PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	James L. Roland Jr.	**Organization:**	The Nakamoto Group, Inc.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	419-610(b) (6), (b) (7)(C)

AGENCY INFORMATION	
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)

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

INFORMATION ABOUT THE FACILITY BEING AUDITED					
Basic Information About the Facility					
Name of facility:	LaSalle ICE Processing Center				
Physical address:	830 Pinehill Road, Jena, LA 71342				
Mailing address: *(if different from above)*					
Telephone number:	318-992-7800				
Facility type:	☐ SPC	☐ CDF	☑ DIGSA	☐ IGSA	☐ FRC
	☐ Other, **Describe:**				

Facility Leadership			
Name of Official/Officer in Charge:	David Cole	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-992-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	Gary B. Cloud	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-992-(b) (6), (b) (7)(C)

AUDIT FINDINGS

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 on-site Prison Rape Elimination Act (PREA) audit of the LaSalle Immigration and Customs Enforcement (ICE) Processing Center (LIPC), was conducted August 22-24, 2017, by James Roland (Lead) and (b) (6), (b) (7)(C) The Nakamoto Group Inc. certified auditors. This was the first PREA audit for this facility. Prior to the on-site audit, the facility provided the auditors with agency and local policy, supporting documents, a description of the facility layout and the Pre-Audit Questionnaire.

An in-brief meeting was held the first day of the audit to discuss the audit process and finalize the facility's tour and interview schedules. The following persons were in attendance: External Review & Analysis Unit (ERAU) Team Lead (b) (6), (b) (7)(C), Facility Administrator David Cole, Assistant Field Office Director (AFOD) (b) (6), (b) (7)(C) t, GEO Group, Inc (GEO) PREA Coordinator (b) (6), (b) (7)(C) LIPC PSA Compliance Manager Gary B. McCloud, Correctional Officer (b) (6), (b) (7)(C), Classification Manager (b) (6), (b) (7)(C), Assistant Administrator of Operations (b) (6), (b) (7)(C) and Health Services Administrator (HSA) (b) (6), (b) (7)(C). The facility has (b) (7)(E) staff on board. The population of the facility was 1147 female and male adult detainees during the audit. After the in-brief meeting, a comprehensive tour of the facility was completed. The tour included the intake processing area, all housing units, including the Restricted Housing Units (RHU), the medical services department, recreation, food service, the l brary, visiting rooms and other facility support areas. During the tour, it was noted that there was sufficient staffing and monitoring technology to ensure a safe environment for detainees and staff. Only female security staff supervise female detainees, who are housed in separate housing units. Signs are posted which remind employees of the opposite gender to announce themselves prior to entering areas where opposite gender detainees are housed. Detainees are able to shower, dress and use the toilet facilities privately, without exposing themselves to employees of the opposite gender. Informal and formal conversations with employees and detainees regarding the PREA standards were conducted. Zero tolerance posters concerning sexual abuse were prominently displayed in all housing units, common areas and throughout the facility. Audit notice postings with the PREA auditors' contact information were also located in the same areas. There were no letters mailed to the auditors.

A total of 31 random staff interviews were conducted during the audit. The interviews included Immigration Health Services Corps (IHSC) and security staff (including supervisors) from all shifts. ICE interview forms were used as a guide. Interviews were conducted in private offices or private rooms. All staff were aware of the agency's zero tolerance policy, their responsibilities to protect detainees from sexual abuse and their duties as first responders as part of a coordinated response. Specialized staff were also interviewed which included the Facility Administrator, Facility PREA Compliance Manager, PREA Investigator, HSA, the Retaliation Monitor, the Human Resource Manager (HRM), a Classification Supervisor, Grievance Coordinator, Training Supervisor and Mental Health Practitioner. No staff refused to be interviewed. All interviewed staff, volunteers and contractors demonstrated an understanding of PREA and their respons bilities under this program, relative to their position at the facility and employment status. A member of the local victim advocate office from Wellspring Rape Crisis Center, the provider of services to the facility, was also interviewed telephonically. A telephonic interview with a Sexual Abuse Nurse Examiner (SANE) confirmed forensic medical examinations are conducted at St. Francis Cabrini Hospital, Alexandria, LA.

