PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	3/22/2022	**To:**	3/24/2022
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
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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
Field Office Director:	Dianne Witte
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1250 Poydras Suite 325 New Orleans, LA 70113
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	South Louisiana ICE Processing Center (SLIPC)		
Physical address:	3843 Stagg Ave. Basile, Louisiana 70515		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	318-668-5900		
Facility type:	D-IGSA		
PREA Incorporation Date:	4/23/2019		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-668-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	1- 318-446-(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 U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the South Louisiana ICE Processing Center (SLIPC) (also known as the South Louisiana Detention Center) was conducted on March 22-24, 2022. The audit was performed by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards during the audit period of March 2021 through March 2022. The SLIPC is privately owned by the GEO Group and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the SLIPC are from Haiti, Nicaragua, and Columbia. The facility does not house juveniles, males, or family detainees. This was the first PREA audit for the facility which is located in Basile, Louisiana.

On March 24, 2022, an entrance briefing was held in the SLIPC Facility Administrator's Office. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) [redacted], opened the briefing, via telephone, and then turned it over to the Auditor. In attendance were:

GEO Staff

(b) (6), (b) (7)(C) Facility Administrator, SLIPC
(b) (6), (b) (7)(C) Prevention of Sexual Abuse (PSA) Compliance Manager, SLIPC
(b) (6), (b) (7)(C) Chief of Security, SLIPC
(b) (6), (b) (7)(C) Human Resource Manager (HRM), SLIPC
(b) (6), (b) (7)(C) HR Specialist, SLIPC
(b) (6), (b) (7)(C) Director of Nursing (DON), SLIPC

ICE Staff

(b) (6), (b) (7)(C) Assistant Field Office Director (AFOD)
(b) (6), (b) (7)(C) Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU - via telephone

Creative Corrections

Thomas Eisenschmidt - Certified PREA Auditor, Creative Corrections, LLC.

The Auditor introduced himself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, documentation review, and conducting both staff and detainee interviews.

Approximately four weeks prior to the audit, ERAU Team Lead, (b)(6), (b)(7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, allegations spreadsheet and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA at SLIPC is 10.1.1, Sexual Abuse Assault Prevention and Intervention (SAAPI) Program for Immigration Detention Facilities. All documentation, policies, and the PAQ were reviewed by the Auditor prior to the site visit. A tentative daily schedule was provided by the Lead Auditor for the interviews with staff and detainees. The Auditor received no correspondence from any detainees or staff prior to the audit or prior to the submission of the report.

Facility Description

SLIPC, located in Basile, Louisiana is a low, medium, and high custody adult female dedicated IGSA facility operated by the GEO Group. The facility, with a rated capacity of 1,000 detainees, had 177 female detainees present on the first day of the audit. The average daily population for the preceding year was 341. The facility housed both male and female detainees, during part of the audit period, until it switched to female detainees only in April 2021. The facility has five housing buildings labeled A-E. A building has three dormitories, B has four, C has six, D has four, and E has four. Only two (D and E) of these dormitory housing buildings were open during the site visit; Buildings A, B, and C were closed. There are 43 cells in the Special Management Unit (SMU) that have not been used during the audit period. The housing units have cameras that are monitored in each of their control rooms and the main Control Center. (b) (7)(E) [redacted] The shower areas in each housing unit, where the detainees are allowed to change their

clothes, were blocked out on the cameras from control room staff view. All detainees arriving at SLIPC enter through the facility Sallyport and then are moved to the detainee processing area. The detainee in-processing area consists of one very large room. The detainees remain in this area until they are individually classified and receive a risk assessment and then are placed under quarantine for 14 days. The infirmary has 6 rooms which are also utilized for suicide watch if needed.

During the site visit, the Auditor observed signage requiring cross-gender staff to announce themselves prior to entering the living areas at the entrance door at each of the dormitories. The Auditor observed this cross-gender announcement procedure during the three day site visit. Based on interviews and Auditor's observations, there is always a female staff member in each of the housing areas.

According to the PAQ and the interview with the PSA Compliance Manager, the staff compliment at SLIPC is all GEO employees except two contractors in the commissary having detainee contact and the Administration Building cleaning crew contractors who have no detainee contact. There are 147 security staff, 26 Medical staff, and the contractors. At the time of the site visit there were no volunteers working with the ICE detainee population. Due to the Pandemic, volunteers have not been utilized in over two years.

At the conclusion of the facility tour, the Auditor was provided with staff and detainee rosters. Randomly selected personnel and detainees from each list were chosen to participate in formal interviews. The auditor interviewed 12 random security staff including first-line supervisors, and 19 specialized staff. The specialized staff included: The Facility Administrator, PSA Compliance Manager, Human Resources Manager, Training Administrator, Intake staff (2) (one was the supervisor), Administrative Investigator, Grievance Coordinator, Classification Manager, Victim Advocate, AFOD, Medical employee, Contractors (2), Non-security First Responder (2), Incident Review Team Member, Retaliation Monitor and Mental Health employee. A total of 20 random detainees were interviewed as well. All 20 detainees were limited English proficient (LEP) and required the use of a language line through Language Services Associates (LSA), a language interpretative service provided through Creative Corrections. There were no transgender or intersex detainees at SLIPC. The Auditor interviewed some members of the lesbian, gay and bisexual community during the 20 randomly chosen detainees interviews. The Auditor also interviewed five detainees who disclosed prior victimization during their risk assessment. Prior to the audit, the Auditor was provided an Excel spread sheet, by the Team Lead, indicating SLIPC had four allegations of sexual abuse during the audit period. Of the four reported investigations, one was staff-on-detainee and three were detainee-on-detainee. All four allegations were investigated, and the cases closed. The one case involving a staff member was substantiated. Of the three detainee-on-detainee allegations, two were determined to be unsubstantiated and one substantiated at the conclusion of the investigations. The Auditor conducted a review of all four investigative files to randomly check: if the investigation was conducted by a trained investigator; to ensure the detainee was seen by medical; to verify if the allegation was referred to law enforcement; and to verify if the case was reported to ICE. SLIPC notified ICE and the Basile Police Department based on the documentation. During the site visit the Auditor also reviewed 10 Employee HR files, 10 Employee Training files (8 Security/2 Contractors), 1 Volunteer Training File, 10 Detainee Detention files and 5 Detainee Medical files.

On March 24, 2022, an exit briefing was held in the SLIPC Facility Administrator's Office. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing, via phone, and then turned it over to the Auditor. In attendance were:

GEO Staff

(b) (6), (b) (7)(C) Facility Administrator, SLIPC
(b) (6), (b) (7)(C) PSA Compliance Manager, SLIPC
(b) (6), (b) (7)(C) Chief of Security, SLIPC
(b) (6), (b) (7)(C) HRM, SLIPC
(b) (6), (b) (7)(C) HR Specialist, SLIPC
(b) (6), (b) (7)(C) DON, SLIPC

ICE Staff

(b) (6), (b) (7)(C) AFOD
(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU - via telephone

Creative Corrections

Thomas Eisenschmidt - Certified PREA Auditor, Creative Corrections, Inc.

The Auditor spoke briefly about the staff and detainee knowledge of the SLIPC PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit, and that he would need to review his findings from the site visit and interviews conducted with staff and detainees. The Auditor explained the audit report process, timeframes, and thanked all present for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 1
§115.31 Staff training

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

Number of Standards Met: 36
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of Audits

Number of Standards Not Met: 2
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.33 Detainee education

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:

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1, that states, "This policy is applicable to all South Louisiana ICE Processing Center (SLIPC) employees, detainees, contractors and volunteers. SLIPC falls within the scope of the Prison Rape Elimination Act of 2003 (PREA) and Subpart A of the U.S. Department of Homeland Security (DHS) Standards to Prevent, Detect and Respond to Sexual Abuse and Assault in Confinement Facilities; 79 Fed. Reg. 13100 dated March 7, 2014. The intent of this policy is to provide guidance for adherence to a zero-tolerance policy for sexual abuse or assault and the following requirements: Employees, contractors and volunteers are informed of GEO's zero tolerance policy regarding Sexual Abuse and Assault; Detainees are informed of SLIPC's zero tolerance policy regarding sexual abuse and assault." The PSA Compliance Manager provided the Auditor written verification that policies 10.1.1 and 10.1.1-A, Investigating Allegations of Sexual Abuse and Assault and Evidence Collection in Immigration detention Facilities were approved by the ICE AFOD. The random staff and detainees interviewed indicated they were aware of the facility's policy on sexual abuse.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1 that requires, "Each Facility Administrator shall designate a local PSA Compliance Manager for each U.S. Corrections and Detention Immigration Facility who will assist in ensuring facility compliance with sexual abuse and assault prevention and intervention policies and procedures and who shall serve as the Facility point of contact for the DHS PSA Coordinator and Corporate PREA Coordinator." The SLIPC has designated a PSA Compliance Manager. During his interview, he indicated he is the point of contact for the agency's PREA Coordinator and has sufficient time and authority to oversee efforts for the facility to comply with the zero-tolerance policy. He also stated he reports to the Facility Administrator on all PREA related matters. The Facility Administrator also confirmed the PSA Compliance Manager reports directly to him. The facility provided an organizational chart and the PSA Compliance Manager position on the chart is a direct report to the Facility Administrator.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that requires, "SLIPC 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. SLIPC 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, SLIPC shall take into consideration: Generally accepted detention and processing 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' (Attachment A) 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." The Facility Administrator confirmed that SLIPC staffing levels for the supervision of the detainees are established as part of the contract agreement between ICE and GEO Corporate staff. He stated that staffing levels are based on direct supervision of the detainees taking into account: video monitoring equipment, generally accepted detention/correctional practices, judicial findings of inadequacy, the physical plant, detainee population, findings of incidents of sexual abuse any recommendations of sexual abuse incident reviews, and any other relevant factors. The interviews with the Facility Administrator and each shift Watch Commander indicated that detainee supervision posts are never closed. Observations made by the Auditor during the three days on site found detainee supervision was as described by the Facility Administrator. During the interview with the PSA Compliance Manager, he detailed the annual staffing review requirements in the policy and the standard. He noted he participated in the last review conducted on September 15, 2021. The review of this document by the Auditor confirmed the review was based on the policy and standard requirements.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1 that requires, "SLIPC 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 log book as PREA unannounced security inspections in red ink. Other members of the executive team shall make less unannounced visits as schedules allow. Such inspections shall be implemented for night as well as day shifts. Employees are prohibited from alerting others that these

