PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Marie J. Carter Calvin	**Organization:**	The Nakamoto Group, Inc.
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AGENCY INFORMATION	
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)

FIELD OFFICE INFORMATION	
Name of Field Office:	Seattle Field Office
Field Office Director:	Bryan S. Wilcox
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	12500 Tukwila International Blvd., Seattle, WA 98168
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INFORMATION ABOUT THE FACILITY BEING AUDITED					
Basic Information About the Facility					
Name of facility:	Northwestern Detention Center				
Physical address:	1623 East J Street, Tacoma, WA 98421				
Mailing address: *(if different from above)*					
Telephone number:	(253) 396-1611				
Facility type:	☐ SPC	☑ CDF	☐ DIGSA	☐ IGSA	☐ FRC
	☐ Other, **Describe:**				

Facility Leadership			
Name of Official/Officer in Charge:	Lowell Clark	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(253) 396-1611
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	Ronald Wheeler	**Title:**	Lieutenant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(253) 396-1611

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 PREA (Prison Rape Elimination Act) audit of the Northwestern Detention Center, Tacoma, Washington was conducted March 28-30, 2017. The audit was completed by Marie J. Carter (Lead) and (b) (6), (b) (7)(C), Nakamoto Group Inc. certified auditors. This was the first PREA audit for this facility. Prior to the on-site audit, the facility submitted the Pre-Audit Questionnaire and provided a comprehensive set of supporting documents for the responses to the questionnaire to the auditors. The documentation consisted of ICE, Northwestern Detention Center (NDC) and ICE Health Service Corps (IHSC) policies and procedures, as well as other supporting documents.

An entrance meeting was held the first day of the audit to discuss the audit process and finalize the facility tour and interview schedules. The following persons were in attendance: External Review and Analysis Unit (ERAU) Chief (b) (6), (b) (7)(C), ERAU Team (b) (6), (b) (7)(C), Assistant Field Office Director (AFOD) (b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (b) (6), (b) (7)(C),, Detention Service Manager (b) (6), (b) (7)(C), GEO PREA Director (b) (6), (b) (7)(C), Warden Lowell Clark, Assistant Warden (b) (6), (b) (7)(C), PREA Compliance Manager Ronald Wheeler, and other ICE and facility support staff.

There were 1380 detainees housed in the facility during the audit which included 1247 males and 133 females. A comprehensive tour of the facility was completed. The tour included the intake processing area, all housing units, the medical services department, recreation, food service, the l brary, visiting room, and other facility support areas. During the tour, it was noted that there was sufficient staffing to ensure a safe environment for detainees and staff. It was observed during the tour that detainees are able to shower, dress and use the toilet facilities without exposing themselves to employees of the opposite gender. Informal and formal conversations with employees and detainees regarding the PREA standards were conducted. It should be noted that that PREA posters were displayed in all the housing units. Audit notifications were also located in the same areas. There were no letters received by the auditor, as a result of the audit notifications.

The Northwest Detention Center (NWDC) provides detention services for the housing and safekeeping of detainees who are in administrative custody of the Immigration and Customs Enforcement (ICE), Department of Homeland Security. The NWDC is privately owned by the GEO Group, Inc. and operates under contract with the Department of Homeland Security, Immigration and Customs Enforcement, Office of Enforcement and Removal Operations (ERO) who process the detainees who are pending immigration review or deportation. Medical services are provided by the Immigration Health Service Corporation (IHSC). The facility is located at 1623 East J Street, Tacoma, Washington. The NWDC was opened in April 2004, with 500 beds. In November 2005, the GEO Group, Inc. acquired the NWDC and the designated capacity was increased to 800 beds in July 2006. In January 2008, the designated capacity was increased to 1000 beds.

The facility houses detainees in 21 housing pods that include open bay/dormitory style beds and multiple occupancy cells. The secure portion of the facility has a laundry, food service area, medical area, intake/booking area, detainee visiting room, barber shop and a program multi-purpose room. A 438 foot long hallway separates the remaining two thirds of the facility from the front one third and allows access to detainee housing Units B, C and D. There are two smaller hallways off the main hallway on both sides of Unit C that lead to a final hallway on the rear of Unit C and allow access to general housing Units A, F and G and also Unit H, the Special Housing Unit.