Forty detainees were randomly selected and interviewed by the auditors from all housing units, including the Restricted Housing Unit, commonly known as Segregation or the Special Management Unit. Interviews were conducted in private offices or private areas adjacent to the housing units. The detainees interviewed were of various ages, nationalities and ethnic backgrounds. Of the interviewed detainees, four self-identified as being members of the LGBTI community, one as being disabled and three were limited English proficient (LEP). A telephonic interpretation service and The Nakamoto staff interpreter were used to conduct interviews with the detainees who mostly spoke Spanish. Three detainees had previously reported sexual abuse. All detainees interviewed demonstrated a good understanding of the PREA program, the prevention, protection and reporting mechanisms, and stated they felt safe at the facility and would contact staff if necessary concerning a PREA issue. No detainees refused to be interviewed.

The LaSalle ICE Processing Center is owned and operated by the GEO Group, Inc. The GEO Group has an intergovernmental services agreement with ICE and the LaSalle Economic Development District. The facility is located in a rural area on the outskirts of Jena, Louisiana. LIPC is a dedicated ICE facility, housing male and female detainees of all security classification levels. On August 22, 2017 the facility count was 1147, including 1019 male and 128 female detainees. The average length of stay is 32 days. An on-site administrative building serves the needs of ICE officials and the Executive Office of Immigration Review (EOIR).

The physical layout consists of nine separate buildings surrounded by a (b) (7)(E) . The facility has [redacted] surveillance cameras monitored by central control security officers and a (b) (7)(E) The housing units consist of 13 dormitory bays, as well as four units equipped with two-person cells, ranging in size from 24-48 beds. Detainees in the housing areas are directly supervised by assigned housing unit officers and are under constant camera surveillance. Housing units provide generous open space. Detainees spend the majority of their time socializing in the day rooms, watching television, working or participating in indoor/outdoor recreation activities. The facility provides each detainee with a set of ear buds and a radio.

There are 25 dormitory style general population housing units located in the facility. Small recreation areas are located in each unit. The facility also has separate male-only and female-only Restricted Housing Units (single or double occupancy cells) for administrative (protective custody) or disciplinary segregation. Each unit is staffed at all times by (b) (7)(E) security officers, who make irregular rounds or inspections and also provide excellent visual supervision from their work station. All detainees have direct contact (b) (7)(E) to make requests or resolve problems. ICE staff routinely visit the detainees. Medical, food service, laundry and other program services are located in the same building near the housing units. Meals are provided inside the housing units. One very large recreation yard is also located on the outside of the main building.

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.

When the on-site audit was completed, a close-out meeting was held with ERAU Team Lead (b) (6), (b) (7)(C), Facility Administrator David Cole, AFOD (b) (6), (b) (7)(C), GEO Group, Inc. PREA Coordinator (b) (6), (b) (7)(C), LIPC PSA Compliance Manager Gary Cloud, Chief of Security (b) (6), (b) (7)(C), GEO Group, Inc. Compliance Administrator (b) (6), (b) (7)(C), HSA (b) (6), (b) (7)(C), Training Administrator (b) (6), (b) (7)(C), Executive Secretary (b) (6), (b) (7)(C), Assistant Business Manager (b) (6), (b) (7)(C), Food Service Manager (b) (6), (b) (7)(C), Transportation Manager (b) (6), (b) (7)(C), Maintenance Superintendent (b) (6), (b) (7)(C), and Human Resource Representative (b) (6), (b) (7)(C). The facility and ICE staff were found to be courteous, cooperative and professional. Staff morale appeared to be good and the observed facility staff/ICE employee/detainee interactions were observed to be appropriate. There were no "blind spots" observed during the tour and adequate video cameras and mirrors supplement the staff monitoring of detainees. The auditors were provided with extensive and lengthy files prior to and during the audit for review, to support a conclusion of compliance. Observations made during the tour and all interviews also supported compliance. All areas of the facility were observed to be very clean and well-maintained. The facility improved detainee privacy in the intake holding areas at the suggestion of the auditors. At the conclusion of the audit, the auditors thanked the facility and ICE staff for their hard work and dedication to the PREA audit process.

The standards used for this audit became effective May 6, 2014. 40 standards were found to be compliant to the PREA, one was found to exceed the standard (115.31) for compliance and one standard (115.14) was found to be not-applicable.

There were four sexual abuse allegations, two cases were closed and two cases were pending during the auditing period. The auditor was able to review the closed investigations. Both investigations were complete with one being unfounded and one being unsubstantiated. The other two investigations were still pending and were not reviewed by the auditor.

