in segregation, he was asked if he felt safe to return to general population. He was followed by mental health staff, and he was satisfied with the treatment he received.

While on-site, the facility provided the reassessment of the detainee conducted prior to returning to general housing requested by the Auditor, and found that it was completed in accordance with policy and the standard.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection

(a)(b): Policy 10.1.1-A states, "An administrative investigation shall be completed for all allegations of sexual abuse at LIPC, regardless of whether a criminal investigation is completed. The Facility Administrator and contracting agencies shall be notified prior to investigating all allegations of sexual abuse. Client notifications shall be documented and maintained as part of the investigative file. When LIPC 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. LIPC shall use investigators who have received specialized training in sexual abuse investigations. In allegations where a criminal investigation is initiated by ICE OPR, DHS OIG or outside law enforcement, LIPC shall begin an administrative investigation as soon as the criminal investigation has

concluded or at such time as the outside investigative entity indicates the facility may begin their administrative investigation."

During the Remote Interview phase, the PSA Compliance Manager/Facility Investigator reported that she conducts all administrative investigations at the facility and Jena Police Department completes all criminal investigations. She also notifies the FOD, GEO Corporate office, and Jena Police department of the allegations, and begins the administrative investigation upon notification of the allegation, contrary to the standard and facility policy. Administrative investigations should begin upon conclusion of the criminal investigation and after consultation with the appropriate investigative office within the DHS and the assigned criminal investigative entity.

Recommendation: Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. For auditing purposes, the consultation and subsequent approval or denial from the appropraie investigative office should be noted to verify compliance with this portion of the standard. The facility should conduct refresher training wen the administrative process should begin and after consultation with the appropriate investigative office.

The Auditor reviewed 9 closed investigations completed within the audit period and found an administrative investigation was completed for all allegations, except for the case in which the alleged victim could not be identified. The administrative investigations were thorough, objective and completed by a PREA trained investigator. Each investigation that may have rose to the level of criminal charges, was appropriately referred to the Jena Police Department and the Jena Police Department responded to each referral. Nine allegations were referred to the Jena Police Department. The Jena Police Department conducted seven investigations and declined to conduct two investigations that did not potentially pose criminal acts.

(c)(e)(f): Policy 10.1.1-A states, "Investigators shall gather and preserve direct and circumstantial evidence, including any physical or 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 credibility of the alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as detainee or staff. No agency shall require a detainee who alleges sexual abuse to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an allegation. Administrative investigations shall include an effort to determine if staff actions or failure to act contributed to the abuse and shall be documented in a written report format that includes at a minimum a description of physical and testimonial evidence, the reason behind credibility assessments, and investigative facts and findings. GEO shall retain all written reports referenced this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years; however, for any circumstance, files shall be retained no less than ten years."

The Facility Administrator stated the After-Action Review team reviews whether actions or a failure to act by staff contributed to the abuse. The Auditor noted that the administrative investigation reports do address actions or a failure to act by staff as it contributed to the abuse, as well.

The Auditor reviewed 9 closed investigations completed within the audit period and found an administrative investigation was completed for all allegations, except for the case in which the alleged victim could not be identified. The administrative investigations listed all evidence relied upon and included telephone and video monitoring, as well as interviews with all victims and witnesses, a review of prior abuse complaints, a determination of whether staff actions or a failure to act contributed to the abuse, and conclusions based on a preponderance of the evidence.

(e): Policy 10.1.1 states, "The departure of the alleged victim or abuser from the employment or control of the facility or agency shall not provide a basis for terminating an investigation." The PSA Compliance Manager/Facility Investigator stated that the departure of the alleged victim or abuser from employment or control by the agency would not be a basis for terminating the investigation. There were three incidents in which a detainee victim was released prior to the completion of the investigation. The investigations continued despite the release of the victim from custody.

(f): Policy 10.1.1 states, "When outside agencies investigate sexual abuse, the facility will cooperate with the outside investigators and shall endeavor to remain informed about the progress of the investigation." The PSA Compliance Administrator stated she has good communication with the Jena Police and stays in touch with the Jena investigators throughout the investigation to remained informed about the investigation and to provide any additional information the Jena investigators may require. The Facility Administrator is the contact person for ICE at the facility and responds to any questions or information ICE needs regarding the incident.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection

Policy 10.1.1-A states, "Facilities shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated."