A total of forty-six staff interviews were conducted during the audit. The interviews included detention officers and supervisors on all shifts. All were aware of the agency's zero tolerance policy and knew their responsibilities to protect detainees from sexual abuse/harassment and their duties as first responders as part of a coordinated response. Specialized staff were also interviewed and included the Warden, the PREA Compliance Manager, the ICE Health Service Corps (IHSC) Health Services Administrator, Human Resource Manager, and the Supervisory Detention and Deportation Officer (SDDO). All interviewed staff and contractors demonstrated an understanding of the PREA and their respons bilities under this program, relative to their position in the organization and employment status. The auditor confirmed that NWDC has agreements with Tacoma General and Saint Joseph Hospitals to conduct forensic examinations, when requested by the facility. In addition, the auditor also confirmed that the facility has a Memorandum Of Understanding (MOU) with the Sexual Assault Center of Pierce County - Rebuilding Hospital to provide victim advocate services. Criminal investigations involving allegations of sexual assault will be referred to the Tacoma Police Department.

Eighty-four (sixty-nine males and fifteen females) were interviewed and were randomly selected from the housing units. The interviewed detainees were of various ages, nationalities and ethnic backgrounds. One detainee self-identified as being gay, two detainees self-identified as being bisexual, and one self-identified as being a lesbian. No detainees self-identified as being intersex or transgender. Twenty-two limited English proficient (LEP) inmates were included in the group of detainees interviewed, utilizing Certified Languages International Translation Service. A majority of the detainees interviewed demonstrated a good understanding of the PREA program, the prevention, protection and reporting mechanisms and stated they felt safe at the facility. No detainees refused to be interviewed.

There were six allegations of sexual abuse, assault or harassment during the audit period; of the six, two were determined to be unfounded and four were determined to be unsubstantiated. The investigative files were reviewed and revealed that the investigations were completed in accordance with the standards.

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 the Acting FOD, the AFOD, ERAU Section Chief, ERAU Team Lead, Warden, and other staff to discuss audit findings. The facility staff were courteous, cooperative and professional. The interaction observed between staff/detainee was considered appropriate.

During the tour it was observed that the announcements were only made in English, which by the employees' own admission, was not the primary language of the majority of the detainees housed at the facility. The auditor recommended the announcements be made in the languages used by the majority of the detainees. At NWDC, it would be Spanish and French Creole.

The facility is not providing the detainees that are LEP (other than Spanish) the information about PREA in a language they can understand. The facility recently received a large influx of Haitian Creole detainees and did not have handbooks in the language they understood upon arrival. The detainees were arbitrarily given handbooks in English and Spanish. The facility did receive the National Detainee Handbook in Haitian Creole and distributed them to the detainees during the audit. However, the detainees from other countries that do not understand English, Spanish and/or Haitian Creole are not receiving information about sexual abuse in a language they understand. (115.33)

Corrective Action Required – The facility has to develop procedures to ensure current and all future LEP detainees that are not Spanish or Haitian Creole are given the information on the rules against sexual abuse and the reporting opportunities available to them in a language they understand. The facility housing unit design has glass windows in the pod areas and the announcement that staff of the opposite gender are entering the housing pod is conducted in that area which does not give the detainees the opportunity to prepare themselves. This was corrected during the audit. The facility placed signs at the entrance to the unit that instructs staff to notify the pod officer by radio that a staff member of the opposite gender will be entering the housing pods. This new procedure was observed and works well.

The review of screening documents, staff and detainee interviews confirmed that NWDC does not reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment (115.41)

Corrective Action Required - The facility must develop policy and procedures to reassess and document each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. NWDC will need to provide documentation that the current resident population has been reassessed.

The facility has posters about zero tolerance and reporting opportunities posted in all housing pods, but the signs are in window areas that are about 15 feet high and the facility PREA Compliance Manager (PCM) name and contact number can not be read. Smaller signs are available on pod bulletin boards; however, those signs do not have the the contact number for the appropriate staff. It is important that the information is distributed consistently throughout the facility and posted in areas of the facility that is easily read by the detainees.

The signs for the Sexual Assault Advocate from Rebuilding Hope are available in the housing pods in both English and Spanish. The facility must develop a procedure that provides this information to the LEP detainees in the language they understand.

The facility has implemented a procedure for the detainees to report anonymously by telephone. The process is presently only in English and Spanish, which covers the majority of the detainees that are housed at the facility. The facility is working on procedures to provide all detainees this information in a language they understand.

The facility has a Kiosk in each housing pod that allows detainees to access information about the facility, to include sexual assault prevention and reporting information.