security inspections are occurring, unless such announcement is related to the legitimate operational functions of SLIPC." Supervisor interviews, conducted on each shift, confirmed they make rounds daily on each of the 12 hour shifts in every area detainees have access to. The supervisors also confirmed that their rounds are made at a different times and at different locations in order not to establish a specific time or pattern to keep staff from know when the supervisors are making rounds. Random security staff interviews confirmed that they are prohibited from alerting other staff that the supervisor is conducting rounds. During the tour, the Auditor observed log entries in randomly chosen area's logbooks demonstrating daily supervisory rounds being conducted in accordance with the standard and policy requirements. The Auditor also reviewed post orders and spoke with line staff confirming their requirement to make and document rounds in their areas.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The PAQ, the Auditor's observations, and interviews conducted with the Facility Administrator and PSA Compliance Manager confirmed SLIPC does not accept juveniles or family detainees; therefore, the Auditor has determined this standard is not applicable.

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

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

Notes:

(b) This subpart is not applicable as SLIPC is an adult female facility.

(c)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that requires, "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." The 12 random security staff interviewed confirmed cross-gender pat-down searches are not permitted at SLIPC except in exigent circumstances and must be documented if performed. The Auditor was informed by the PSA Compliance Manager that cross-gender pat-down searches were not conducted at SLIPC during the audit period. The Auditor reviewed the search log (attachment N) indicating no cross-gender frisks were logged as being completed during the audit period. A review of the search training curriculum provided to the SLIPC security staff, covered these subpart requirements. The training file review of 8 random security training files documented receipt of this search training.

(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that requires, "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. All strip searches, visual body cavity searches and cross-gender pat-down searches shall be documented." The PSA Compliance Manager and the Facility Administrator confirmed the facility had no instances of cross-gender strip searches or visual body cavity searches conducted during the audit period; however, if there had been, the search would have required prior approval and would have been documented. As noted in subparts (c)(d), the Auditor reviewed the search training curriculum provided to SLIPC security staff; the curriculum covered the (e)(f) subpart requirements as well. The 8 random security training files reviewed documented that this search training was received. The random security staff (12) interviews confirmed that they are not allowed to conduct cross-gender strip searches or body cavity searches, and also confirmed same gender strip searches must be approved by the Facility Administrator. The Facility Administrator confirmed there were no cross-gender strip searches or cross-gender visual body cavity searches completed during the audit period.

(g) The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1 that requires, "SLIPC 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." There is always a female security staff member assigned to each of the housing unit dormitories. The Auditor observed the camera views in the shower areas in each housing unit, where the detainees are allowed to change their clothes, were blocked out on the cameras from control room staff view. The Auditor observed the practice of male staff announcing themselves prior to entering the female dormitories during the site visit. The 20 random detainees interviewed confirmed that this announcement process is done consistently. The interviews with the 12 random security staff confirmed this announcement practice and the Auditor randomly picked 5 recent shift post assignments (night and days) and verified that on those dates, at least one female was assigned in each detainee dormitory.

(h) This subpart is non-applicable. SLIPC is not a Family Residential Facility.

(i)(j) The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that requires, "Staff shall not search or physically examine a detainee for the sole purposes of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or by learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private by a Medical Practitioner. 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." As previously noted, the Auditor reviewed the facility training curriculum for conducting searches. Both the (i)(j) subpart requirements were specifically addressed in

the curriculum. The eight random security training files documented the staff members' participation. The 12 random security staff interviews confirmed their knowledge of the prohibition of searching detainees to determine their genital status and their responsibility to perform all pat-down searches in a professional and respectful manner. They also confirmed the search training they received included cross-gender, transgender and intersex searching techniques. At the time of the audit site visit, there were no transgender or intersex detainees present at the facility to interview.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1 that requires, "SLIPC shall ensure that detainees with disabilities (i.e., those who are deaf, hard of hearing, blind, have low vision, intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from the Company's efforts to prevent, detect, and respond to sexual abuse and assault. SLIPC shall provide written materials to every detainee in formats or through methods that ensure effective communication with detainees with disabilities, including those who have intellectual disabilities, limited reading skills or who are blind or have low vision. The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in English proficiency (LEP). The facility will provide detainees with disabilities with effective communication, which may include the provision of auxiliary aids, such as readers, materials in Braille, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters and note takers, as needed. The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities." The policy further requires in matters relating to sexual abuse, "SLIPC 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 interviews conducted with the 12 security staff confirmed their knowledge that minors, alleged abusers, detainees who witnessed the alleged abuse and detainee who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of sexual abuse. They were also aware that interpretation, by someone other than another detainee, is prohibited unless the detainee expresses a preference for a detainee interpreter and the facility determines that such interpretation is appropriate. According to two intake staff, the Classification Manager, and the PSA Compliance Manager, each detainee arriving at SLIPC receives the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese), the DHS-prescribed Sexual Assault Awareness Information pamphlet available in nine languages (English, Spanish, Arabic, Chinese, French, Haitian Creole, Hindi, Portuguese, and Punjabi) and the South Louisiana Handbook available in English and Spanish. The two informational videos (PREA and Know Your Rights) run continuously in the intake area and in each housing unit. The videos are in English and Spanish. The Auditor was also informed by the two intake staff that when SLIPC intake staff are confronted with a detainee who may be hearing impaired or deaf, orientation information is provided to them in writing or through use of the facility text telephone (TTY). If staff is confronted with a detainee who is blind or has limited sight, they would be provided individualized service by a staff member to read information to them. The Auditor was also informed by the two intake staff that if they encounter any detainee with intellectual deficiencies, the staff would try to communicate to them to the best of their abilities. If there was any difficulty, then the detainee would be referred to a supervisor, medical, or mental health staff based on the detainee's limitation. The review of the investigative files confirmed that in all four of the investigations, SLIPC utilized their contracted interpretive services to conduct interviews with LEP detainees. The two intake staff also indicated when staff encounters a detainee who speaks/understands a language not provided in one of the 14 languages represented in the ICE National Detainee Handbook, staff utilizes the ERO language line interpretive services and reads pertinent information from a manuscript.

The Auditor interviewed 20 random detainees, one not speaking one of the 14 languages (Nepali) supported with the ICE National Detainee Handbook. She indicated she never received sexual safety information in a format she understood. Detainees arriving at SLIPC sign that they have received orientation materials, clothing, pamphlets, etc. upon arrival as noted above. The two intake staff and PSA Compliance Manager informed the Auditor that the detainee, indicating she never received the information, would have been read the sexual safety manuscript in her language through the language line. The review of her detention file did not demonstrate she received this information through the facility contracted interpretive services. During the site visit, the PSA Compliance Manager confirmed he was adding a line on the manuscript in which a staff member could note the ID number of the interpreter used to provide this information to the detainee.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard as it could not demonstrate it provides detainees who are LEP with language assistance, through bilingual staff or professional interpretation and translation services, ensuring detainees receive meaningful access to its programs and activities, particularly those detainees who speak/understand languages other than English and Spanish. To become compliant, the facility needs to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainee who are LEP. The facility needs to provide five samples of intake information provided to detainees speaking a language not covered by one of the 14 languages covered by the ICE National Detainee Handbook. As previously noted, the PSA Compliance Manager was adding a line on the manuscript that

outlines the facility's efforts to prevent, detect, and respond to sexual abuse, for intake staff to note the interpreter's ID number. The facility must provide evidence of the new process implementation that was being developed by the PSA Compliance Manager at the time of the audit, or some other process if this was not implemented to completion, and evidence that the process is being complied with; documentation of the interpretation service used to deliver the manuscript and signature of detainee's participation for detainees who speak languages other than English and Spanish. If available, the sample must include detainees who speak a language other than one of the 14 languages covered by the ICE National Detainee Handbook.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 10.1.1, Executive Order (EO) 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive, which detail suitability requirements for candidate hirings. Facility policy 10.1.1 states, "SLIPC 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. SLIPC 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. 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. Unless prohibited by law, SLIPC 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 HRM at SLIPC confirmed employees on an annual basis, during their evaluations, acknowledge by signature that they have not engaged in any activity prohibited by policy 10.1.1. She also confirmed the facility would provide information on substantiated allegations of sexual abuse involving former employees, upon any request from an institutional employer for which the employee has sought new employment. She indicated that this information is provided through GEO Corporate. She stated the facility would request information from prior institutions, where the prospective candidate was previously employed, and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire. The Auditor was provided a file for an employee who was recently promoted and found a self-declaration form signed indicating he/she has not engaged in any prohibited conduct and a completed background check, which was completed prior to the promotion. During the 10 staff employee file reviews (8 staff/2 contractors), the Auditor found signed PREA Annual Disclosure forms in the staff files as required by policy and standard.