The PSA Compliance Manager/Investigator stated for administrative investigations only a preponderance of the evidence is required to substantiate allegations of sexual abuse. During the on-site visit, the Auditors interviewed the new Facility Investigator. He stated for administrative investigations the facility cannot impose any standard of evidence higher than a preponderance of the evidence. A review of the administrative investigations confirms the level of proof required was no higher than a preponderance of the evidence.

The facility meets the requirements of this standard.

§115.73 - Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection
- Exhibit 38 – Notification of Outcome of Allegations

Policy 10.1.1-A states, "At the conclusion of all investigations conducted by facility investigators, the facility 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 detainee shall receive the original completed "Notification of Outcome of Allegation" form in a timely manner and a copy of the form shall be retained as part of the investigative file. The detainee will be provided an updated notification at the conclusion of a criminal proceeding if the detainee is still in custody at the facility. LIPC's obligation to report under this section shall terminate if the detainee is released from custody. If the facility did not conduct the investigation, it shall request the relevant information from the investigating agency in order to inform the detainee. At the conclusion of every investigation of sexual abuse, the written results shall be promptly forwarded to the Corporate PREA Coordinator for review."

The Facility Administrator confirmed that a written notification is provided to the detainee victim notifying them of the results of the investigation. The detainee signs the written notification acknowledging receipt. The Auditor reviewed the investigation files and found written notification of the outcome of the investigation is provided to detainees and maintained in the investigation file. If the detainee was released prior to the notification, this is noted on the notification form and placed in the investigation file.

During the audit period, the Auditors reviewed nine closed investigations. Three detainees left before investigations were closed. One investigation was closed when the victim and abuser could not be identified. Three detainees were provided with investigation findings. Two detainees were not provided notification of the investigation findings.

Does Not Meet: The agency shall, when the detainee is still in immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation of sexual abuse, notify the detainee as to the result of the investigation and any responsive action taken. The Auditor was unable to verify that all detainee victims are notified of the results of PREA investigations. The agency needs to provide notifications after the completion of the investigation by the agency. The facility's practice to provide notifications after the administrative investigations must be consistent to inform all detainees the outcome of the administrative investigations. The agency and facility must develop a process to ensure all detainees are provided the outcome of an investigation or attempts are made to forward the notification to detainees transferred to another ICE facility. The agency and facility must provide the process as well as training for agency staff on the process and requirement to make outcome notifications for compliance review. The agency and facility must provide three examples of outcome notifications made for compliance.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection
- Exhibit 39 – Memorandum – No staff resignation or dismissals due to sexual abuse reports

(a)(b)(c)(d): Policy 10.1.1-A states, "Staff shall be subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies. 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, as defined under the definition of sexual abuse of a detainee by an employee, contractor, or volunteer. LIPC 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. LIPC shall make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known."

The facility policies were approved by the Acting AFOD on July 7, 2020.

The Facility Administrator confirmed that staff are subject to removal from their position for substantiated allegations of sexual abuse. He added that unless the action was clearly not criminal, a report would be made to law enforcement. He explained that most of the licensed staff work for the medical department and that reports would be made to any applicable licensing body for violation of sexual abuse policies that resulted in a removal or resignation in lieu of removal from employment.

The facility provided a memorandum stating that during the audit period, there have been no instances where a staff member was terminated, resigned, or where other sanctions were given to a staff member for violating sexual abuse policies. The memorandum is consistent with the Auditor's findings, after reviewing the facility's sexual abuse investigations for the audit period. Of the allegations, one closed investigation involved a staff-on-detainee allegation, which was determined to be unfounded. There was another case for staff-on-detainee that was still open. The remaining staff on detainee allegation was reported by another facility. The abuser was not identified, and the victim could not be identified from the information provided. The case was closed.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection
- Exhibit 40 – Memorandum – No volunteer or contractor termination/resigned due to sexual abuse allegations

(a)(b)(c): Policy 10.1.1-A states, "Any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees. LIPC 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. Contractors and volunteers

suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. LIPC 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 stated the facility would follow the coordinated response plan regarding a volunteer or contractor who engages in sexual abuse. The contractor or volunteer would be prohibited from having any contact with detainees and would be reported to law enforcement and relevant licensing bodies notified.