The standards used for this audit became effective in March 2014. Thirty-six standards were found to "Meet" the standards, two standards were determined to be "Not-Applicable" and two standards were rated as "Does Not Meet" and require corrective action. The auditor had been provided with extensive and lengthy documents and files prior to and during the audit to support the findings of the audit. At the conclusion of the audit, the auditor thanked the Acting FOD, Warden, and the facility staff for their hard work and dedication to the PREA audit process.

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	0
Number of standards met:	36
Number of standards not met:	2

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:

IHSC Directive 01-20 and GEO policy 3.1.1 address the requirements of this standard. The policies mandate zero tolerance towards all forms of sexual abuse. The facility's zero tolerance against sexual abuse is clearly established and the policy also outlines the facility's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. In addition to the facility PREA Compliance Manager, there is a designated GEO PREA Director to ensure adherence to 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:

GEO policy 3.1.1 and post orders outline the requirements of this standard. Policy requires each facility to review the staffing plans on an annual basis. A review of the staffing plan, organizational chart, post orders, as well as interviews with the Warden, Assistant Warden, and the Human Resource Manager confirmed that the facility has a staffing plan which provides adequate staff to ensure a safe and secure environment for staff and detainees. The staff/detainee ratio is (b)(7)(E), which is supplemented by video cameras, and various ICE and IHSC on-site staff. The facility is in compliance with the 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:

Non-Applicable. NWDC does not house juvenile or family detainees.

§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:

GEO policies 3.1.1, 3.1.10, and 5.1.2 outline the requirements of the standard. NWDC 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 was no cross-gender visual body cavity or strip searches conducted during the audit period. When conducted, the search is required to be documented. During the tour, it was observed that the announcements were only made in English, which by the employees' own admission, was not the primary language of the majority of the detainees housed at the facility. (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

GEO policy 3.1.1 outlines the requirement of the standard. NWDC takes appropriate steps to ensure detainees with disabilities and detainees with Limited English Proficiency have an opportunity to participate in and benefit from the institution's efforts to prevent, detect and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings and detainee handbooks are in both English and Spanish. The facility has a contract with a translation service to provide interpretation services for detainees who have a need that exceeds English or Spanish. Staff interviewed confirmed they were well aware of the policy that, under no circumstances, are detainee interpreters or assistants to be used when dealing with PREA issues. (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:

GEO policy 3.1.1 outlines the requirements of this standard. The Warden and the Human Resource Manager were interviewed and stated that all components of this standard have been met. All employees and volunteers receive background investigations by ICE. A tracking system, which was reviewed by the auditor, is in place to ensure that updated background checks are conducted every five years. Policy clearly states the submission of false information by any employee is grounds for termination. (continued on last page)

§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:

Non-Applicable. NWDC has an extensive video and monitoring system in place. Since May 2014, there has not been any significant upgrades, to include monitoring technologies, at the facility.

§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:

IHSC Directive 01-20, GEO policies 3.1.1 and 5.1.2-F address the requirements of this standard. Facility staff and health care providers were interviewed concerning this standard and all were knowledgeable of their responsibilities as first responders and the procedures required to preserve usable physical evidence, when sexual abuse is alleged. Staff were also aware that the Tacoma Police Department conducts investigations relative to sexual abuse allegations. All forensic medical examinations would be conducted by a SAFE/SANE through an agreement with Tacoma General and Saint Joseph Hospitals. An interview with the service provider verified the agreement for the SAFE/SANE protocols to be performed at their hospital. There were no forensic medical exams conducted during the audit period.

§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 policy 3.1.1 outlines the requirements of this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/harassment. The local investigator and the Tacoma Police Department may conduct investigations. The facility investigators were interviewed and found to be very knowledgeable concerning their respons bilities in the investigative process. All allegations are reported immediately to the on-site ICE staff. The on-site ICE staff have the responsibility of notifying the Joint Intake Center, Office Professional Responsibility (OPR), and the Office of Inspector General when necessary. (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:

GEO policy 3.1.1 outlines the requirements of the standard. A review of the annual training plan and curriculum showed all the mandatory training outlined in the standard. Staff receive initial PREA training when they are hired and annually thereafter. In addition, staff receive additional training during monthly meetings and roll calls. Contractors and volunteers are provided training relative to their duties and responsibilities.

§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:

ICE Health Service Corps (IHSC), the facility's health care provider, employs contractors for medical and mental health services. . IHSC Directive 301 outlines the training for medical and mental health staff. A review of the training records, interviews and the ICE provided PREA PowerPoint presentation revealed that all have 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. Religious services volunteers receive initial PREA training and annually thereafter. A review of the training documents confirmed their receipt of the training.