The acting Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in November 2021, about candidate suitability for all applicants to include 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 Auditor reviewed 10 employee files and found ICE approvals to hire each of the staff prior to their actual start date as well as a signed self-declaration that each employee had not engaged in behavior outlined in subpart (a) as a condition for hiring.

(c)(d) The Federal Statute 731.202 (b), EO 10450, ICE Personnel Security and Suitability Program Directive 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 requires "the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees prior to being allowed entrance into the facility." It further requires "a background recheck be conducted every five years on all employees and unescorted contractors." The HRM stated ICE completes all background checks for all staff and contractors prior to hiring and then again, every five years. The review of documentation provided by ICE's Personnel Security Office (PSO) confirmed that the eight randomly selected employees (six facility staff and two ICE staff) had background checks performed prior to them reporting to work. The documentation also confirmed the due dates for the five-year background rechecks. The Auditor determined the provided background check information was compliant with the standard.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) These subparts of the standard are not applicable at SLIPC. The Facility Administrator and the PAQ confirmed the facility has not made any upgrades to the facility or to their technologies during the audit period.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on review of policy 10.1.1A, that requires, "SLIPC 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 Department of Homeland Security

(DHS)." The Auditor reviewed the facility's uniform evidence protocol policy and determined it does in fact meet the standard's requirement. The Facility Administrator confirmed the policy outlining the protocol was reviewed and approved by ICE and provided this documentation to the Auditor. The Facility Investigator confirmed he follows the evidence protocols provided in his training, and as required in policy, to ensure he obtains the physical evidence needed to properly conduct his administrative investigations. The Agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sexual assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of the Inspector General (OIG), OPR, or the local law enforcement agency, the ERO AFOD would assign an administrative investigation to be conducted. The Auditor found, after the review of four investigative files, uniform evidence protocols were followed during the administrative investigations.

(b)(d) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that states, "SLIPC shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation and the prosecution of Sexual Abuse perpetrators to most appropriately address victim's needs." The Auditor conducted an interview with a staff member from the St. Landry-Evangeline Sexual Assault Center (SLESAC), a community local advocacy service that provides counseling services and community outreach and educational programs to St. Landry and Evangeline Parishes since 1999, who confirmed these services. This advocate confirmed her agency, the SLESAC, provides short-term crisis intervention to victims and survivors of sexual assault, rape, and molestation. SLESAC provides a 24-hour crisis hotline (1-800-656-4673) services, medical escorts, and criminal justice advocacy to its survivors and their family members. The MOU, dated 10-21-2021 with no sunset date, between SLIPC and SLESAC states SLESAC shall "provide legal advocacy and confidential emotional support services for immigrant victims if requested." The staff member from SLESAC confirmed a qualified staff person from the organization would provide emotional support, crisis intervention, information, and referrals, if needed, and would accompany the victim through any forensic exam and investigative process. She also confirmed the center provides contact information for detainees through the provided telephone number and mailing address. The facility reported four sexual abuse investigations during the audit period. In review of those four closed investigative files, the Auditor determined the alleged victims were offered victim advocacy services as documented in the files. The facility Investigator confirmed that the detainee is provided victim advocate information by both the Investigator and Medical staff when taken to medical after every report of an allegation.

(c) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1-A that requires, "SLIPC shall offer to all detainees who experience Sexual Abuse access to forensic medical examinations (whether onsite 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. Facility medical staff shall not participate in sexual assault forensic medical examinations or evidence gathering. Examinations shall be performed by a Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE). An offsite Qualified Medical Practitioner may perform the examination if a SAFE or SANE is not available." The Medical staff confirmed forensic examinations are conducted at the Acadian Medical Center by a trained SANE practitioner; SLIPC Medical staff only stabilizes the individual, if necessary, in preparation for transport. According to the Medical staff SLIPC, has tried and continues to try to establish an MOU with the hospital but has been unsuccessful thus far. The Auditor also tried for two weeks to speak with someone at Arcadian Medical Center to confirm the hospital protocol when dealing with victims of sexual assault. Based on interviews with the PSA Compliance Manager, the Medical staff, review of the facility's PAQ and investigation reviews, the facility had no forensic examinations conducted during the audit period.

(e) The Auditor determined compliance with this subpart of the standard based on the MOU request between SLIPC and the Basile Police Department (PD). The MOU requires the law enforcement department be contacted in every case of sexual abuse alleged at the facility. The MOU and interview with the Chief of Police confirmed their office is contacted upon every allegation of sexual abuse and they would conduct a criminal investigation if it was determined the incident was criminal in nature. He also confirmed, that although not specifically stated in the MOU, his department would comply with subparts (a) through (d) of this standard. During the review of investigative files, the Auditor observed the Basile PD was notified in each of the allegations of sexual abuse made at SLIPC during the audit period. None of the four allegations were investigated criminally based on documentation provided and the interview with the Chief of Police. The facility has requested the specific language of subpart (e) be added to the MOU but has not heard back from the Basile PD.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "An administrative or criminal investigation shall be completed for all allegations of Sexual Abuse. Coordination of internal administrative investigations as well as coordination with the ICE Office of Responsibility (OPR) should be coordinated in a way as to not interfere with the assigned criminal investigative entity criminal investigations. SLIPC 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. SLIPC shall document all referrals. SLIPC 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." Criminal investigations are conducted by the Basile PD as noted in

115.21. The agency's policy 11062.2 outlines the evidence and investigation protocols. All investigations are to be reported to the Joint Intake Center (JIC), which routes allegations for assessment to determine which allegations fall within the PREA purview. The PREA allegations are then referred to DHS OIG or OPR. DHS OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation, and the ERO AFOD would assign an administrative investigation to be completed. The facility had a total of four allegations: three incidents were detainee-on-detainee, and one was staff-on-detainee. All four allegations were referred to ICE OPR and none were deemed criminal. The Auditor reviewed the four investigative case files and determined they were completed in accordance with the standard and policy 10.1.1-A. The SLIPC Investigator was interviewed and found to be very knowledgeable concerning his responsibilities in the investigative process. He also confirmed he assists with outside law enforcement when required.

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

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

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "All employees, contractors and volunteers shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program. SLIPC staff receive upon hiring and during annual refresher, PREA training that includes the facility's zero-tolerance policy for sexual abuse and assault. The training fulfills their responsibilities under the agency's sexual abuse and assault prevention, detection, reporting, and response policies and procedures, recognition of situations where sexual abuse may occur, the right of detainees and employees to be free from sexual abuse and retaliation for reporting sexual abuse and assault, definitions and examples of prohibited and illegal sexual behavior, recognition of physical, behavioral, and emotional signs of sexual abuse, methods of preventing and responding to such occurrence; how to detect and respond to signs of threatened and actual sexual abuse, how to avoid inappropriate relationships with detainees, how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, and intersex (LGBTI) or gender non-conforming detainees, and the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. Employees must acknowledge, by signature, they have received and understood this training, on the PREA Basic Training Acknowledgement Form (Attachment F)." This form is used to document pre-service and annual in-service training. The Auditor reviewed 10 random training files (8 Staff and 2 Contractors) and found each file contained a signed training certification form (Attachment F). The random 12 SLIPC staff and 2 ICE staff interviewed by the Auditor confirmed each had received PREA pre-service training. They also confirmed the instruction they received included the requirements outlined in subpart (a) of the standard. The interview with the SLIPC Training Administrator and the review of the training curriculum, confirmed the subpart (a) requirements are part of the PREA training. The Training Administrator confirmed contractors at SLIPC receive the same training all staff members receive. They document, by signature, their understanding of the PREA training that each receives annually. The Auditor interviewed two contracted staff, and each confirmed they had received the agency's sexual abuse training that included their responsibilities on prevention, detection, and response policies and procedures. The Auditor indicated the facility exceeds the requirement of the standard as PREA refresher training is provided annually at SLIPC instead of the standard requirement of bi-annually.