The facility provided a memorandum stating, "There were no volunteer or contractor terminations or resignations due to sexual abuse allegations, which is consistent with the Auditor's review of the facility's sexual abuse investigations within the past 12 months." This was confirmed through the Auditor's review of the investigation files for the audit period. None of the investigations involved a volunteer or contractor.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection
- Exhibit 41 – Detainee Disciplinary Action for Sexual Abuse

(a)(b): Policy 10.1.1-A states, "LIPC shall 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."

The Facility Administrator explained all disciplinary charges are processed in accordance with the disciplinary code. The detainees are provided a facility handbook at intake. The facility handbook has a section "Disciplinary Procedures," that outlines the disciplinary process and prohibited acts of conduct and sanctions.

(c)(d): Policy 10.1.1 states, "LIPC shall have a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure. The disciplinary process shall consider 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 Administrator explained as part of the disciplinary appeal process, a detainee may also file a grievance. The facility provided documentation of disciplinary action taken against a detainee for inappropriate touching. The incident was outside of the audit period but was provided to verify the process used when a detainee-on-detainee allegation is substantiated. The disciplinary sanctions were commensurate with the infraction. The facility is accredited by the American Correctional Association (ACA) which also has standards with strict requirements for disciplinary process which includes progressive levels of appeals and review and requires a mental health review of any detainee who may be suffering from mental illness or other disabilities that may have affected their behavior or thinking at the time of the incident. The Facility Administrator also added that a mental health assessment would be completed for any detainee suspected of suffering from a mental disability or illness.

Disciplinary Procedures outlines prohibited acts of conduct and sanctions, which are broken into offense categories of Greatest (sexual assault), High (engaging in sexual acts, making sexual proposals or threats), High Moderate, and Low Moderate. The handbook outlines the detainee can appeal the decision of the Disciplinary Officer within seven days using the grievance procedure.

(e): Policy 10.1.1 states, "LIPC 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." The Facility Administrator stated that consensual sex is not allowed between detainees and staff. A detainee is not disciplined for sexual abuse unless the staff member did not consent to the sexual contact.

(f): Policy 10.1.1 states, "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 PSA Compliance Manager shall receive copies of all disciplinary reports regarding sexual activity and sexual abuse for monitoring purposes." The Facility Administrator added that detainees are not punished for making a good faith report of sexual abuse.

Of the investigations reviewed for the audit period, no disciplinary action was taken against a detainee related to the sexual abuse incident.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 42 – Alleged Victim Mental Health Evaluation

(a)(b)(c): Policy 10.1.1 states, "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. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. 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. Information related to

sexual victimization or abusiveness in an institutional setting is limited only to medical and mental health practitioners and other employees as necessary to inform treatment plans, security and management decisions, or otherwise required by federal, state or local law."

The Auditor interviewed two detainees who reported they had experienced prior sexual victimization. A review of facility detainee medical files confirmed that these detainees were evaluated by mental health staff within 72 hours of the referral.

The medical staff interviewed confirmed that detainee referrals are seen by medical for a health evaluation no later than 2 days after the referral and within 72 hours for any mental health referrals. The intake and classification staff confirmed that detainees who report having experienced prior sexual abuse are referred to the mental health department. According to the HSA, the medical and mental health records are maintained in the medical area and have very strict access. Detainee files are also stored securely with restricted access.