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	1
Number of standards met:	39 (of the 41 total, one was not applicable)
Number of standards not met:	0

PROVISIONS

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

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Written policy mandates zero tolerance toward all forms of sexual abuse and outlines the agency's approach to preventing, detecting and responding to such conduct. The Facility Administrator appointed a PSA Compliance Manager who reports directly to him on PREA issues. The PSA Compliance Manager and PREA Field Coordinator confirmed they have sufficient time and authority to oversee compliance with the PREA. (continued on last page)

§115.13 – Detainee supervision and monitoring.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Policy requires that a comprehensive staffing analysis be completed annually. A review of the staffing plan, organizational chart, post orders and interviews with the Facility Administrator and HRM confirmed that the facility has a staffing plan which provides adequate staff to ensure a safe and secure environment for staff and detainees. Supervision is supplemented by video cameras and various ICE staff routinely visit the units to address detainee issues. The auditor examined the video monitoring systems, ICE visit logs, unannounced rounds reports and staff deployment along with staff/detainee interviews. The supervision and monitoring of detainees was found to be compliant with this standard.

§115.14 – Juvenile and family detainees.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)
- ☐ Not Applicable (provide explanation in notes):

Notes:

Not applicable. The facility does not house juveniles or family units.

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of the standard. LIPC does not permit cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or when performed by medical practitioners. The facility reported there were no cross-gender visual body cavity or strip searches conducted during the audit period. If conducted, the search is required to be documented. Additionally, interviews confirmed detainees have privacy to shower, change clothes and perform bodily functions without being seen by staff of the opposite gender. (continued on last page)

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes

LIPC Policy and Procedure Manual 2.1.1 addresses the requirement of the standard. The facility takes appropriate steps to ensure detainees with disabilities and detainees with limited English proficiency (LEP) have an opportunity to participate in and benefit from the institution's efforts to prevent, detect and respond to sexual abuse. PREA handouts, bulletin board postings, an orientation video, staff reading or writing information and detainee handbooks are provided in English and Spanish (primary languages). Additionally, the facility has bilingual (English/Spanish) staff and a contract with a interpretation service to provide interpreter services in any language to detainees who do not speak English. (continued on last page)

§115.17 – Hiring and promotion decisions.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirement of the standard. The facility requires all staff to pass a background investigation to ensure compliance with this standard. The Facility Administrator and HRM were interviewed and stated that all components of this standard have been met. All employees, contractors and volunteers have had background checks completed. A tracking system, which is in place to ensure that updated background checks are conducted when staff are promoted and every five years, was reviewed by the auditor. Policy clearly states the submission of false information by any applicant is grounds for termination.

§115.18 – Upgrades to facilities and technologies.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)
- ☐ Not Applicable (provide explanation in notes):

Notes:

The facility has undergone an upgrade (modification) of its monitoring technology. Relevant PREA issues (broader video monitoring abilities) were taken into consideration during the design phase of this upgrade. There has been the installation of updated video monitoring systems, electronic surveillance systems and other monitoring technology since May 6, 2014. Interviews with staff, auditors' observations, an examination of supporting documentation (i.e., purchase orders), and an inspection of the equipment confirm compliance with this standard. The facility also provides communication assistance to detainees with disabilities.

§115.21 – Evidence protocols and forensic medical examinations.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

GEO Corporate Policy and Procedure Manual 5.1.2-F addresses the requirements of this standard. GEO, mental health, and IHSC staff were interviewed concerning this standard and all were knowledgeable of the procedures required to secure and obtain usable physical evidence when sexual abuse is alleged. Staff were also aware that OPR conducts administrative investigations relative to sexual abuse allegations and the Jena Police Department conduct criminal investigations. All forensic medical examinations are conducted by a Sexual Abuse Nurse Examiner at the St. Francis Cabrini Hospital in Alexandria, LA. (continued on last page)

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

GEO Corporate Policy and Procedure Manual 5.1.2-F and the ICE SAAPI Directive 11062.1 address the requirements of this standard. Administrative and/or criminal investigations are completed on all allegations of sexual abuse. OPR or the Jena Police Department conduct investigations at the facility. The facility PSA Compliance Manager/Investigator (who does not complete investigations (OPR does), but is trained to do so) was interviewed and found to be very knowledgeable concerning his responsibilities in the investigative process. All allegations are reported immediately to the on-site ICE staff (AFOD) via email, in-person or by phone call, who in-turn notifies the JIC. (continued on last page)

§115.31 – Staff training.