§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:

GEO policies 3.1.1 and 5.1.2-D address the requirements of the standard. During intake, each detainee receives a pamphlet descr bing ICE's Sexually Abuse and Awareness policy, the National Detainee Handbook and the facility handbook. The pamphlet and handbooks identify the key elements of the program and informs detainees of the zero-tolerance policy regarding sexual abuse/assault and multiple ways to report any such incidents. The information is only available in English, Spanish and Haitian Creole. However, the facility is not providing the detainees that are LEP (other than Spanish) the information about the PREA in a language they can understand. (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:

GEO policies 3.1.1 and 5.1.2-D outline the requirements of this standard. The facility investigators have received PREA specialized training. This auditor reviewed specialized training documentation and interviewed the investigators which confirmed compliance with this standard.

§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:

IHSC Directive 03-01 outlines the requirements of this standard. All mental health and medical services are provided by IHSC and its contractors. The review of the IHSC Sexual Assault and Prevention - PREA Power Point presentation, training documents and interviews with IHSC personnel confirmed that all had received specialized training on victim identification, interviewing, reporting and clinical interventions. This training is provided when initially hired and annually thereafter. All cases requiring the processing of a sexual assault evidence collection kit are transported to a local hospital for a forensic exam. This was confirmed through an interview with the vendors (Tacoma General and Saint Joseph Hospitals) who confirmed that there is SAFE/SANE staff available at all times.

§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:

IHSC directive 03-25, IHSC LOP 203, and GEO policy 3.1.1 outline the requirements of this standard. The facility does not reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment as outlined in standard. All detainees are assessed by facility and IHSC personnel, during in-processing procedures, for their risk of being sexually abused or being sexually abusive towards other detainees. In-processing screening occurs within 12 hours of the detainee's arrival. A case management staff member reviews all relevant information from other facilities within 72 hours. (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:

IHSC directive 03-25 and NWDC policy 3.1.1 address the requirements of this standard. The facility uses in-processing screening information (reviewed by auditor) to determine proper housing, bed assignment and other program assignments, with the goal of keeping detainees at high risk of being sexually abused/sexually harassed 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. Interviews with the case management supervisor also supports the finding that the facility is in compliance with this standard. Detainees are cleared for work assignments throughout the facility. (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:

GEO policies 3.1.1 and 3.4.1 outline the requirements of this standard. Policy states detainees at high risk for sexual victimization shall not be placed in special housing, unless an assessment of all available alternatives has been made and there is no available means of separating the detainee from the abuser. The detainee will be assessed with 72 hours and reassessed every 7 days thereafter while in restricted housing. There were no detainees at risk of sexual victimization held in involuntary segregated housing in the past 12 months for one to 24 hours awaiting completion of assessment. Additionally, there were no detainees who were assigned to involuntary segregated housing for longer than 30 days awaiting alternative placement. Interviews with staff and an examination of documentation confirm compliance with this standard.

§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:

GEO policies 3.1.1 and 5.1.4-D outline the requirements of this standard. A review of documentation and staff/detainee interviews indicated that there are multiple ways (verbally, in writing, anonymously, privately and from a third party) for detainees to report sexual abuse. The facility has procedures in place for staff to document all allegations. There are posters and other documents on display throughout the facility (observed by auditor) which also explain reporting methods. Facility staff accept reports made verbally, in writing, anonymously and from third parties and promptly document any form of reporting. Family and friends of detainees may report sexual abuse by using the GEO and DHS website or contacting any facility staff. (continued on last page)

§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:

GEO policies 3.1.1 and 3.5.3 address the requirements of this standard. Detainees may file a grievance; however, all allegations of sexual abuse or sexual assault, when received by staff, would immediately result in an administrative or criminal investigation. Detainees are not required to use the informal or formal grievance 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 outside sources to complete their grievance. There were six grievances alleging sexual assault in the last year and each was forwarded to the investigators and an investigation was completed.

§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:

GEO policy 3.1.1 and 5.1.4-D outline the requirements of this standard. The auditor confirmed that Tacoma General and Saint Joseph Hospitals have an agreement to conduct forensic examinations, when requested by the facility. In addition, the auditor also confirmed that the facility has a MOU with the Sexual Assault Center of Pierce County - Rebuilding Hope for detainee reporting and victim advocate services. Interviews with staff and detainees support the compliance with this standard. The signs for Rebuilding Hope are available in the housing units in both English and Spanish. The facility is developing a procedure that will also provide this information to the LEP detainees in a language other than Spanish.