While on-site, the Auditors observed the intake processing of a detainee. The detainee did not report a history of sexual abuse, but intake staff reported they immediately refer any detainee who reports a prior history of sexual abuse to mental health staff for evaluation.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 43 – Documentation of Mental Health contact

(a)(b): Policy 10.1.1 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 medical staff interviewed stated that when an allegation is made of sexual abuse, the alleged victim is brought to the medical department immediately and is examined and treated as necessary. If the detainee is to be transported for a forensic examination, medical staff will attend to any urgent medical needs, and stabilize the detainee prior to transport to the medical facility. The staff explained that mental health staff work at the facility seven days per week and are on-call after normal working hours for emergencies. The staff also explained that if the mental health staff is not present, the detainee would be seen the next working day. All services are free to the detainee, regardless of whether the alleged victim names the abuser or cooperates with the investigation. If necessary, medical staff can provide pregnancy tests and sexual transmitted disease prophylaxis. Facility medical staff confirmed detainees are seen by medical staff when a PREA allegation is made but that medical staff are not trained, nor do they conduct SAFE/SANE examinations. The medical staff will stabilize the detainee for transportation to the hospital. Medical staff confirmed there is no cost to the detainee for the forensic examinations. The Auditor reviewed 12 sexual abuse investigations, one of these investigations required a forensic examination.

The Auditor reviewed nine closed sexual abuse investigations during the audit period and found that the alleged victims were taken to medical when the allegation was received, and that the alleged victims were seen within 24 hours by mental health staff. One detainee victim was interviewed during the on-site visit that confirmed he was taken to medical.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 44 – Mental Health Segregation Rounds

(a)(b)(c): Policy 10.1.1 states, "LIPC shall 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. These services shall be provided in a manner that is consistent with the level of care the individual would receive in the community."

The medical staff reported that all detainee victims of sexual abuse are afforded medical and mental health evaluations and on-going care as necessary. This care includes follow-up services, treatment plans, and referrals for continued services if the detainee is transferred to another facility. Most healthcare staff interviewed reported the care provided exceeds the standard of care provided in the community. This was supported through a review of the nine closed investigation files reviewed during the audit period.

(d)(e)(f): Policy 10.1.1 further states, "Victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services. Victims shall also be offered tests for sexually transmitted infections as medically appropriate. 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."

Medical staff also reported that if the assault involved vaginal penetration by a male, the victim would be offered pregnancy tests. Victims are also provided sexual transmitted disease testing and treatment. All services provided to the victim are free.

During the audit period, the Auditors reviewed nine closed investigations and interviewed one detainee victim. The investigation files indicated each detainee victim was offered medical and mental health services. The detainee victim stated he was offered and received continued mental health care following the incident.

(g): Policy 10.1.1 also states," LIPC shall 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. Note: "known abusers" are those detainee abusers in which a SAAPI investigation determined either administratively substantiated or substantiated by outside law enforcement. All refusals for mental health services shall be documented."

Medical staff confirmed detainee abusers are offered mental health services. These services include mental health evaluation and treatment. The Auditor reviewed medical records provided by the facility and found a clinical note made by mental health staff for an alleged abuser. A preliminary evaluation was conducted, and the detainee was offered services, which he declined.

During the audit period, the Auditors reviewed nine closed investigations. Mental health staff attempted to conduct an evaluation of six alleged abuser within 60 days, but three abusers were not evaluated. For one investigation, the alleged abuser was seen by mental health during routine segregation rounds but there is no indication in the file that an evaluation of the detainee was conducted. The detainee had been receiving mental health services weekly prior to the allegation, so the Auditor determined that mental health staff was aware of the needs of the abuser and was willing to continue providing services if the detainee agrees. Mental health evaluations of the abuser were not found for the remaining two alleged abusers.

The facility meets the requirements of this standard.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

- LIPC Policy 10.1.1 Sexual Abuse/Assault Prevention and Intervention (SAAPI) Program
- Exhibit 45 – Sexual Abuse Incident Review Form; Memo – No incidents resulting in policy or practice changes
- Exhibit 46 – Annual Review

(a)(b): Policy 10.1.1 states, "LIPC is required to 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. The review team shall consist of upper-level management officials, the local PSA Compliance Manager, and medical and mental health practitioners. The Corporate PREA Coordinator may attend via telephone or in person. A "DHS Sexual Abuse or Assault Incident Review" form of the team's findings shall be completed and submitted to the local PSA Compliance Manager and Corporate PREA Coordinator no later than 30 working days after the review via the GEO PREA Database. LIPC shall implement the recommendations for improvement; or document its reasons for not doing so."