- ☑ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of the standard. The review of training documents/curriculum, training logs, GEO Group, Inc. agency training and staff interviews confirmed that all staff, ICE employees, IHSC staff received PREA training that includes each element required of the standard. IHSC staff receive additional specialized training that includes detecting and assessing signs of sexual assault and abuse, preservation of physical evidence, responding effectively and professionally to victims and how to report sexual assault/abuse. (continued on last page)

§115.32 – Other training.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. A review of the training records revealed that all have personnel received PREA training, to include the facility's zero-tolerance policy, reporting and responding requirements. The training is documented and copies of training sign-in sheets and other related documents were reviewed by this auditor. Volunteers and contractors also receive PREA training. Interviews with one contractor and one volunteer confirmed they received this training. Contract and IHSC staff are also provided with a PREA pocket-sized reference guide.

§115.33 – Detainee education.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of the standard. During intake, each detainee receives a Sexual Abuse and Assault Awareness pamphlet, the ICE National Detainee Handbook and the LIPC Handbook. This information is available in English and Spanish, and translated for detainees needing it in other languages (using staff interpretors or the language line). Detainees sign a form acknowledging receipt of these documents. The pamphlet and handbooks identify the key elements of the program and inform detainees of the zero-tolerance policy regarding sexual abuse and assault and multiple ways to report any such incidents. (continued on last page)

§115.34 – Specialized training: Investigations.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC policy and Procedure Manual 2.1.1 addresses the requirements of this standard. OPR investigators have completed a specialized investigator training program that meets the requirements of this standard. The facility investigator also completed training provided by GEO Group. The training covered the required procedures for obtaining, preserving, and securing physical evidence, interviewing victims and witnesses, investigating in a detention facility when sexual abuse is alleged. The auditor reviewed the specialized training documentation and interviewed the facility investigator, ICE staff, and the facility training officer for compliance.

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 and IHSC policy directive 03-01 address the requirements of this standard. All mental health and medical staff are provided specialized training on victim identification, interviewing, reporting and clinical interventions. This training is provided initially for new employees and annually with updates if necessary. The auditor reviewed the training lesson plan, training sign-in sheets and interviewed the HSA, who confirmed the IHSC staff received the necessary training.

§115.41 – Assessment for risk of victimization and abusiveness.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. All detainees are assessed at intake immediately upon arrival at the facility for their risk of being sexually abused or being sexually abusive towards other detainees. The initial screening considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse. The review of medical intake screening documents, as well as interviews with staff and detainees, confirm compliance. All new arrivals are assessed within their first 12 hours. Detainees identified as high risk for sexual victimization or at risk of sexually abusing other detainees are referred to the mental health staff for additional assessment. (continued on last page)

§115.42 – Use of assessment information.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. The facility uses a screening instrument (reviewed by the auditor) to determine proper housing and program assignments, as well as risk ratings. The goal of the assessment is to keep detainees who are at high-risk of being sexually abused separate from those detainees who are at a high-risk of being sexually abusive. Housing and program assignments are made on a case-by-case basis and detainees are not placed in housing units based solely on their sexual identification or status. Transgender and intersex detainees are not housed separately from the general population. Detainees are given the opportunity to shower separately from other inmates. (continued on last page)

§115.43 – Protective custody.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. The policy states that detainees at high-risk for sexual victimization shall not be placed in restricted housing (Protective Custody) unless an assessment of all available alternatives has been made and there is no available means of separating the detainee from the abuser. There were no detainees placed in PC during the audit period. The FOD is notified via email if a detainee would be placed in PC. The facility must document detailed reasons for placement of an individual in administrative restriction on the basis of vulnerability of sexual abuse or assault. Detainee victims could be transferred to another unit or placed in the medical unit. (continued on last page)

§115.51 – Detainee reporting.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. A review of documentation and staff/detainee interviews indicated that there are multiple ways (verbally to staff, in writing via a letter to ICE, to the DHS Office of the Inspector General (OIG), anonymously, privately and from a third party) for detainees to report sexual abuse. Policy requires staff to document all allegations. There are posters and other documents on display throughout the facility (observed by the auditor) which also explain reporting methods. Facility staff accept reports made verbally, in writing, anonymously and from third parties, and would initiate the process to promptly open an investigation. The PSA Compliance Manager (Facility Investigator) was interviewed concerning this standard.