§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:

NWDC has established procedures for third-party reporting which includes the ICE ERO Reporting and Information Line and the Office of Inspector General telephone number. Mailing addresses are posted in the units and made available in the detainee handbook. The company website: http://www.geogroup.com/prea assist third party reporters on how to report allegations of sexual abuse. Staff and detainees interviewed were aware of the procedures for third-party reporting. The facility also has signs in the facility lobby and visiting room which allows for 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:

GEO policies 3.1.1 and 5.1.4-D outline the requirements of this standard. Staff confirmed during interviews that they are aware of their responsibility for immediately reporting any knowledge, suspicion, or information about any incident of sexual abuse or retaliation against detainees or staff who report or participate in an investigation about such actions. Policy requires the information concerning the identity of the alleged detainee victim and the specific facts of the case be limited to staff who need-to-know, because of their involvement with the victim's welfare and the investigation of the incident. Interviews with employees and contractors confirmed they were aware of their reporting duties. There were no volunteers on duty during the on-site audit

§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:

GEO policy 3.1.1 outlines the requirements of this standard. Interviewed staff were well aware of their duties and responsibilities, as it relates to them having knowledge of an detainee being at imminent risk for being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the detainee. Detention officers are issued a pocket PREA guide outlining all actions to be taken. They also stated they would separate the potential victim/predator, secure the scene to protect poss ble evidence, not allow detainees to destroy poss ble evidence and contact their supervisor, medical and psychology staff.

§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:

GEO policy 3.1.1 outlines the requirements of this standard. Policy requires the reporting of any PREA related allegation by a detainee that occurred at another facility to the CEO of the facility where the incident is alleged to have occurred, by the Warden (or equivalent person) of the facility in which the detainee is currently housed. The notification is to occur as soon as possible, but always within 72 hours of receiving the allegation. Policy also requires that an investigation be initiated. During the last year, there was no case of a PREA allegation reported that took place at another facility. Interviews with staff and an examination of documentation confirm compliance with this standard.

§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:

GEO policies 3.1.1 and 5.1.4-D outline the requirements of this standard. All staff interviewed were knowledgeable concerning their first responder responsibilities, when learning of an allegation of sexual abuse/harassment. They 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 the operations lieutenant, medical and psychology staff. The supervisor would continue to protect the detainee by immediately notifying investigative and administrative 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 an detainee had been a victim of sexual abuse.

§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:

GEO policies 3.1.1 and 5.1.4 -D outline the requirements of this standard. The facility has established a PREA checklist to aid in their response to allegations of sexual abuse/harassment. The policies provide direction to security, medical and mental health practitioners, investigators, community providers (SAFE/SANE and victim advocates) and facility leadership. Staff and community provider interviews confirmed that they were knowledgeable regarding their responsibilities in the coordinated response. Interviews and an examination of documentation also confirm compliance to this standard.

§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:

GEO policies 3.1.1 and 5.1.4 - D outline 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 facility investigators and a review of investigative files 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:

ICE Directive 11062.2 and GEO policy 3.1.1 outline the requirements of this standard. Policy prohibits any type of retaliation against any staff or detainee who has reported sexual abuse, sexual harassment or cooperated in any related investigation. The facility PREA Compliance Manager is the designated retaliation monitor. He stated he follows up on all potential cases to ensure policy is being enforced and conducts periodic status checks on the frequency of incident reports, housing reassignments and negative performance reviews/staff job reassignments. There have been no suspected or actual incidents of retaliation in the previous 12 months.

§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:

GEO policies 3.1.1 and 5.1.4-D outline the requirements of the standard. The policies require the facility to notify the ICE Field Office of any detainee that has been held in restricted housing for 72 hours. This notification is given to the on-site AFOD at NWDC. A detainee that has been placed in protective custody shall not be returned to general population until completion of a proper reassessment. Staff indicated that the detainee would be placed in the most supportive environment to ensure his/her well-being. There have been no detainees placed in post-allegation protective custody during the last 12 months.

§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:

ICE Directive 11062.2, Sexual Abuse and Assault Prevention and Intervention and GEO policies 3.1.1 and 5.1.4-D address the requirements of this standard. The facility investigators conduct administrative investigations within the facility and refer criminal investigations to the Tacoma Police Department. There were no criminal prosecutions during this auditing period. According to the investigators, the facility fully cooperates with any outside agency who initiates an investigation. The facility investigators serve as liaisons that provide the requested information to the outside agency and provide access to the detainees.