The Facility Administrator and PSA Compliance Manager confirmed that sexual abuse incident reviews are conducted for each sexual abuse allegation. The Auditor reviewed nine closed sexual abuse investigations within the audit period and found that the facility conducted an incident review at the conclusion of each investigation. Except for two reviews, the sexual abuse incident review date was not entered on the form. Of the two completed reviews in which a date was entered, the sexual abuse incident reviews were not conducted within 30 days of the completion of the investigation's completion.

Does Not Meet: The facility could not demonstrate if seven incident reviews were conducted within 30 days of the conclusion of the investigation the other two incident reviews were outside the 30 day period. The facility must develop a process to ensure incident reviews are conducted and documented within 30 days of the conclusion of the investigation. The facility must provide training with staff of the standard requirement and process developed. The facility must submit the process developed, documented staff training, and three examples of incident reviews completed within 30 days of the investigation for compliance review.

(c): Policy 10.1.1 states, "Annually, LIPC shall conduct a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If there have not been any reports of sexual abuse during the annual reporting period, then LDF shall prepare a negative report. LIPC shall document the review utilizing the "DHS Annual Review of Sexual Abuse Incidents" form. The results and finding shall be provided to the Facility Administrator, FOD or his/her designee, and Corporate PREA Coordinator upon completion."

The Facility Administrator and PSA Compliance Manager explained that an annual review of all sexual abuse investigations is conducted. The Auditor reviewed the completed annual assessment for 2019, which covered the period of October 1, 2018, through September 30, 2019. The report, sent to the FOD, indicated there had been an increase of one sexual abuse allegation from the preceding year and increase of one substantiated finding. The report attributed this increase, in part, to an increase in the detainee population, a longer average length of stay, and a higher custody classification of detainees. The corrective action plan was to fill two open positions, PSA Compliance Manager and Facility Investigator. The facility has filled these two positions.

During the audit period, the Auditors reviewed nine closed investigations. Of these investigations, sexual incident reviews were conducted for each closed investigation except for one case in which the allegation was determined to be unfounded and one case in which the alleged victim and abuser could not be identified.

The facility meets the requirements of this standard.

§115.87 - Data collection.

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

Notes:

(a): Policy 10.1.1 states, "LIPC shall collect and retain data related to sexual abuse as directed by the corporate PREA coordinator. LIPC shall maintain in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender

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 policy also states, "The LIPC PSA Compliance Manager shall work with the DHS PSA Coordinator on an ongoing basis to share data regarding effective response methods to sexual abuse. The LIPC PREA Compliance Manager shall be responsible for compiling data collected on sexual activity and sexual abuse incidents and forwarding statistical reports to the Corporate PREA Coordinator on a monthly basis. In addition to submitting the Monthly PREA Incident Tracking Log, PSA Compliance Managers will ensure that a PREA Survey is created, updated, and submitted for review and approval in the PREA Portal for every allegation of sexual abuse and sexual activity as required."

The PSA Compliance Manager verified that she collects and maintains the above information and uses this information to provide required reporting information to GEO corporate and ICE officials. She also reported that this information is maintained in her office, in a locked gun safe.

During the on-site visit, the Auditors verified the secure storage of data related to sexual abuse was maintained under lock and key.

The facility meets the requirements of this standard.

§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): During the on-site visit, the Auditors were given full access to all areas accessible to detainees, with the exception of the cohort pods.

(e): During the Pre-Audit and Remote Interview phases of the contingency audit, the Auditors reviewed all policies, memos, and other documents required to make assessments on the facility's PREA compliance. During the on-site visit of the audit, the Auditors reviewed additional compliance documentation, detainee, and staff files.

(i): Interviews with detainees conducted remotely through WebEx were conducted in private and remained confidential, as were the interviews conducted with staff via a conference line. The Auditor was provided with a private room to interview staff and detainees while on-site.

(J): The Auditors received no communication from detainees or staff.