§115.52 – Grievances.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. All detainees may file a grievance; however, all allegations of sexual abuse, when received by staff, would immediately result in the opening of an administrative or criminal investigation. Detainees are not required to use the informal grievance process. Detainees have no time limit as to when they can submit a grievance regarding sexual abuse. The final decision of the grievance is within five days of the initial filing of the grievance and the agency may claim an extension of a time to respond up to 70 Days. All appeals are answered within 30 days. Third parties shall be permitted to assist detainees in filing for administrative remedies to allegations of sexual abuse. (continued on last page)

§115.53 – Detainee access to outside confidential support services.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. The ICE National Detainee Handbook and the Sexual Abuse and Assault Pamphlet, as well as posters found throughout the facility, list support services. The auditor also confirmed that the facility has an agreement with WellSpring Rape Crisis Center, a local victim advocacy agency, to provide services if requested by a detainee. Interviews with staff, detainees and the local victim advocate agency (telephonic interview) support compliance with this standard.

§115.54 – Third-party reporting

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. The facility has established procedures for third-party reporting which are accepted in accordance with the process listed in standard 115.51. The GEO Group, Inc. and ICE websites also list procedures and telephone numbers for third party reporting. Staff and detainees interviewed were aware of the procedures for third-party reporting. The facility also has posters in the visiting room which allows family and friends of detainees to note the procedures for reporting allegations.

§115.61 – Staff reporting duties.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Staff confirmed during interviews that they are aware of their responsibility to immediately report any knowledge, suspicion or information about any incident of sexual abuse or retaliation against detainees or staff who report or participate in an investigation concerning such an incident. Staff may report misconduct outside of their chain of command by calling or writing upper-level management or as indicated on the DHS OIG posters located throughout the facility. Policy requires the information concerning the identity of the alleged detainee victim and the specific facts of the case to be limited to staff only on a need-to-know basis.

§115.62 – Protection duties.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Interviewed staff were well aware of their duties and responsibilities, as they relate to the staff member having a reasonable belief that a detainee is at imminent risk of sexual abuse. All staff indicated they would act immediately to protect the detainee. Staff are issued a pocket-sized PREA guide which outlines all actions to be taken. Staff also stated they would separate the potential victim/predator, secure the scene to protect possible evidence, not allow detainees to destroy possible evidence and contact their supervisor. (continued on last page)

§115.63 – Report to other confinement facilities.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses requirements of this standard. Policy requires that upon receiving an allegation that a detainee was sexually abused while confined at another facility, the facility must contact the administrator of the facility where the alleged abuse occurred and report the information. The notification must be completed as soon as possible, but no later than 72 hours after staff become aware of the allegation, and it must be documented. An interview with the PSA Compliance Manager and Facility Administrator confirmed their awareness of this requirement in the standard. (continued on last page)

§115.64 – Responder duties.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. All staff interviewed were knowledgeable concerning their required first responder actions, when learning of an allegation of sexual abuse. They stated they would separate the victim from the perpetrator, secure the scene to protect possible evidence, not allow the detainees to destroy poss ble evidence and contact their supervisor. The supervisor would continue to protect the detainee and immediately notify the PSA Compliance Manager, ICE staff, the Facility Investigator and upper-level staff. Staff are issued and carry a pocket-sized PREA first responder card for quick reference and were able to describe all first responder actions when advised that a detainee has been a victim of sexual abuse. (continued on last page)

§115.65 – Coordinated response.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Policy establishes written procedures for a coordinated, multidisciplinary team approach when responding to allegations of sexual abuse. In addition to first responders, the team consists of management officials, ICE staff, medical and mental health providers, the PSA Compliance Manager and community resources from the local hospital and victim advocate services. Further, the facility has established a PREA checklist to aid in the team's response to allegations of sexual abuse. All Investigations reviewed were conducted properly. (continued on last page)

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Staff, contractors and volunteers suspected of perpetrating sexual abuse shall be removed from their duties requiring detainee contact, pending the outcome of an investigation. Interviews with the PSA Compliance Manager and the Facility Administrator confirm compliance with this standard.