§115.32 - Other training.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "all Employees, Contractors and Volunteers shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program. Volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention, and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and

contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed how to report such incidents." The Training Administrator stated that the facility has not provided training to volunteers in over two years due to the pandemic. She informed the Auditor that prior to the pandemic and once volunteers return, regardless of the service, they will be provided the PREA training curriculum staff and contractors receive. Even though there are no current volunteers, the Auditor requested and reviewed the training records of one volunteer approved prior to the pandemic; this file contained a signed training certification form (Attachment F) acknowledging the volunteer received and understood the agency's sexual abuse training. There were no records to review for "other contractors," as delineated in subpart (d) of the standard or volunteers present during the audit to interview.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f) The Auditor evaluated compliance with these subparts of the standard based on policy 10.1.1 that requires, "during the intake process SLIPC ensure that the detainee orientation program notifies and informs detainees about the zero-tolerance policy regarding all forms of sexual abuse and assault and includes instruction on prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, employee-on-detainee sexual abuse and coercive sexual activity, explanation of methods for reporting sexual abuse or assault, including to any employee, including an employee other than immediate point-of contact line officer (i.e. the PSA Compliance Manager or mental health staff), the Detention and Reporting Information Line (DRIL), the DHS OIG, and JIC and the ICE/OPR investigation process, information about self-protection and indicators of sexual abuse, prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." This policy further requires "education/notification be provided in formats accessible to all detainees, including those [who] are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. SLIPC shall maintain documentation of detainee participation in the intake process orientation which shall be retained in their individual files." As noted in 115.16, detainees arriving at SLIPC are provided an ICE National Detainee Handbook, the South Louisiana handbook, the DHS-prescribed SAAPI pamphlet. They are also shown a PREA video (PREA and Know Your Rights) which is available in English and Spanish. The ICE National Detainee Handbook is available in 14 languages. The South Louisiana handbook is available in Spanish and English only. The DHS-prescribed Sexual Assault Awareness pamphlet is provided in nine languages. The two intake staff interviewed by the Auditor confirmed that orientation information is provided to all detainees regardless of the detainee's language or disability. During interviews with two intake staff, each explained the intake process and confirmed the materials noted above as being provided to each detainee upon arrival, either through written formats, staff assistance and/or interpretive services. The two intake staff also indicated when staff encounters a detainee who speaks/understands a language not provided in one of the 14 languages represented in the ICE National Detainee Handbook, staff utilizes the ERO language line interpretive services and reads pertinent information from a manuscript. They also confirmed any detainees the facility staff encounter that may be hearing impaired or deaf would require staff to utilize the text telephone (TTY). Those detainees arriving at SLIPC with limited sight or who are blind would be provided individualized attention by staff that may include reading the information to her. In cases where the detainee has low intellect or limited reading skills, depending on the degree of limitation, the detainee would be referred initially to a supervisor or the medical/mental health department to provide the necessary orientation information. Also noted in 115.16, during the 20 random detainee interviews, all but one confirmed she had received copies of these documents or pertinent portions in a format she understood. The review of her file did not demonstrate she received this information through the facility contracted interpretive services. The PSA Compliance Manager informed the Auditor that he was adding a line on a manuscript, that outlines the facility's efforts to prevent, detect, and respond to sexual abuse with orientation information, for intake staff to note the interpreters' ID number. The Auditor randomly selected and reviewed nine other detainee files and reviewed signed documentation indicating the detainees received both the ICE National Detainee Handbook and the South Louisiana handbook, and viewed the PREA video in a language they understood.

Does Not Meet (b)(c): The facility is not compliant with subsection (b)(c) of the standard as it could not demonstrate it provides detainees who are LEP with language assistance, through bilingual staff or professional interpretation and translation services, ensuring detainees receive meaningful access to the orientation program that informs them about the agency's and facility's zero tolerance policies for all forms of sexual assault to include the 6 subpart (a) requirements, particularly those detainees who speak/understand languages other than English and Spanish. The facility must provide evidence of the new process implementation that was being developed by the PSA Compliance Manager at the time of the audit, or some other process if this was not implemented to completion, and evidence that the process is being complied with; documentation of the interpretation service used to deliver the manuscript and signature of detainee's participation for detainees who speak languages other than English and Spanish. If available, the sample must include detainees who speak a language other than one of the 14 languages covered by the ICE National Detainee Handbook. This evidence must include documentation that clearly confirms interpreters or translation services were used when needed.

(d) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC 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 site visit, the Auditor observed the required DHS poster with the name of the PSA Compliance Manager in each area of SLIPC that detainees have access to, including in all housing dormitories. These areas also contained the victim advocate contact information. The 20 random detainee interviews confirmed their knowledge of these posters and the required information.

§115.34 - Specialized training: Investigations.

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

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "in addition to the general training provided to all facility employees, the facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training must cover, at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The facility must maintain written documentation verifying specialized training provided to investigators pursuant to this paragraph." The primary Facility Investigator confirmed he received specialized training through GEO, as documented in his training record. The Auditor reviewed the GEO Investigator Training and found the curriculum provided the standard subpart (a) requirements. The Auditor confirmed, after the four investigative files were reviewed, all investigations that were conducted at SLIPC were conducted by trained investigators. The agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault." The lesson plan for this specialized training is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirements.

§115.35 - Specialized training: Medical and mental health care.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b) These subparts of the standard do not apply to SLIPC as the facility medical department is operated by the GEO group.

(c) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC 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. Facility medical staff shall not participate in sexual assault forensic medical examinations or evidence gathering." The Medical staff confirmed that all current Medical and Mental Health Practitioners have been provided this training. The Medical staff interview also confirmed that the SLIPC Medical staff are prohibited from participating in sexual assault forensic medical examinations or evidence gathering. Detainees requiring this service are sent to the Acadian Medical Center. The Auditor randomly chose two medical staff training files and found this required training documented in their files. The policy was approved by the AFOD. Of the four allegations that occurred during the audit period, none required forensic examinations as confirmed by interviews with the Medical staff and PSA Compliance Manager.

§115.41 - Assessment for risk of victimization and abusiveness.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "All detainees 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 process and initial housing assignment shall be completed within 12-hours of admission to the Facility. Facilities shall use the GEO PREA Risk Assessment Tool (See Attachment B) to conduct the initial risk screening assessment. SLIPC shall also consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: whether the detainee has a mental, physical, or developmental disability, the age of the detainee, the physical build and appearance of the detainee, whether the detainee has previously been detained, the nature of the detainee's criminal history, whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as LGBTI, or gender nonconforming, whether the detainee has self-identified as having previously experienced sexual victimization, and the detainees' own concerns about his or her physical safety."

The two intake staff interviewed stated that, by policy, they consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to them and the facility through documents provided through ICE (e.g., medical files or 213/216 records, etc.) in assessing their risk of being sexually abusive. Detainees are to be kept separate from general population until the assessment and classification processes are completed, but no more than 12 hours. Policy 10.1.1 requires the PSA Compliance Manager to "maintain an "at risk log" of potential victims and potential abusers determined from this PREA Risk Screening Assessment. The "at risk log" will be kept current and include current housing locations." Additionally, "following any reported allegation of sexual abuse, the PREA Compliance Manager will ensure victims are placed on the "at risk log" as soon as possible and tracked as a potential victim and housed separate from potential abusers pending the outcome of the investigation. If the investigation is determined "unfounded," the victim may be removed from the "at risk log". The PSA Compliance Manager will also maintain a tracking log of those individuals who self-identify as LGBTI with their housing location as a result of information obtained during the risk screening." Ten detainee detention files were randomly chosen and reviewed while on site. Each of these files

contained a completed risk assessment, utilizing the GEO PREA Risk Assessment Tool, that was completed on the day of the detainee's arrival. The detention file review also confirmed each detainee received their initial classification assessment on their day of arrival as well. The random detainees' interviews indicated that the classification and risk assessment were completed within the first couple hours of the detainee's arrival. The intake supervisor stated SLIPC detainees remain in the intake area until the risk assessment and classification process are completed. She confirmed the intake process, to include the completion of the risk assessment and classification, are typically competed within the first 3 hours of arrival but never beyond the 12 hour requirement. The 20 random detainee interviews confirmed their assessment and risk assessment were completed upon their first couple hours after arriving at SLIPC.

Recommendation (b): The Auditor recommends that the initial classification and initial housing assignment documents be updated to include a field for date and time to be recorded to provide clear evidence that these activities are completed within 12 hours as required by this subpart.

(e) Policy 10.1.1 requires, "SLIPC 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. 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." The interview with the PSA Compliance Manager and Classification Manager confirmed SLIPC conducts reassessments on all detainees at the facility between the 60-90-day requirement. During the review of 10 detainee detention files, only one detainee was in the facility long enough for a reassessment and reclassification. The file noted a completed reassessment in accordance with policy and standard requirements. The four investigative files were reviewed. Two of the detainees received a reassessment as a result of the allegation and two did not. One of these detainees left the custody of the facility within two days of the allegation and the second left on the sixth day after the allegation.

(f) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1,that requires, "Disciplining detainees for refusing to answer or not providing complete information in response to certain screening question is prohibited." The Classification Manager, one intake supervisor, and the one intake staff confirmed detainees are not disciplined for refusing to answer any of the questions asked during the risk assessment.

Recommendation (f): The Auditor recommends the policy be updated to indicate detainees are not disciplined for refusing to answer any of the screening questions instead of the policy stating "certain questions."

(g) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "SLIPC 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 is to be limited to staff on a need-to-know basis only for treatment, programming, housing, security, and management decisions." The Classification Manager confirmed appropriate controls are placed on all detainee records and information, including reassessments, which are maintained in the detainee's detention file and secured in the records room file cabinet, under lock and key. The PREA training all staff and contractors receive at SLIPC includes the requirement to limit their dissemination of responses to the questions asked during screening to only those personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. Employees acknowledge by signature they have received and understood this training. The 12 random staff interviews confirmed their responsibility of remaining confidential with all information they become knowledgeable about during incidents of sexual abuse, discussing it only with their supervisor or investigator.

§115.42 - Use of assessment information.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "screening information from the vulnerability assessment shall be used to assign detainees to housing, recreation and other activities, and voluntary work and shall make individualized determinations about how to ensure the safety of each detainee." The Classification Manager confirmed all housing, voluntary work, and activities are assigned based on each detainee's interview and their individual responses to the GEO PREA Risk Assessment Tool, and other pertinent information she receives from ICE about the detainee, to make determinations for the safety of each detainee. The Auditor reviewed 10 detention files, and each appeared to have an individualized determination regarding housing and programming.