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:	0
Number of standards met:	35
Number of standards not met:	4
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Margaret L. Capel 9/13/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/13/2021

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/13/2021

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:	Margaret L. Capel	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(479) 422-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(772) 579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	New Orleans		
Field Office Director:	Diane L. Witte		
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:	LaSalle ICE Processing Center		
Physical address:	830 Pinehill Road, Jena, LA 71342		
Mailing address: *(if different from above)*	P.O. Box 2826, Jena, LA 71342		
Telephone number:	318-992-7800		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-992-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Compliance Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(318) 992-(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 U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of LaSalle ICE Processing Center (LIPC) was conducted on June 22 – 23, 2021 by U.S. Department of Justice (DOJ) and (DHS) certified PREA Auditors, Margaret Capel and Assistant Program Manager (APM) (b) (6), (b) (7)(C) for Creative Corrections, LLC. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) and Assistant Program Manager, (b) (6), (b) (7)(C) DOJ and DHS certified PREA Auditors. The facility's last PREA audit was conducted August 22-24, 2017. LIPC is operated by GEO Corporation.

The facility processes detainees who are pending immigration review or deportation. The purpose of the June 2021 audit was to determine compliance with DHS PREA Standards. The incorporation date for the LIPC was June, 18, 2015. This was the second DHS PREA audit for LIPC , and the audit review period included 24 months from June 2019 through June 2021. Upon completion of the audit, the LIPC was found to be non-compliant with four standards. The facility's Corrective Action Period (CAP) began September 16, 2021 and ended March 15, 2022.

The agency provided the Auditor the Corrective Action Plan (CAP) November 2021 which was reviewed by the Auditor who provided responses to the proposed corrective actions. The 180-day CAP process ending date was March 15, 2022. The facility submitted documentation for the corrective action process on November 29, 2021 through March 11, 2022. The final supplied documentation was reviewed by the Auditor on March 11. 2022. The review of this documentation confirmed that all four standards are compliant in all material ways.

The Auditor notes that during the review of documentation provided by the facility during the CAP, specifically the investigation file and corresponding documentation, it was determined that two staff members were named as alleged perpetrators by a female detainee in an allegation of sexual abuse by a female detainee. The corresponding emails from corporate dictated that the supervisory staff person "needs to avoid Falcon until the completion of the investigation." The corporate email further stated that the officer "was not allowed to work in Falcon until the completion of the investigation." The Auditors notation is relevant as standard 115.66 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed for all duties requiring detainee contact pending the outcome of the investigation;" and therefore, the facility, in not removing the two staff members from all duties requiring detainee contact, have violated standard 115.66.

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. 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:

(e)(f): The facility neglected to report three allegations of sexual abuse, including one against a staff member, to the JIC, ICE OPR or the DHS OIG, as well as to the appropriate ICE FOD as required by the standard.

Does Not Meet (e)(f): The facility neglected to report three allegations of sexual abuse, including one against a staff member, to the JIC, ICE OPR or the DHS OIG, as well as to the appropriate ICE FOD as required by the standard. To gain compliance, the facility must provide documentation, if available, that all incidents of sexual abuse are reported to ICE personnel as dictated by the standard. This can be achieved through documentation of any future sexual abuse allegations at the facility. In addition, the PREA Compliance Manager, and other involved upper management staff must receive documented training regarding their responsibility to report all incidents of sexual abuse to ICE personnel.

Corrective Action Taken (e)(f): The Auditor requested the most current PREA allegation spread sheet to confirm that allegations made during the CAP period were referred to the JICMS. The facility provided the current allegation spreadsheet and corresponding email regarding case #202203676, confirming the JIC and FOD were notified of a possible PREA incident concerning a detainee at LaSalle ICE Processing Center. The facility is in compliance with standard 115.22.

§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:

(e)(g) The policy 10.1.1 continues to state, "LIPC shall ensure that between 60 and 90 days from the initial assessment at the facility, staff shall reassess each detainee's risk for victimization or abusiveness using the PREA Vulnerability Reassessment Questionnaire which is to be completed by case managers. Facilities shall use the GEO PREA Vulnerability Reassessment Questionnaire to conduct the reassessment. 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 or abuse or victimization." During the on-site visit, the Auditors reviewed 10 detainee files and found reassessments were completed within 60-90 days of admission for all detainees except one. Access to this information is restricted to those individuals with a need to know.