§115.67 – Agency protection against retaliation.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Policy prohibits any type of retaliation against any staff or detainee who has reported sexual abuse or cooperated in any related investigation. The PSA Compliance Manager is the designated Retaliation Monitor. When interviewed, he stated he would follow up on all potential sexual abuse cases to ensure that this protection is being enforced. Detainees are monitored at least 90 days following a report of sexual abuse. The monitoring protection consists of detainee disciplinary reports , housing, or program changes. There have been no suspected or actual incidents of retaliation in the last 12 months. Staff interviews also confirmed they were aware of the prohibition regarding any type of retaliation.

§115.68 – Post-allegation protective custody.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of the standard. A detainee that has been placed in Protective Custody status shall not be returned to general population until completion of a proper reassessment. Interviewed security staff indicated that a detainee would be placed in the most supportive environment to ensure their safety and well-being. Appropriate ICE ERO FOD is notified whenever a Detainee victim has been held in administrative restriction for 72 hours. Detainees shall not be held for longer than 5 days in any type of administrative restriction. There were no detainees placed in PC for post-allegations during the review period.

§115.71 – Criminal and administrative investigations.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

According to LIPC Policy and Procedure Manual 2.1.1 Sexual Abuse/Assault Prevention and Intervention Programs, the facility PSA Compliance Manager/Investigator will conduct an initial finding as part of the sexual abuse/assault prevention and intervention program to determine if the allegation is in fact related to PREA. In the event the investigation is potentially criminal, on-site ICE staff (AFOD) and Jena Police Department are contacted for further assistance. Per phone call interview with the LIPC AFOD, the AFOD notifies Joint Intake Center (JIC) of the allegation. (continued on last page)

§115.72 – Evidentiary standard for administrative investigations.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Administrative investigations impose no standard higher than the preponderance of evidence to substantiate an allegation of sexual abuse or assault. An interview with the PSA Compliance Manager confirms compliance with this standard.

§115.73 – Reporting to detainees.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

GEO Corporate Policy and Procedure Manual 5.1.2-F addresses the requirements of this standard. The policy indicates that a detainee shall be notified of the result of the investigation and any additional information required in the standard. All such notifications are documented and placed in the facility investigative file. Compliance with this standard was also determined through an interview with the PSA Compliance Manager. Notifications were included in both investigative case files.

§115.76 – Disciplinary sanctions for staff.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

GEO Corporate Policy and Procedure Manual 5.1.2-F addresses the requirements of the standard. Staff are subject to disciplinary or adverse action up to and including removal from their position for substantiated allegations of sexual abuse or violating agency sexual abuse policies. Policy requires the facility to report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies or licensing agencies, unless the activity was clearly not criminal. There were no substantiated staff-on-detainee sexual abuse investigations in the last 12 months. Compliance with this standard was determined by a review of policy, supporting documentation.

§115.77 – Corrective action for contractors and volunteers.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

GEO Corporate Policy and Procedure Manual 5.1.2-F addresses the mandates of this standard. Any contractor or volunteer who engages in sexual abuse would be prohibited from contact with detainees and will be reported to law enforcement agencies and relevant professional/licensing/certifying bodies, unless the activity was clearly not criminal in nature. During the past year, there were no incidents where a contractor or volunteer was accused or found guilty of sexual abuse. Compliance with this standard was determined by a review of policy, supporting documentation and an interview with the PSA Compliance Manager.

§115.78 – Disciplinary sanctions for detainees.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

GEO Corporate Policy and Procedure Manual 5.1.2-F addresses the requirements of this standard. Policy does not permit the discipline of detainees who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Detainees found guilty of sexual abuse shall be disciplined in accordance with established disciplinary procedures and sanctions shall be commensurate with the nature and circumstances of the abuse committed. The detainee's disciplinary history of mental disease or defect shall also be considered. (continued on last page)

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Interviews with IHSC medical and mental health staff confirm the facility has a thorough system for collecting medical and mental health information and has the capacity to provide continued re-assessment and follow-up services. All evaluations are completed within 48 hours. The policy also allows detainees who report being sexual abusive to be offered a follow-up meeting with mental health staff. Treatment services are offered without financial cost to the detainee. All information is handled confidentially and interviews with IHSC staff support a finding that the facility is in compliance with this standard.