(b)(c) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that states, "Transgender and intersex detainees may be housed in medical for up to 72-hours (excluding weekends, holidays and emergencies) until the appropriate housing determination is made by the Transgender Care Committee (TCC). TCC members shall consist of the Facility Administrator or Assistant Facility Administrator, Chief of Security, Classification Manager, Medical and/or Mental Health staff and PSA Compliance Manager. The Corporate PREA Coordinator may also be consulted. The detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. 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 TCC shall at a minimum consider: the detainee's documented criminal history and past/present behavior; the detainee's physical, mental, medical and special needs; the detainees self-assessment of his/her safety needs (do they feel threatened or at risk of harm);

privacy issues, including showers, available beds and or housing all records and prior assessments of the effects of any housing placement on the detainee's health and safety that has been conducted by a medical or mental health professional. The TCC is required to attempt to reach consensus on all decisions made regarding the detainee's assessment. Summary notes shall be documented on the Transgender Care Committee Summary, Attachment D, for each TCC meeting to include persons attending and conclusions reached. A copy of the notes shall be retained in the detainee's institutional file and a copy forwarded to the Corporate PREA Coordinator upon completion. Transgender and intersex detainees are to be reassessed for vulnerability at least twice a year, and when operationally feasible, transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." The PSA Compliance Manager confirmed SLIPC has several options available for accommodating a transgender or intersex detainee who requests to shower alone. The detainee could shower during count times, when other detainees are locked down, or in the medical area. SLIPC had no transgender or intersex detainees at the facility during the on-site audit. The PSA Compliance Manager confirmed placement and program assignments for any transgender or intersex detainee would be assessed twice a year. The PSA Compliance Manager also informed the Auditor that SLIPC has not had a transgender or intersex detainee housed at the facility during the audit period.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c)(e)(f) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC shall develop and follow written procedures governing the management of its administrative restriction unit. These procedures should be developed in conjunction with the ICE Enforcement and Removal Operations Field Office Director having jurisdiction for the facility, must document detailed reasons for placement of an individual in administrative restriction on the basis of a vulnerability to sexual abuse or assault. The use of administrative restriction to protect detainees vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing option exists, as a last resort. SLIPC should assign detainees vulnerable to sexual abuse or assault to administrative restriction 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. If restricted 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." The interview with the Facility Administrator indicated the SMU was not used for a detainee who was identified as being vulnerable to sexual assault or abuse during the audit period, or after victimization of sexual abuse. He also stated the written procedures for the SMU were approved by the AFOD. He indicated that the SMU would not typically be used to protect any vulnerable detainee or sexual abuse victim. He stated that alternative housing, including the use of medical beds would be utilized. However, he informed the Auditor that if the SMU was ever utilized for that purpose, the policy would be followed ensuring confinement would not exceed 30 days and he would notify the appropriate ICE FOD no later than 72 hours after the initial placement for this purpose.

(d) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that states, "Facilities shall implement written procedures for the regular reviews of all detainees held in administrative restriction for their protection as follows: A supervisory staff member shall conduct a review within 72 hours of the detainee's placement in administrative restriction to determine whether the restriction is still warranted; and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in administrative restriction, and every week thereafter for the first 30 days, and every 10 days thereafter. Facilities shall utilize the "DHS Sexual Assault/Abuse Available Alternatives Assessment" form to document the assessments (See Attachment G). All completed forms shall be reviewed and signed by the Facility Administrator or Assistant Facility Administrator upon completion." The Facility and PSA Compliance Manager confirmed no detainee has been placed in SMU over the audit period for sexual assault/abuse allegations.

§115.51 - Detainee reporting.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 which requires, "SLIPC 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, the DHS Office of [the] Inspector General, the Joint Intake Center, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents. 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." The Auditor placed a call, utilizing the same calling information available to the detainee, to the OIG reporting number and the DRIL from three different housing locations at SLIPC. In each of the three attempts, the Auditor connected to the reporting line and the connection did not require the use of a detainee PIN. Information on how to contact DHS OIG, and DRIL, is located above the detainee telephone. These reporting methods are also provided to the detainee upon arrival through the ICE National Detainee Handbook (in 14 languages) and are prominently displayed in each of the living areas in Spanish and English on posters, noting anonymous reporting is accepted, on the ICE and DHS posters. Instructions to place pro bono calls are posted on the detainee bulletin boards. The interview with the PSA Compliance Manager confirmed each detainee arriving at SLIPC receives this contact and reporting information within their intake orientation materials provided at intake. As noted in standards 115.16 and 115.33, the Auditor interviewed 20 randomly chosen detainees that were LEP during the site visit. One of them indicated they were

not provided information on sexual safety and reporting in a format they understood upon arrival. She indicated in her interview she did not know how to report an allegation of sexual abuse. The Auditor provided her with options of reporting sexual abuse through the interpreter during her interview. As previously noted in 115.16, the facility could not demonstrate that the detainee was provided the SAAPI information, which includes the reporting information, in a language that she understood The Auditor informed the PSA Compliance Manager who provided her with additional information. The agency has provided multiple ways for detainees to report sexual abuse meeting the requirements of subpart (b) and since 19 of the 20 detainees interviewed indicated each had received reporting information, the facility has met the requirement to inform the detainees of this information based on substantial compliance. The facility's obligation to inform LEP detainees of the SAAPI program in a manner of their understanding is covered in 115.16 and 115.33.

(c) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "employees accept reports made verbally, in writing, anonymously and from third parties and shall promptly document any verbal reports." The PSA Compliance Manager, Facility Investigator, and the facility's PAQ confirmed that of the four allegations reported during the audit period, one was reported through the DRIL and also through the facility's Grievance Process, one was reported via third party, and two were reported verbally to security staff. The Facility Investigator informed the Auditor that in each case where the incident was reported verbally to staff, the incident was documented in writing. In each of the reported allegations the language line for interpretation was used. During the investigative file reviews, the Auditor found written staff reports of the allegations in each of the files. During the random staff interviews, they confirmed this subpart requirement that they are to accept and immediately report all allegations of sexual abuse, regardless of how the report was made, and that all verbal reports from detainees or third parties must be documented promptly in writing to their supervisors.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 which states, "SLIPC grievance policies shall include the following procedures regarding sexual abuse grievances: SLIPC 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. SLIPC shall not impose a time limit on when a detainee may submit a grievance regarding allegation of sexual abuse. SLIPC 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. SLIPC staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment. SLIPC shall issue a decision on the grievance within five (5) days of receipt and shall respond to an appeal of the grievance decision within 30 days. SLIPC shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process." The Auditor interviewed the Grievance Officer who confirmed the PSA Compliance Manager and Facility Administrator are immediately notified of all allegations of sexual abuse made through the grievance process. The Grievance Officer also confirmed allegations of sexual abuse made in a grievance are handled through the grievance process as an emergency grievance and those grievances alleging sexual abuse, requires the alleging detainee be taken immediately to the proper medical personnel for assessment. The Grievance Officer also stated emergency grievances are responded to within 5 days of receipt and responses to an appeal of the grievance decision are responded to within 30 days. The interview with the Facility Administrator confirmed that, once notified of a sexual abuse allegation through the grievance process, he notifies the AFOD of the allegation, who then notifies the FOD. The interview with the AFOD also confirmed the notification process. One of the four allegations within the audit period was made through the grievance process. The investigative file review noted that the AFOD was notified.

(f) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "To prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties." The 12 random security staff interviewed confirmed their knowledge of allowing the housing officer or other facility staff, family members, another detainee, or legal representatives to assist the detainee with a grievance. About half of the 20 random detainee interviews confirmed their knowledge of the grievance process being used to address sexual abuse/assault allegations and that they may obtain assistance to prepare a grievance.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires "SLIPC 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. SLIPC 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, SLIPC shall make available the same information about national organizations. SLIPC 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." SLIPC entered into a MOU with St. Landry-Evangeline Sexual Assault Center in 2020 with no sunset date. This local community victim advocacy organization provides emotional support and crisis intervention services to victims of abuse regardless of when the abuse occurred. The Auditor spoke with a representative of this center who confirmed the

MOU and services the center provides. The South Louisiana handbook details for detainees the extent to which regular mail and the regular use of the telephones are monitored. The PSA Compliance Manager confirmed that contact with the rape crisis center as well, as the reporting of allegations to the DRIL or OIG, is confidential and unmonitored and does not require the use of a PIN. The Auditor reviewed four investigative files and found notation that victim advocate service information was offered in each instance. There were no detainees present at the facility that had filed a sexual abuse allegation for the Auditor to interview. The Facility Investigator confirmed that when the detainee is first taken to medical, they are provided information for the Sexual Assault Center, by both the investigator and medical staff; this was further confirmed through interviews with Medical staff.

§115.54 - Third-party reporting.

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

Notes:

The Auditor determined compliance with this standard based on policy 10.1.1 that requires, "SLIPC 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." The review of the ICE National Detainee Handbook and the South Louisiana Handbook provide information for the reporting of sexual abuse by third parties. The Auditor's review of the ICE website, www.ice.gov/prea, and GEO website, https://www.geogroup.com/PREA, confirmed the websites have third-party reporting information available to the public on behalf of detainees as well. The PSA Compliance Manager and Facility Investigator confirmed SLIPC received one allegation of sexual misconduct reported through the DRIL during the audit period. The review of investigative files also demonstrated the allegation was received from one of the third-party sources (DRIL). The random interviews with detainees indicated that over half were aware that reports of sexual abuse could be made on their behalf from third parties.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "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; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. 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." As noted earlier in the report, this policy was reviewed and approved by the AFOD. The 12 random security staff interviews confirmed the reporting requirements as outlined in policy and as required by the standard. These staff interviews also confirmed their understanding of their ability to report sexual abuse incidents outside their chain of command to the Chief of Security, upper-level executives privately, the employee hotline, or the Corporate PREA Coordinator. The Auditor reviewed the training curriculum for PREA pre-service and annual refresher training and found the reporting information requirements detailed as outlined by the standard. Of the four allegations reported during the audit period, two were reported to staff. The Facility Investigator informed the Auditor that, in each case where the incident was reported verbally to staff, the incident was promptly documented in writing. During the investigative file reviews, the Auditor found written staff reports in each of the investigative files.