§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:

GEO policy 3.1.1 and 5.1.2-F outline the requirements of this standard. The evidence standard is a preponderance (51%) of the evidence in determining whether allegations of sexual abuse/assault are substantiated.

§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 policies 3.1.1 and 5.1.2-F outline the requirements of this standard. The policy indicates that a detainee shall be notified of the result of the investigation and any responsive action taken as a result of an allegation of sexual abuse. All such notifications are documented. Through interviews with staff and a review of the investigative files, detainees were notified in accordance with the standards.

§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 policies 3.1.1 and 5.1.2-F outline the requirements of this standard. Staff are subject to disciplinary sanctions for violating agency sexual abuse policies. All terminations for violations of agency sexual abuse policies, or resignations by staff who would have been terminated, if not for their resignation, are reported to law enforcement agencies and to any relevant professional/certifying/licensing agencies by the facility, 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, documentation and staff interviews.

§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 policies 3.1.1 and 5.1.2-F outline the requirements of the standard. Any contractor or volunteer who engages in sexual abuse would be prohibited from contact with detainees and would 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, documentation and staff interviews.

§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 3.1.1 and 3.3.1 outline 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 the disciplinary procedures and sanctions shall be commensurate with the nature and circumstances of the abuse committed. The detainee's disciplinary history, mental disabilities, and mental illness should be considered in all decisions. Interviews with the facility investigators, PREA Compliance Manager and the Warden support a finding that the facility is in compliance with this standard.

§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:

IHSC 03-01 outlines the requirements of this standard. Interviews with 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. When detainees are referred for medical follow-up, procedures indicate that the health evaluation would take place within two working days. The procedures also allow for 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. There were no detainees determined during their intake to have experienced prior sexual victimization or perpetrated sexual abuse in the last 12 months.

§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:

IHSC 03-01 outlines the requirements of this standard. ICE Immigration Health Service Corps provides medical and mental health services at NWDC. 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 offered through an agreement with a community provider. There is no financial cost to the detainee for any sexual abuse/assault related incident, related medical or mental health care or advocacy service, regardless of whether the victim names the abuser or cooperates with the incident investigation.

§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:

IHSC 03-01 outlines the requirements of this standard. Medical and mental health evaluations and, as appropriate, treatment to all detainees who have been victimized by sexual abuse is offered immediately. 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 review of documentation and interviews with medical/mental health staff support the finding that this facility is in compliance with this standard.

§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:

GEO policies 3.1.1 and 5.1.2-D outline the requirements of this standard. The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was proven to be unfounded. 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, and status and/or gang affiliation. The team also makes a determination as to whether additional monitoring technology should be added to enhance staff supervision.

§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:

GEO policy 3.1.1 addresses the requirements of this standard. All PREA related allegation documentation will be maintained for five years, after the detainee is released from custody. Interviews with the staff support compliance with this standard.

§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 auditor was able to access and observe all areas of the facility. The auditor was provided with all relevant documents and conducted private interviews with detainees. Audit notices were posted in each housing unit, common area and telephone rooms, giving the detainees an opportunity to confidentially correspond with the auditor. The auditor did not receive any correspondence from the detainees at NWDC.

ADDITIONAL NOTES

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

115.11 - Zero tolerance posters are displayed throughout every area of the facility. The audit included an examination of video monitoring systems, unannounced rounds reports, detainees' access to telephones, rosters, and staff/detainee interviews. Staff receive initial training and annual training on the facility's zero-tolerance policy. Interviews with staff and detainees confirmed that each was aware of the zero-tolerance policy towards all forms of sexual abuse. The facility PREA Compliance Manager reports to the Warden and indicated, during his interview, that he has enough time to perform his duties overseeing the PREA process.

115.15 - The auditor recommended the announcements be made in the languages used by the majority of the detainees. At NWDC, it would be Spanish and French Creole. Detainees are allowed to shower, change their clothing and use the toilet without staff of the opposite gender viewing. Training sign-in sheets and staff interviews confirmed that staff received cross-gender pat search training (including how to search transgender and intersex detainees). Training is conducted during initial training and annually thereafter. In addition, training is also received monthly through meetings and roll calls. Interviewed staff also acknowledged they were well aware of the policy prohibiting the search of a transgender or intersex detainee for the sole purpose of determining the detainee's genital status. Interviews with detainees confirmed that none of them had been visual body cavity or strip searched by staff of the opposite gender.