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. IHSC staff provides medical and mental health services to detainees. Detainee victims of sexual abuse receive timely, unimpeded access to emergency medical/mental health treatment and crisis intervention services within the facility or are transported to a health care facility in the community, when health care needs exceed the level of care available within the facility. Victim advocacy is provided through an agreement with a community provider. There is no financial cost to the detainee for any sexual abuse related incident, related medical or mental health care or advocacy service, regardless of whether the victim names the abuser or cooperates with the investigation of the incident. (continued on last page)

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

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. Medical and mental health evaluations and treatment to all detainees who have been victimized by sexual abuse are offered immediately and may be ongoing. Services are consistent with a community level of care, without financial cost to the detainee. Detainee victims of sexual abuse, while detained, are offered tests for sexually transmitted infections and lawful and timely pregnancy-related medical services, in accordance with professionally accepted standards of care, where medically appropriate. A mental health evaluation is conducted at 60 days for all detainees involved in detainee on detainee abuse. A review of documents of the metal health evaluation was conducted by the auditor. (continued on last page)

§115.86 – Sexual abuse incident reviews.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. LIPC conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation. The Incident Review Team consists of a upper-level management official, the local PSA Manager, Medical and Mental Health Practitioners. The Corporate PREA Coordinator may attend via telephone or in person. Based on interviews with members of the incident review team, the review is conducted within 30 days of the conclusion of the investigation and consideration is given as to whether the incident was motivated by race, ethnicity, gender identity or status and/or gang affiliation. Incident Review Team report minutes were reviewed for compliance to the standard. (continued on last page)

§115.87 – Data collection.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

LIPC Policy and Procedure Manual 2.1.1 addresses the requirements of this standard. All sexual abuse and assault data collected pursuant to this policy shall be maintained for at least 10 years after the date of initial collection. The interview with the PSA Compliance Manager, Facility Administrator and other staff support compliance with this standard. DHS OIG maintains the official investigative file related to claims of sexual abuse.

§115.201 – Scope of audits.

- ☐ Exceeded Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does not meet Standard (requires corrective action)

Notes:

The auditors were able to access and observe all areas of the facility. The auditors were provided with all relevant documents and conducted private interviews with staff/detainees. Audit notices were posted in each housing unit giving the detainees an opportunity to confidentially correspond with the auditors. The auditors did not receive any correspondence from the detainees at the facility. All staff were helpful, cooperative and professional. All requested documentation was accurate and promptly provided.

ADDITIONAL NOTES

Directions: Please utilize the space below for additional notes, as needed. Ensure the provision referenced is clearly specified.

115.11 - Staff receive initial PREA training and annual training, as well as updates, throughout the year when needed. Security staff are issued a pocket-sized PREA Standards/First Responder Guideline card to carry for reference. Interviews with staff, the volunteer, contractors and detainees confirmed that each was aware of the zero-tolerance policy towards all forms of sexual abuse. A review of documentation, observation of zero tolerance posters during the tour and interviews with staff and detainees confirms the facility is compliant with this standard.

115.15 - Staff of the opposite gender are required to announce their presence when entering housing areas. Announcements were observed by the auditors. All security staff received training on the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees. Staff interviews confirmed their knowledge of cross-gender viewing and search policies and procedures, and that pat-down searches are not performed for the sole purpose of determining the genital status of a transgender or intersex detainee. The review of training documents and interviews with security personnel confirmed that they were educated in the proper procedures for conducting pat-down searches, cross-gender pat-down searches and searches of transgender and intersex detainees. As confirmed by observation, all pat-down searches were conducted in a professional and respectful manner and in the least intrusive manner possible.

115.16 - This may be achieved via bilingual (English/Spanish) staff, interpretation services or other means (reading to the detainee, etc.) for LEP detainees or in the form of auxiliary aids for detainees with other disabilities (deaf, blind etc.), including hearing aids, audio equipment, and additional staff assistance. The facility has a contract with Language Solutions Line for all language services. The auditor tested the facility language service to determine it's function.

115.21 - Local victim advocacy services were confirmed through an interview with staff from WellSpring, the local victim advocate agency. Interviews with staff, the criminal investigator (confirmed the forensic examination procedures) and victim advocate, observations and an examination of support documentation confirm compliance with this standard. The policy does outline how evidence is preserved. It is the responsibility of all 1st responders to preserve the evidence. Investigator(s) are then required to preserve and protect that evidence to further the investigation process.