The Classification Supervisor stated the facility completes reassessments within 60-90 days of the initial assessment but that the facility does not complete a risk assessment following an incident of sexual abuse. He confirmed transgender detainees are reassessed every six months. While on-site, the Auditor reviewed the transgender detainee's initial risk assessment and the detainee's mental health file. The transgender detainee had only recently been identified as transgender. The initial risk assessment did not indicate the detainee was transgender, although the detainee reports giving this information to the intake officer. The transgender detainee stated he also reported this information to mental health staff. This was confirmed through a review of the mental health file, but the mental health staff failed to inform medical staff or the facility. The mental health staff member is no longer employed by the facility. The PSA Compliance Manager stated she would ensure the 6-month reassessment of transgender detainees would be completed. An interview with the PSA Compliance Manager indicated the facility does not complete a reassessment of the victim or abuser immediately following an incident of sexual abuse.

Does Not Meet (e): The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The facility must develop a process to ensure reassessments are completed on all victims and abusers after an allegation of sexual abuse, within 24 hours of the incident. The facility must provide training to staff on the reassessment process, provide this reassessment process in writing, and the documented staff training for compliance review.

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

§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:

(b): Policy 10.1.1 states, "When making assessments and housing decisions for transgender and intersex detainees, LIPC shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. A medical or mental health practitioner shall be consulted as soon as practicable on these assessments and placement decisions which shall not be based solely on the identity documents or physical anatomy of the detainee. Unless client written mandates differ, the following guidelines will be adhered to if for security reasons general population housing is not assigned after intake processing, and involuntary segregation is used, the guidelines for Protective Custody of this policy must be followed. Serious consideration shall be given to the individual's own views with respect to his/her own safety. 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 AFA, 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. Placement into administrative segregation due to a detainee's identification as transgender or intersex should be used only as a last resort and when no other viable housing options exist. The detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. Housing and programming assignments for each transgender and intersex detainee shall be reassessed at least twice each year to determine any threats to safety experienced by the detainee. This assessment is completed by the PREA PSA Compliance Manager. Serious consideration shall be given to the individual's own views with respect to his/her own safety. LIPC shall use the Transgender Care Committee Summary form to conduct the six-month reassessment."

Interviews with the Classification Supervisor and security staff confirmed transgender detainees were housed in Special Housing Unit (SHU). Several security staff reported that most transgender detainees are housed in the segregation area. Although the information received during the interviews does not support compliance, the facility policy and practice supported compliance. The transgender detainee interviewed onsite was not placed in SHU, but rather was allowed to remain in general population, as he requested.

The Auditor reviewed a risk assessment of a transgender detainee provided by the facility during the pre-audit phase. The facility also provided a memorandum stating there have been no transgender detainees who have remained in the facility past 60 days, so an example of a reassessment of a transgender detainee was not available. During the on-site audit, the facility shared there had been no transgender detainees housed longer than 60 days; therefore, there were not files to review.

During the on-site visit, the Auditor interviewed a transgender detainee. The detainee said he was asked if he was transgender at intake, but no further actions were taken by the facility. He stated he also told mental health staff he was transgender but again nothing happened. Approximately two months later, he submitted a request for hormone therapy. After this request, staff met with him to determine necessary accommodations and he was allowed to shower separately from other detainees. The Auditors met with medical and mental health staff and reviewed the detainee's medical and mental health files. The mental health file confirmed the detainee informed the mental health worker that he was transgender, but the mental health worker did not share this information with medical or facility staff. The mental health worker is no longer on staff. Healthcare staff stated they were not aware the detainee was transgender until he submitted a request for hormone therapy. The Auditors also reviewed the PREA risk assessment. The risk assessment includes one question, in two parts, related to sexual orientation and gender identity. The detainees are asked, "Do you wish to identify as gay, bisexual, transgender, intersex or gender non-conforming." The interviewer then answers the question, "Is the detainee perceived to be gender non-conforming?" If the detainee answers in the affirmative and/or if the interviewer determines the detainee is gender non-conforming, the detainee is given one point on the risk assessment. The risk assessment does not specify the detainee's sexual orientation or gender identity. The interviewer is given instruction on the form to refer all detainees to medical if they answer in the affirmative to questions related to past sexual abuse or abusiveness but no instructions to refer a detainee to medical and mental health staff if the detainee identifies as transgender or intersex (as per facility policy).