115.16 - Staff interviewed confirmed they were well aware of the policy that, under no circumstances, are detainee interpreters or assistants to be used concerning PREA issues. Within their first hour of arrival to the facility, detainees are interviewed by medical personnel as to their physical, intellectual or psychological needs. If such a need exists, a Special Needs Form is prepared or, in the case of juveniles, a Health and Safety Plan is prepared and transmitted to a supervisor before a housing assignment is made. If required, a teletype telephone device would be made available for detainees who are hearing impaired. Blind or seriously visually impaired detainees would not be housed in this facility.

115.17 - The facility makes its "best effort" to contact all prior employers for information on substantiated allegations of sexual abuse or resignations which occurred during a pending investigation of sexual abuse. The auditor reviewed a random sampling of hiring and promotion packets during the audit and found them to be in compliance with the standard.

115.22 - The Tacoma Police Department conducts the criminal investigations for the facility.

115.33 - The facility recently received a large influx of Haitian Creole detainees and did not have handbooks in the language they understood upon arrival. The detainees were arbitrarily given handbooks in English and Spanish. The facility did receive the National Detainee Handbook in Haitian Creole and distributed them to the detainees during the audit. However, the detainees from other countries that do not understand English, Spanish, and/or Haitian Creole are not receiving information about sexual abuse in a language they understand.

Corrective Action Required – The facility has to develop procedures to ensure current and all future LEP detainees that are not Spanish or Haitian Creole are given the information on the rules against sexual abuse and the reporting opportunities available to them in a language they understand. The facility housing unit design has glass windows in the pod areas and the announcement that the opposite gender staff are entering the pod is conducted in that area which does not give the detainees the opportunity to prepare themselves. This was corrected during the audit. The facility placed signs at the entrance to the unit that instructs staff to notify the pod officer by radio that a staff member of the opposite gender will be entering the housing pods. This new procedure was observed and works well.

115.41 - 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. Information received during the screening is only available to staff with a need to know and never to other detainees.

Corrective Action Required - The facility must develop policy and procedures to reassess and document each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment and, at any other time, when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization.

115.51 - The facility has implemented a procedure for the detainees to report anonymously by telephone. The process is presently only in English and Spanish, which covers the majority of the detainees that are housed at the facility. The facility is working on procedures to provide all detainees this information in a language they understand. The facility has a Kiosk in each housing pod that allows detainees to access information about the facility, to include sexual assault prevention and reporting information.

ADDITIONAL 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.

Marie J. Carter Calvin

Auditor's Signature

April 8, 2017

Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	William Willingham	**Organization:**	The Nakamoto Group, Inc.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-672-(b) (6), (b) (7)(C)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Seattle
Field Office Director:	Bryan S. Wilcox
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	12500 Tukwila International Blvd., Seattle, WA 98168
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Northwest Detention Center		
Physical address:	1623 East J Street, Tacoma, WA 98421		
Mailing address: *(if different from above)*			
Telephone number:	(253) 396-1611		
Facility type:	CDF		
Facility Leadership			
Name of Officer in Charge:	Lowell Clark	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(253) 396-1611
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	Ronald Wheeler	**Title:**	
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(253) 396-1611

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 on-site Prison Rape Elimination Act (PREA) audit of the Northwest Detention Center (NWDC), Tacoma, Washington was conducted March 28-30, 2017. The audit was completed by Marie J. Carter Calvin (Lead) and (b) (6), (b) (7)(C), certified auditors with Nakamoto Group Inc. This Corrective Action Plan was completed by William Willingham, a certified PREA auditor, due to Ms. Carter Calvin's retirement. This was the first PREA audit for this facility. Prior to the onsite audit, the facility completed and submitted the Pre-Audit Questionnaire and provided a comprehensive set of supporting documents for the responses to the questionnaire to the auditors. The documentation consisted of Immigration and Customs Enforcement (ICE), NWDC and ICE Health Service Corps (IHSC) policies and procedures, as well as other supporting documents.

During the course of the audit, it was determined that the facility's current policy and procedures did not comply with the requirements of standard 115.33, specifically not providing the detainees that are limited English proficient (LEP) the information about the PREA in a language they can understand. Over the next 180 days, the facility developed a corrective action plan (CAP). The CAP includes the intake staff issuing the ICE National Detainee Handbook and Sexual Abuse and Assault Prevention and Intervention (SAAPI) pamphlet to each detainee upon arrival in the spoken language of the detainee. Intake staff will read the Orientation Script to the detainees individually or to the group. The language phone-line will be utilized and documented in the detainee file for all detainees where staff interpreters are not available.