115.22 - The facility PSA Compliance Manager/Investigator assists OPR or the Jena Police in gathering evidence and maintaining files. He functions in a liaison role. This process of notification was confirmed by the facility PSA Compliance Manager/Investigator. Four investigations into allegations were conducted during the audit review. Investigation of two allegations were ongoing. Of the two completed investigations, one allegation was unsubstantiated and one was unfounded. Both completed investigations were found to be completed promptly and throughly and to be well documented. PREA protocols are posted on the GEO GROUP website at https://www.geogroup.com/PREA.

115.31 - Staff receive this training when hired and during annual refresher training. The facility provides a daily briefing which covers PREA issues, in writing and verbally, to security staff. A PREA compliance pocket-sized guide is also provided to all staff. Quarterly refresher and other reminders of the importance of PREA compliance are also provided to security staff. Security supervisors have also been trained to be investigators. This additional training and the excellent knowledge level of security staff supports the facility exceeding compliance concerning this standard.

115.33 - Detainees indicated, at the time of arrival, they received information about the PREA, their right to be free from sexual abuse, harassment, retaliation for reporting sexual abuse and multiple ways how to report such abuse. This information was also noted in the posters throughout the facility. The tour of the facility confirmed that PREA education posters were prominently displayed in all housing units and common areas. Interviews with staff and detainees; as well as an examination of support documentation, confirm compliance with this standard.

115.41 - Information received during the screening is only available to staff with a need-to-know and no others. Detainees are reassessed based upon a random sample of documentation was reviewed for re-assessment of detainees. Reassessment is done by mental health staff.

115.42 - During the audit, four detainees self-identified as being members of the LGBTI community. They were interviewed and stated they felt safe at the facility. Interviews with IHSC staff confirmed compliance with this standard.

115.43 - The detainee will be assessed within 72 hours and re-assessed every seven days, thereafter, while in Protective Custody. There were no detainees considered at risk of sexual victimization held in Protective Custody status in the past 12 months. Interviews with security staff, detainees and an examination of support documentation confirm compliance with this standard.

115.52 - There were no grievances filed by detainees during the review process. Facility procedures allow a detainee to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Detainees are also able to request assistance from staff, other detainees and outside sources to complete their grievance. There were no grievances alleging sexual abuse filed in the past 12 months. Interviews with the Grievance Coordinator, security staff, detainees and a review of documentation confirm compliance with this standard.

115.62 - In the past 12 months, there were no instances in which the facility staff determined that an detainee was subject to substantial risk of imminent sexual abuse. Interviews with security and medical staff and an examination of documentation confirm compliance with this standard.

115.63 - During the last twelve months, there were no allegations received from a detainee of an incident that occurred at another facility or from another facility concerning an incident at the LIPC.

115.64 - Interviews with staff and an examination of documentation confirm compliance with this standard.

115.65 - Staff and community service provider interviews confirmed that they were knowledgeable regarding their responsibilities in the coordinated response. All investigations from the coordinated response were reviewed for compliance.

ADDITIONAL NOTES

115.71 - All case Information is shared between the outside investigator and the facility to ensure informed progress of the investigation. Investigations are completed regardless of whether a detainee is transfered or released. Four investigations into allegations were conducted during the audit review. Investigation of two allegations were ongoing. Of the two completed investigations, one allegation was unsubstantiated and one was unfounded. Both completed investigations were found to be completed promptly and throughly and to be well documented.

115.78 - There were four detainee allegations of sexual abuse. The two investigative reports that the auditor examined were in compliance with investigative protocols The facility may discipline an detainee for sexual contact with a staff only upon finding that the staff member did not consent to such contact. Interviews with the Facility Investigator and a review of documentation support a finding that the facility is in compliance with this standard.

115.82 - Detainee victims of sexual abuse, while detained, would be offered information about sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Follow-up mental health services and follow-up testing and treatment for sexually transmitted diseases are provided at the facility. Compliance with this standard was determined by a review of policy and an interview with the HSA.

115.83 - A review of documentation and interviews with IHSC staff support the finding that this facility is in compliance with this standard. All treatment services are provided to detainees without financial cost.

115.86 - The team also makes a determination as to whether additional monitoring technology should be added to enhance staff supervision. Results of the interviews with the PSA Compliance Manager and Facility Administrator confirm compliance with this standard. An annual review is conducted of all incidents reports.

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.

James L. Roland Jr.

Auditor's Signature

November 30, 2017

Date