(d) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "Allegations of sexual abuse in which the alleged victim is under the age of 18 or considered a vulnerable adult under State or local vulnerable person's statute, SLIPC shall report to designated State or local services agencies under applicable mandatory reporting laws." The Facility Administrator and PSA Compliance Manager confirmed that juveniles are never placed at SLIPC. They also stated within the audit period, the facility has not had a vulnerable adult placement at SLIPC. Both indicated if a vulnerable adult was ever the victim of sexual abuse at the facility the Basile Police Department and the AFOD would be notified.

§115.62 - Protection duties.

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

Notes:

The Auditor determined compliance with the standard based on policy 10.1.1 that requires, "When an employee or SLIPC 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." The interview protocols for the Facility Administrator and random staff specifically ask how each would respond to a situation where a detainee may be in substantial risk of sexual abuse. During each of the random staff interviews and the Facility Administrator's interview, the responses were that all would immediately remove the detainee from the perceived danger. The Facility Administrator, PSA Compliance Manager, and the facility's PAQ confirmed SLIPC had no detainees at substantial risk of imminent sexual abuse during the audit period. In the review of the four completed sexual abuse reports and investigations, the Auditor determined the facility took immediate action to protect the detainee victims.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "In the event that a detainee alleges that Sexual Abuse occurred while confined at another facility, SLIPC shall document those allegations and the Facility Administrator or Assistant Facility Administrator (in the absence of the Facility Administrator) where the allegation was made shall contact the Facility Administrator or designee where the abuse is alleged to have occurred and notify the ICE Field Office Director as soon as possible, but no later than 72-hours after receiving the notification. SLIPC 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. If the facility "receives [from another facility] notification of alleged abuse [that occurred at SLIPC], the facility is required to ensure that the allegation is investigated in accordance with PREA standards and reported to the appropriate ICE Field Office Director." The Facility Administrator informed the Auditor if staff received a report of sexual abuse from a detainee on arrival at SLIPC that occurred at another facility, he would notify the sending facility within 72 hours and immediately notify the AFOD. He further stated that any reports received from another facility that an alleged sexual abuse incident occurred at SLIPC it would be investigated according to the same protocols as any other sexual abuse allegation. There were no allegations made at other facilities reported to have occurred at SLIPC or any allegations made occurring at other facilities reported to SLIPC during the audit period.

§115.64 - Responder duties.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "upon learning of an allegation that a detainee was sexually abused, or if the employee sees abuse, the first security staff member to respond to the incident shall separate the alleged victim and abuser; immediately notify the on-duty security supervisor and remain on the scene until relieved by responding personnel; preserve and protect to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; if the sexual abuse occurred within the past 96-hours, ensure that the alleged victim and abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating […] until the forensic examination can be performed. 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." During the review of investigative files, the Auditor confirmed that the security staff members responding to the incident appeared to have followed these required protocols. The 12 security staff interviewed detailed their first responder obligations, as outlined in policy and per the standard requirement, when responding to incidents of sexual abuse. In each of two cases where the alleged victim was responded to initially by a security staff member, it appeared the security staff member followed policy and standard responder requirements.

(b) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "if the first responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, remain with the alleged victim, and notify security staff." The Auditor interviewed two non-security first responders while on site. These two non-security staff confirmed that if a detainee reported to them that they had been sexually abused, they would ensure the victim and perpetrator were separated, not allow either to destroy evidence, and immediately call for a security staff member. During the interview with the Facility Investigator and review of the four allegations made during the audit period, it was determined that none were made to a non-security staff member.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC 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. SLIPC shall use a coordinated multidisciplinary team approach to responding to sexual abuse and assault to include addressing any safety, medical, or mental health needs. The PSA Compliance Manager shall be a required participant and the Corporate PREA Coordinator may be consulted as part of this coordinated response. The Coordinated Response Team will include: Facility Administrator, Assistant Facility Administrator, Chief of Security, PREA Compliance Manager, PREA Investigator, Health Services Administrator, Director of Nursing, and the Classification Manager." The PSA Compliance Manager confirmed that the 10.1.1 and 10.1.1-A policies outline the primary duties of each participant in response to any sexual abuse allegation to include responding to reported incidents of sexual abuse, responding to victim assessment and support needs, ensuring policy and procedures are enforced to enhance detainee safety, and participating in the development of practices and/or procedures that encourage prevention of sexual abuse. The Auditor reviewed the four closed investigative files and found that each file documented the multidisciplinary and coordinated responses taken by SLIPC staff members in response to allegations of sexual abuse.

(c)(d) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "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." The Facility Administrator and PSA Compliance Manager confirmed that no SLIPC detainee victim has been transferred from SLIPC to any detention facility. They further

stated if a detainee were to be transferred under these conditions, a Notification of Transfer by email would be completed to include the information of potential services needed and a copy forwarded to the AFOD.

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

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

Notes:

The Auditor determined compliance with this standard based on policy 10.1.1 that requires, "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 PSA Compliance Manager and Facility Administrator both confirmed that any employee, contractor, or volunteer who was an alleged perpetrator of sexual abuse of a detainee would be removed from any further contact with detainees pending the investigation outcome. SLIPC had one allegation of sexual abuse made against a staff member during the audit period. The staff member resigned the day the allegation was made and the investigative file contained the resignation email; therefore, it was not necessary for the "no contact" email/memorandum due to the same day resignation.

§115.67 - Agency protection against retaliation.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that 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. SLIPC 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. SLIPC'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 investigators." The interviews with the Facility Administrator and PSA Compliance Manager confirmed SLIPC prohibits any form of retaliation. The PSA Compliance Manager confirmed he is the primary staff member who monitors retaliation for staff and detainees at SLIPC with the Mental Health practitioner as his backup. He stated that retaliation monitoring starts the day the allegation is made and continues for at least 90 days or longer, if needed. He indicated that he personally meets with the detainee weekly, and documents the meeting on the Protection from Retaliation Log, Attachment B. He stated that detainee monitoring includes a review of the detainee's disciplinary reports and/or housing changes or program changes. He stated that staff monitoring is done for 90 days or more, if needed. He confirmed that monitoring includes a monthly in-person meeting with staff and includes monitoring negative performance reviews, time off refusals, and change of duties or reassignment requests. The Auditor was provided documentation of retaliation monitoring and found examples of retaliation monitoring in the four completed investigative files reviewed. In each case, retaliation monitoring was conducted for at least 90 days, except in the cases where the detainee was released from SLIPC and ICE custody before the end of the 90-day period. The PSA Compliance Manager confirmed SLIPC has had no cases requiring staff retaliation monitoring nor any allegations of retaliation by a detainee or staff member during the audit period.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible, subject to the requirements of 115.43. Detainee victims shall not be held for longer than five (5) days in any type of administrative restriction, except in unusual circumstances or at the request of the detainee. SLIPC shall notify the appropriate ICE Enforcement and Removal Operations Field Office Director whenever a detainee victim has been held in administrative restriction for 72-hours. A detainee victim, who is in protective custody after having been subjected to sexual abuse, shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." The Facility Administrator confirmed the use of administrative segregation, in the SMU, for any detainee victim of sexual abuse or based on their vulnerability to sexual abuse or assault would be highly unlikely at SLIPC. He stated if the SMU was ever used to protect a victim of sexual abuse, he would make the required 72-hour notification to the AFOD. He further stated that a classification and vulnerability assessment would be completed on the detainee prior to the detainee being placed back in general population. As noted in 115.43, the SMU has not been open during the audit period. There were no detainees, who alleged sexual abuse, present at SLIPC at the time of the site visit to interview.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "When SLIPC 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. SLIPC shall use investigators who have received specialized training in Sexual Abuse investigations. An administrative or criminal investigation shall be completed for all allegations of Sexual Abuse. Coordination of internal administrative investigations as well as coordination with the ICE Office of Professional Responsibility (OPR) should be

coordinated in a way as to not interfere with the assigned criminal investigative entity criminal investigations. Within 30 days of the conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Within 30 days of the conclusion of a criminal investigation where the allegation was unsubstantiated, SLIPC shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity." This policy was approved by the AFOD. The Facility Investigator stated that he conducts an administrative investigation on every allegation of sexual abuse, regardless if a criminal investigation is conducted and the outcome of a criminal investigation if one is done. None of the four allegations at SLIPC were determined to be criminal. The review of those four investigative files indicated the investigations appeared to be completed promptly, thoroughly, and objectively and as required in subpart (a) of this standard. The Auditor conducted a thorough review of these case files and confirmed the investigation was conducted by the facility's trained Investigator.