Additionally, it was also determined that the facility's current policy and procedures did not comply with the requirements of standard 115.41, specifically reassessment of detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment. Over the next 180 days, the facility developed a CAP. The CAP includes the SAAPI Lieutenant training the Shift Supervisors to conduct the PREA Vulnerability Reassessment Questionnaire. The classification staff will add the PREA Vulnerability Reassessment Questionnaire tool to the current 60/90day classification reassessment process. Beginning 9/01/17 the Classification Staff will run the 60/90day classification report and conduct the file review portion, and then SAAPI / Shift Supervisors will complete the SAAPI Reassessment Tool.

Number of standards exceeded: 0
Number of standards met: 38
Number of standards not met: 0

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. 33 - Detainee education

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

Notes:

GEO policies 3.1.1 and 5.1.2-D address the requirements of the standard. During intake, each detainee receives a pamphlet describing ICE's Sexual Abuse and Awareness policy, the ICE National Detainee Handbook and the facility handbook. The pamphlet and handbooks identify the key elements of the program and inform detainees of the zero-tolerance policy regarding sexual abuse/assault and multiple ways to report any such incidents. The information is only available in English, Spanish and Haitian Creole. However, the facility is not providing the detainees that are LEP (other than Spanish) the information about the PREA in a language they can understand. The facility recently received a large influx of Haitian Creole detainees and did not have handbooks in the language they understood upon arrival. The detainees were arbitrarily given handbooks in English and Spanish. The facility did receive the ICE National Detainee Handbook in Haitian Creole and distributed them to the detainees during the audit. However, the detainees from other countries that do not understand English, Spanish, and/or Haitian Creole are not receiving information about sexual abuse in a language they understand.

Corrective Action Required - The facility has to develop procedures to ensure current and all future LEP detainees that are not Spanish or Haitian Creole are given the information on the rules against sexual abuse and the reporting opportunities available to them in a language they understand.

Additional documentation was received by the auditor (Corrective Action Plan) to support compliance to this standard. The auditor reviewed the PREA Audit Corrective Action Plan, which detailed the facility's plan to ensure compliance with providing all detainees PREA education materials in the language they comprehend; the plan is addressed in the following paragraph.

Corrective Action - Beginning on August 28, 2017, intake staff will issue ICE National Detainee Handbook and SAAPI pamphlet to each detainee upon arrival in the spoken language of the detainee. Intake staff will read the Orientation Script to the detainees individually or to the group to ensure all elements of Standard 115.33 are covered. The language phone-line will be utilized and documented in the detainee file for all detainees where staff is not available.

Final Determination - The facility now meets all requirements of the standard.

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

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

Notes:

The IHSC directive 03-25, IHSC LOP 203, and GEO policy 3.1.1 outline the requirements of this standard. The facility does not reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment as outlined in standard. All detainees are assessed by facility and IHSC personnel, during in-processing procedures, for their risk of being sexually abused or being sexually abusive towards other detainees. In-processing screening occurs within 12 hours of the detainee's arrival. A case management staff member reviews all relevant information from other facilities within 72 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. Information received during the screening is only available to staff with a need to know and never to other detainees.

Corrective Action Required - The facility must develop policy and procedures to reassess and document each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment and, at any other time when warranted, based upon the receipt of additional, relevant information or following an incident of abuse or victimization.

Additional documentation was received by the auditor (assurance memo, change in GEO policy, a sample "call-out" and a sample classification reassessment form) to support compliance to this standard. The auditor reviewed the PREA Audit Corrective Action Plan, the NWDC Reassessment Assurance Memorandum, the 60-90 Day Assessments call-out log (used to track completed detainee reassessments), the PREA Vulnerability Reassessment Questionnaire and the GEO Corrections Policy and Procedure Manual 3.1.1 to support compliance to this standard.

Correction Action - The SAAPI Lieutenant trained the Shift Supervisors to conduct the PREA Vulnerability Reassessment Questionnaire. The Classification Staff will add the PREA Vulnerability Reassessment Questionnaire tool to the current 60/90-day classification reassessment process. Beginning 9/01/17 the Classification Staff will run the 60/90day classification report and conduct the file review portion, and then SAAPI Shift Supervisors will complete the SAAPI Reassessment Tool. Within 120 days following 9/01/17 the backlog of reassessments are expected to be complete.

Final Determination - The facility now meets all requirements of 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.

William Willingham November 6, 2017

Auditor's Signature & Date