Does Not Meet (b): An initial risk assessment did not specify the detainee was transgender, and the detainee was not referred to medical and mental health; also, housing and showering accommodations were not made until two months

following his admission to the facility. Mental health staff were informed the detainee was transgender but did not ensure the information was passed on to medical or facility staff. The risk assessment should specify if the detainee answered in the affirmative to being gay, lesbian, bisexual, transgender, or intersex. The risk assessment should direct the intake officer to refer transgender or intersex detainees to medical and mental health to ensure their specific needs are addressed, as outlined in the facility's policy and the standard. The facility must develop a process to ensure that medical and mental health staff are consulted as soon as possible on the detainee's assessment and housing placement for the detainee's health and safety or complete a Transgender Care Committee as required by policy within the appropriate time frame which includes medical and mental health staff. The facility must provide the process that will be used to making assessments for transgender detainees and provide documented training of staff on the process as well as an example of an initial risk assessment and the housing placement determination for a transgender detainee made based on TCC or another process for compliance review.

Corrective Action Taken (b): The Auditor required that staff are trained in the process which requires staff to identify transgenders and immediately take action to refer transgender or intersex detainees to medical and mental health to ensure their specific needs are addressed, as outlined in the facility's policy and the standard. In addition, the Auditor required that the facility document the training of medical and mental health staff to ensure proper follow-up as required by the standard. The facility provided training and attendance records that confirmed applicable staff were trained on Local Policy 10.1.1 SAAPI and the SAAPI PREA Risk Assessment Form. The facility is now compliant with standard 115.42.

§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): Policy 10.1.1 states, "LIPC is required to 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. The review team shall consist of upper-level management officials, the local PSA Compliance Manager, and medical and mental health practitioners. The Corporate PREA Coordinator may attend via telephone or in person. A "DHS Sexual Abuse or Assault Incident Review" form of the team's findings shall be completed and submitted to the local PSA Compliance Manager and Corporate PREA Coordinator no later than 30 working days after the review via the GEO PREA Database. LIPC shall implement the recommendations for improvement; or document its reasons for not doing so."

The Facility Administrator and PSA Compliance Manager confirmed that sexual abuse incident reviews are conducted for each sexual abuse allegation. The Auditor reviewed nine closed sexual abuse investigations within the audit period and found that the facility conducted an incident review at the conclusion of each investigation. Except for two reviews, the sexual abuse incident review date was not entered on the form. Of the two completed reviews in which a date was entered, the sexual abuse incident reviews were not conducted within 30 days of the completion of the investigation's completion.

Does Not Meet (a): The Auditor reviewed nine incident reviews submitted by the facility. In seven of the incident reviews the Auditor could not confirm that the facility conducted the review within 30 days of the conclusion of the investigation as required by the standard. In addition, the Auditor determined in the remaining two reviews that they were conducted outside the required 30 days from the conclusion of the investigation. The facility must develop a process to ensure incident reviews are conducted and documented within 30 days of the conclusion of the investigation. The facility must provide training with staff of the standard requirement and process developed. The facility must submit the process developed, documented staff training, and three examples of incident reviews completed within 30 days of the investigation for compliance review.

Corrective Action Taken (a): The facility submitted a Report Form "OPR Referral - case #2022-44," and the corresponding Investigative Report, dated 3/2/22. In addition, the facility submitted an incident review for case #2022-44. Although the review was undated, based on the timing of the investigation closure date and the date records were submitted by the facility, the Auditor can confirm the review was completed within 30 days of the conclusion of the investigation as required by the standard. The facility is now compliant with standard 115.86.

Recommendation: The Auditor recommends that the facility date all incident reviews to confirm future standard compliance.

§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.

Margaret L. Capel March 24, 2022
Auditor's Signature & Date

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

(b) (6), (b) (7)(C) April 5, 2022
Program Manager's Signature & Date