(c) The Auditor determined compliance with this subpart of the standard based on the review of Policy 10.1.1-A that requires "Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of Sexual Abuse involving the suspected perpetrator. Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse and shall be documented in a written report format that includes at a minimum, a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The credibility of an 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. SLIPC shall not 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. SLIPC 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 Investigator stated that upon every allegation of sexual assault he notifies the Basile PD and waits to conduct his administrative investigation after consultation with the appropriate investigative offices within DHS. He also stated that he cooperates with the outside agency conducting the criminal investigation and provides assistance as needed. He also confirmed during his interview that the administrative investigations are based on direct and circumstantial evidence; available physical DNA evidence; available electronic monitoring data; interview notes from alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator. He stated he assesses the credibility of any alleged victim, suspect, or witness, based on evidence without regard to their status as a detainee, employee, or contractor and without requiring any detainee who alleges sexual abuse or assault to submit to a polygraph. As noted earlier in the report there were four allegations reported during the audit period that were handled administratively and determined not criminal by the Basile PD.

(e) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1-A that requires, "the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation." The Facility Investigator confirmed that the departure of the alleged abuser or victim from employment or control of the facility does not affect the investigation from being completed. The one staff-on-detainee investigative case reviewed confirmed the investigation continued and was completed after the staff member resigned the day the accusation was made. In the other three cases, the detainee victims were released prior to the completion of the investigation, and based on review of the investigative files, each investigation continued after the departure of the detainee victims.

(f) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1-A that requires, "When outside agencies investigate Sexual Abuse, SLIPC shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." The Facility Investigator stated that he is the point of contact for any outside investigative agency if a criminal investigation is conducted, or if an administrative investigation is conducted by an external entity. He stated that he cooperates with the outside investigative agency by providing assistance when needed.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with the standard based on Policy 10.1.1-A that requires "facilities impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated." The interview with the Facility Investigator confirmed the standard he uses when determining a sexual abuse investigation is the preponderance of evidence. Based on the review of the four investigative case files, the Auditor determined a preponderance of the evidence was the standard used in determining the outcome of the investigations.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with the standard based on Policy 10.1.1-A that requires, "At the conclusion of all investigations conducted by 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. SLIPC's obligation to report under this section shall terminate if the detainee is released from custody." The Auditor provided the Team Lead with the names of the detainee investigative files from the four investigative case files reviewed. Each of the four cases demonstrated the detainee was provided the result of the investigation outcome either in person or by mail.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "The agency shall review and approve facility policies and procedures regarding disciplinary or adverse actions for staff and shall ensure that the facility policy and procedures specify disciplinary or adverse actions for staff up to and including removal from their position and from the Federal service for staff, when there is a substantiated allegation of sexual abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Removal from their position and from the Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in Sexual Abuse, as defined under the definition of Sexual Abuse of a detainee by an employee, contractor or volunteer." The Facility Administrator, HRM, and the PSA Compliance Manager confirmed staff removal from their position and from Federal service would be the presumptive disciplinary sanction for staff having engaged in or attempted or threatened to engage in sexual abuse. There was one allegation of sexual abuse involving a staff member during the audit period. The allegation was determined to be substantiated. The staff member resigned at the onset of the investigation for the case.

(c)(d) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "SLIPC shall report all removals or resignations in lieu of removal for violations of Agency or facility Sexual Abuse policies to appropriate law enforcement agencies, unless the activity was clearly not criminal. The facility shall also report all such incidents of substantiated abuse, removals or resignations in lieu of removal to the Field Office Director, regardless of whether the activity was criminal and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known." The HRM indicated this is the responsibility of the Facility Administrator. The Facility Administrator confirmed that he is responsible for making these notifications when it becomes necessary. He also confirmed all allegations of sexual abuse are immediately reported to the Basile PD, regardless if the staff member resigns or not. The Auditor found notifications made to the Basile PD in each of the four investigative files reviewed. There were no reported terminations of any SLIPC employee for violation of the facility's zero-tolerance policy. As previously noted one staff member resigned during a PREA investigation. The Basile PD did not prosecute the case.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "Any contractor or volunteer who has engaged in Sexual Abuse shall be prohibited from contact with detainees. SLIPC shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated Sexual Abuse by a contractor or volunteer. Such incidents shall also be reported to law enforcement agencies, unless the activity was clearly not criminal. The facility shall also report all such incidents of substantiated abuse by a contractor or volunteer to the Field Office Director, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known. Contractors and volunteers suspected of perpetrating Sexual Abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. SLTPC shall take appropriate remedial measures, and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in Sexual Abuse, but have violated other provisions within these standards." The Facility Administrator confirmed that any contractor or volunteer suspected of perpetrating sexual abuse would be removed from all duties requiring detainee contact pending the outcome of the investigation. He also stated he would take appropriate remedial measures and consider whether to prohibit further contact with detainees by any contractor or volunteer who has not engaged in sexual abuse but has violated other provisions within these standards. He also stated that there were no reported incidents at SLIPC requiring the removal of a contractor or volunteer during the audit period. He also stated that if there were, the incidents would be reported to the Basile PD, the FOD, and any relevant licensing body.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1-A that requires, "SLIPC 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 to rules and regulations in the future. SLIPC 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. SLIPC shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of

disciplinary action, a report of Sexual Abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The Facility Administrator and PSA Compliance Manager confirmed that the disciplinary process at SLIPC allows for progressive levels of reviews, appeals, procedures, and that the entire hearing is documented. They also confirmed that staff assistance is provided upon any detainee's request. There were three allegations of detainee-on-detainee sexual abuse with one allegation substantiated upon completion of the investigation. The abuser was not disciplined because she had left the custody of ICE prior to the conclusion of the investigation.

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

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "If during the intake assessment, persons tasked with screening determine that a detainee is at risk for either sexual victimization or abusiveness, or if the detainee has experienced prior victimization or perpetrated sexual abuse, the detainee shall be referred to a qualified Medical and/or Mental Health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two (2) 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." Interviews with the two intake staff confirmed that when staff learn a detainee was ever a victim of sexual abuse or was an abuser, as appropriate he/she ensures that the detainee is immediately referred to a qualified Medical or Mental Health practitioner for follow-up as appropriate. Both indicated notifications are typically done by email, telephone call, or discussion with Medical staff in the intake area at the time. The interviews with the Medical practitioner confirmed when a medical follow-up is initiated, the detainee receives a health evaluation typically the same or next day, but no later than two working days from the date of the assessment. The interview with the Mental Health practitioner confirmed when a referral for mental health is initiated, the detainee receives a mental health evaluation no later than 72 hours after the referral. The Auditor interviewed five detainees who disclosed prior victimization during their initial risk assessment. Each indicated they were offered and received medical/mental health referral on the day they arrived. Their medical records were reviewed, and confirmed they were seen by health services, within 24 hours of their arrival.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "Victims of sexual abuse in custody shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by Medical and Mental Health Practitioners. This access includes offering timely information about and timely access to 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 Auditor's review of the four investigative files completed during the audit period confirmed that each of the four alleged victims was immediately brought to the medical unit and evaluated by Medical staff and/or Mental Health. The interview with the Medical practitioner confirmed that all detainees alleging sexual abuse are seen by Medical and/or Mental Health staff and provided with services that are consistent with community standards, and at no cost to the detainee regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

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

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC 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. 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." The Medical practitioner confirmed any detainee who experiences sexual abuse while in detention would receive medical and mental health services with treatment consistent with the community-level of care without cost to the detainee, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. She also stated her medical department would provide pregnancy and sexually transmitted disease testing and provide medications where appropriate. SLIPC had four allegations of sexual abuse reported during the audit period. None of those detainees were present at the facility at the time of the site visit. The Auditor reviewed their investigative files and found where each was seen and evaluated by Medical/ Mental Health practitioners the same day as the allegation was reported.

(g) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC attempt to conduct a mental health evaluation on all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by mental health practitioners". This same policy defines "Known abusers as those abusers in which a SAAPI investigation determined either administratively substantiated or substantiated by outside law enforcement." The

facility had one detainee-on-detainee substantiated allegation during the audit period requiring this type of evaluation. The Mental Health practitioner confirmed all known abusers at SLIPC would be offered evaluation and treatment. She also confirmed the one substantiated detainee-on-detainee allegation did not result in the offering of mental health services to the abuser as she left the facility before the conclusion of the investigation.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 10.1.1 that requires, "SLIPC is required to conduct a Sexual Abuse incident review at the conclusion of every sexual abuse investigation utilizing the DHS Sexual Abuse or Assault Incident Review form (see attachment J). 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 Manager, Medical and Mental Health Practitioners." The interview with the PSA Compliance Manager, who is a member of the incident review team, indicated the form and the review itself considers race; ethnicity; gender identity; LGBTI identification; status, or perceived status; gang affiliation; or whether the incident was motivated or otherwise caused by other group dynamics at the facility, while conducting their incident review. The PSA Compliance Manager advised the Auditor the completed incident review reports and responses are forwarded to the FOD for distribution to the agency PREA Coordinator per the standard's requirement. The Auditor reviewed four investigative files and found an incident review form in each file, conducted within 30 days of the investigation being completed. There were no recommendations for improvement made in any of these completed incident reviews.

(c) The Auditor determined compliance with this subpart of the standard based on policy 10.1.1 that requires, "Annually, SLIPC 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 SLIPC shall prepare a negative report. SLIPC shall document the review utilizing the 'DHS Annual Review of Sexual Abuse Incidents' form, Attachment K." The PSA Compliance Manager provided the Auditor with the annual review completed in November 2021 that was addressed to the FOD.

Recommendation (c): The annual review was conducted in accordance with subpart (c) however the DHS Annual Review of Sexual Abuse Incident Abuse Incidents form was not used. The facility should consider changing the policy or use the correct form indicated in policy 10.1.1.

§115.87 - Data collection.

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

Notes:

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

§115.201 - Scope of audits.

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

Notes:

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

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	1
Number of standards met:	36
Number of standards not met:	2
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 5/17/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 5/17/2022

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 5/18/2022

Assistant Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-[redacted]
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-[redacted]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	New Orleans Field Office		
Acting Field Office Director:	(b)(6), (b)(7)(C)		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1250 Poydras Suite 325 New Orleans, LA 70113		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	South Louisiana ICE Processing Center (SLIPC)		
Physical address:	3843 Stagg Ave. Basile, Louisiana 70515		
Mailing address: *(if different from above)*			
Telephone number:	318-668-5900		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-668-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	1-318-446-[redacted]

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 the South Louisiana ICE Processing Center (SLIPC) (also known as the South Louisiana Detention Center) was conducted on March 22-24, 2022. The audit was performed by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), [redacted], both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards during the audit period of March 2021 through March 2022. The SLIPC is privately owned by the GEO Group and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the SLIPC are from Haiti, Nicaragua, and Columbia. The facility does not house juveniles, males, or family detainees. This was the first DHS PREA audit for the facility, which is located in Basile, Louisiana.

During the audit, the Auditor found SLIPC met 36 standards, had 1 standard (115.31) that exceeded, had 2 standards (115.14 and 115.18) that were non-applicable, and 2 non-compliant standards (115.16 and 115.33). As a result of the facility being out of compliance with 2 standards, the facility entered into a 180-day corrective action plan (CAP) period which began on May 20, 2022, and ended on November 16, 2022. The purpose of the of the CAP is for the facility to develop and implement a plan to bring these standards into compliance.

The Auditor received the first CAP via email on June 27, 2022, through OPR ERAU. The CAP was reviewed and approved by the Auditor for the two standards that did not meet compliance during the PREA audit site visit and documentation review. The Auditor received the final CAP documents provided by the facility for review on September 6, 2022. This documentation was reviewed, and the Auditor determined that the facility demonstrated compliance with each of the two standards found non-compliant at the time of the site visit.

Number of Standards Met: 2

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

§115.33 Detainee education

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. 16 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c) Policy 10.1.1 requires, "SLIPC shall ensure that detainees with disabilities (i.e., those who are deaf, hard of hearing, blind, have low vision, intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from the Company's efforts to prevent, detect, and respond to sexual abuse and assault. SLIPC shall provide written materials to every detainee in formats or through methods that ensure effective communication with detainees with disabilities, including those who have intellectual disabilities, limited reading skills or who are blind or have low vision. The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in English proficiency (LEP). The facility will provide detainees with disabilities with effective communication, which may include the provision of auxiliary aids, such as readers, materials in Braille, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters and note takers, as needed. The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities." The policy further requires in matters relating to sexual abuse, "SLIPC 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."

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard as it could not demonstrate it provides detainees who are LEP with language assistance, through bilingual staff or professional interpretation and translation services, ensuring detainees receive meaningful access to its programs and activities, particularly those detainees who speak/understand languages other than English and Spanish. To become compliant, the facility needs to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainee who are LEP.

Corrective Action Taken (b): On June 6, 2022, SLIPC provided the Auditor a copy of the facility manuscript detailing the PREA information taken from the ICE National Detainee Handbook, new signature forms, instructions for staff delivery of this manuscript information to LEP detainees during intake processing (PREA Guidelines & Procedures), and email notification to staff of the new procedures. The Auditor was also informed of the staff training which occurred April 11, 2022, and April 14, 2022, on the new procedure, which included instruction on the use of the manuscript being read to LEP detainees by utilizing an interpreter through the language line for detainees not speaking a language covered by the ICE National Detainee Handbook. Additionally, the facility provided two examples of delivery of the PREA information to LEP detainees using the new procedures. The Auditor accepted the CAP as presented. Full compliance was pending the Auditor's review of 3 additional examples of this manuscript utilization to LEP detainees using the new procedures (for detainees who required a language not covered by the 14 available ICE National Detainee Handbook publication languages, if possible); the revised SLIPC Policy 10.1.2, (Detainee Movement into and Out of the Facility), and revised Post Order #034 Intake Officer. The Auditor received a revised CAP on September 6, 2022, containing the revised SLIPC Policy 10.1.2, revised Post Order #034 Intake Officer and 3 additional examples of this script utilization. SLIPC is now compliant with the standard.

§115. 33 - Detainee education
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(e)(f) The Auditor evaluated compliance with these subparts of the standard based on policy 10.1.1 that requires, "during the intake process SLIPC ensure that the detainee orientation program notifies and informs detainees about the zero-tolerance policy regarding all forms of sexual abuse and assault and includes instruction on prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, employee-on-detainee sexual abuse and coercive sexual activity, explanation of methods for reporting sexual abuse or assault, including to any employee, including an employee other than immediate point-of contact line officer (i.e. the PSA Compliance Manager or mental health staff), the

Detention and Reporting Information Line (DRIL), the DHS OIG, and JIC and the ICE/OPR investigation process, information about self-protection and indicators of sexual abuse, prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." This policy further requires "education/notification be provided in formats accessible to all detainees, including those [who] are LEP, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. SLIPC shall maintain documentation of detainee participation in the intake process orientation which shall be retained in their individual files." As noted in 115.16, detainees arriving at SLIPC are provided an ICE National Detainee Handbook, the South Louisiana handbook, the DHS-prescribed SAAPI pamphlet. They are also shown a PREA video (PREA and Know Your Rights) which is available in English and Spanish. The ICE National Detainee Handbook is available in 14 languages. The South Louisiana handbook is available in Spanish and English only. The DHS-prescribed Sexual Assault Awareness pamphlet is provided in nine languages. The two intake staff interviewed by the Auditor confirmed that orientation information is provided to all detainees regardless of the detainee's language or disability. During interviews with two intake staff, each explained the intake process and confirmed the materials noted above as being provided to each detainee upon arrival, either through written formats, staff assistance and/or interpretive services. The two intake staff also indicated when staff encounters a detainee who speaks/understands a language not provided in one of the 14 languages represented in the ICE National Detainee Handbook, staff utilizes the ERO language line interpretive services and reads pertinent information from a manuscript. They also confirmed any detainees the facility staff encounter that may be hearing impaired or deaf would require staff to utilize the text telephone (TTY). Those detainees arriving at SLIPC with limited sight or who are blind would be provided individualized attention by staff that may include reading the information to her. In cases where the detainee has low intellect or limited reading skills, depending on the degree of limitation, the detainee would be referred initially to a supervisor or the medical/mental health department to provide the necessary orientation information. Also noted in 115.16, during the 20 random detainee interviews, all but one confirmed she had received copies of these documents or pertinent portions in a format she understood. The review of her file did not demonstrate she received this information through the facility contracted interpretive services. The PSA Compliance Manager informed the Auditor that he was adding a line on a manuscript, that outlines the facility's efforts to prevent, detect, and respond to sexual abuse with orientation information, for intake staff to note the interpreters' ID number. The Auditor randomly selected and reviewed nine other detainee files and reviewed signed documentation indicating the detainees received both the ICE National Detainee Handbook and the South Louisiana handbook and viewed the PREA video in a language they understood.

Does Not Meet (b)(c): The facility is not compliant with subsection (b)(c) of the standard as it could not demonstrate it provides detainees who are LEP with language assistance, through bilingual staff or professional interpretation and translation services, ensuring detainees receive meaningful access to the orientation program that informs them about the agency's and facility's zero tolerance policies for all forms of sexual assault to include the 6 subpart (a) requirements, particularly those detainees who speak/understand languages other than English and Spanish. The facility must provide evidence of the new process implementation that was being developed by the PSA Compliance Manager at the time of the audit, or some other process if this was not implemented to completion, and evidence that the process is being complied with; documentation of the interpretation service used to deliver the manuscript and signature of detainee's participation for detainees who speak languages other than English and Spanish. If available, the sample must include detainees who speak a language other than one of the 14 languages covered by the ICE National Detainee Handbook. This evidence must include documentation that clearly confirms interpreters or translation services were used when needed.

Corrective Action Taken (b)(c): On June 6, 2022, SLIPC provided the Auditor a copy of the facility manuscript detailing the PREA information taken from the ICE National Detainee Handbook, new signature forms, instructions for staff delivery of this manuscript information to LEP detainees during intake processing (PREA Guidelines & Procedures), and email notification to staff of the new procedures. The Auditor was also informed of the staff training which occurred April 11, 2022, and April 14, 2022, on the new procedure, which included instruction on the use of the manuscript being read to LEP detainees by utilizing an interpreter through the language line for detainees not speaking a language covered by the ICE National Detainee Handbook. Additionally, the facility provided two examples of delivery of the PREA information to LEP detainees using the new procedures. The Auditor accepted the CAP as presented. Full compliance was pending the Auditor's review of 3 additional examples of this script utilization to LEP detainees using the new procedures (for detainees who required a language not covered by the 14 available ICE National Detainee Handbook publication languages, if possible); the revised SLIPC Policy 10.1.2, (Detainee Movement into and Out of the Facility), and revised Post Order #034 Intake Officer. The Auditor received a revised CAP on September 6, 2022, containing the revised SLIPC Policy 10.1.2, revised Post Order #034 Intake Officer and 3 additional examples of this script utilization. SLIPC is now compliant with the standard.

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

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

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

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

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

Thomas Eisenschmidt September 17, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) September 20, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) September 20, 2022
Program Manager's Signature & Date