PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Donald Chadwick	**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:	Buffalo
Field Office Director:	(b) (7)(C), (b) (6) (Acting)
ERO PREA Field Coordinator:	(b) (7)(C), (b) (6)
Field Office HQ physical address:	250 Delaware Avenue, Buffalo, NY 14202
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED					
Basic Information About the Facility					
Name of facility:	Buffalo Federal Detention Facility				
Physical address:	4250 Federal Drive, Batavia, NY 14020				
Mailing address: *(if different from above)*					
Telephone number:	(585) 344-6500				
Facility type:	☑ SPC	☐ CDF	☐ DIGSA	☐ IGSA	☐ FRC
	☐ Other, **Describe:**				
Facility Leadership					
Name of Official/Officer in Charge:	Jeffrey J. Searls	**Title:**	Assistant Officer in Charge		
Email address:	(b) (7)(C), (b) (6)	**Telephone number:**	(585) 344-(b) (7)(C), (b) (6)		
Facility PSA Compliance Manager					
Name of PSA Compliance Manager:	Martin Bermudez	**Title:**	Supervisory Detention and Deportation Officer		
Email address:	(b) (7)(C), (b) (6)	**Telephone number:**	(585) 344-(b) (7)(C), (b) (6)		

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 Buffalo Federal Detention Facility (BFDF), Batavia, New York, was conducted July 11-13, 2017, by Donald Chadwick, Nakamoto Group Inc. a certified auditor. This was the first PREA audit for this facility. Prior to the on-site audit, the facility provided responsive documents, the facility layout, and the completed Pre-Audit Questionnaire. The documentation consisted of U.S. Immigration and Customs Enforcement (ICE) Directives, ICE Health Service Corps (IHSC) and BFDF policies and procedures, as well as copies of posters, training documents, unit sign-in logs and memos.

An in-brief 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 & Analysis Unit (ERAU) Unit Chief (b) (7)(C), (b) (6), Acting Prevention of Sexual Assault (PSA) Compliance Manager/ Supervisory Detention and Deportation Officer (SDDO) (b) (7)(C), (b) (6), and SDDO (b) (7)(C), (b) (6) Additional ICE staff in attendance were Assistant Chief of Security (b) (7)(C), (b) (6) , Deportation Officers (b) (7)(C), (b) (6) ,and Detention Services Manager (b) (7)(C), (b) (6) (ICE/HQ). IHSC staff in attendance were, Health Services Administrator (HSA) (b) (7)(C), (b) (6), , Assistant HSA (b) (7)(C), (b) (6), and Project Manager (b) (7)(C), (b) (6) . Security staff representation included Project Manager (b) (7)(C), (b) (6), Akima Global Services (AGS), Assistant Project Manager (b) (7)(C), (b) (6), and Detention Captain (b) (7)(C), (b) (6).

There were 554 adult male detainees on the first day of the audit. A comprehensive tour of the facility was completed. The tour included the intake processing area, general population housing units, special housing unit, medical department, recreation, food service, library, visiting room, chapel and the control center. During the tour, the auditor observed staffing; reviewed logs; observed the physical layout; assessed sight lines and camera coverage; and observed institution operations. Particular interest was directed to the intake process and how the abusiveness and victimization propensity screening is performed. Based on information provided in the Pre-Audit Questionnaire, BFDF is staffed with [redacted] contract security staff and has [redacted] cameras. Cross-gender viewing was assessed during the tour of housing units to determine if detainees can shower and use the toilet facilities without being viewed by employees of the opposite gender, other than viewing that is incidental to routine security inspections. The level and nature of detainee PREA education and related postings throughout the facility was also observed.

A total of [redacted] random security staff interviews were conducted on all shifts (0800-1600;1600-0000;0000-0800) during the audit. Specialized staff were also interviewed which included the BFDF Assistant Officer-in-Charge (AOIC), the Acting PSA Compliance Manager, HSA, Human Resource Specialist, Intake staff, Classification staff, Training Officer, Supervisory staff and Grievance Officer.

Twenty detainees were randomly selected from the housing units for an interview. The interviewed detainees were of various ages, nationalities and ethnic backgrounds. None of the detainees interviewed had previously reported a history of sexual abuse. One physically disabled detainee and one detainee who self-identified as being gay were interviewed. Sixteen limited English proficient (LEP) detainees were included in the group of detainees and were interviewed utilizing an interpretation service. One detainee verbally requested to speak to the auditor while on-site, concerning a non-PREA matter. The detainee was referred to ICE staff and was advised of the grievance process.

There were three allegations of sexual abuse during the last twelve months.

BFDF is located in Batavia, NY, approximately 30 miles east of Buffalo, NY. BFDF is an ICE detention facility. The facility is under the operational authority of ICE. The mission of the facility is create and maintain, a set of standards and conduct ensuring detainees are treated with respect and dignity and provided the best possible care while they are in the custody of the facility. BFDF is used to provide the secure detention of aliens who are either subject to mandatory detention, considered to be a danger to the community or likely to abscond if allowed to remain at large pending immigration proceedings. Detainees classified as low, low medium, high medium or high security are housed at BFDF.

The facility is comprised of one building. The front portion of the facility is the administration building, which is comprised of a lobby that serves as the pedestrian point of entry, reception area, central control room, court rooms, administrative and attorney offices, classrooms, mail room, staff gym and locker room. The back portion of the facility contains housing units and ancillary services. A corridor divides ancillary services to the left and housing units to the right. There are three general population housing units and a 32-bed segregation unit. The housing units are populated with detainees of similar security requirements. There are three-celled units in which security officers control detainee egress and six open bay units. Celled housing units contain toilets within cells. Open bay housing units have toilet facilities down range. There are also detainee toilet facilities in the intake processing area.

BFDF is accredited by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC). The facility provides programs and services consistent with the Performance Based National Detention Standards requirements. IHSC operates medical and mental health care at the facility. Akima Global Services (AGS) is contracted to provide security, transportation and food services. The Centurion Group Inc. is contracted to provide janitorial and maintenance services. Jesuit Religious Services (JRS) is contracted to provide religious services.

During the last twelve months, 2,672 adult male detainees were booked into the facility. The average time in custody is 74 days. The facility does not house juveniles or females.

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 ERAU Unit Chief, the AOIC, Acting PSA Compliance Manager, ICE SDDO, ICE DOs, IHSC HSA, AGS Project Managers and Detention Captain, and numerous other ICE and contract staff. The facility staff were courteous, cooperative, and professional. Staff morale appeared to be good and the interaction observed between staff and detainee was considered appropriate. (b) (7)(E) were noted during the tour. Staff assessed the level of supervision currently in place to mitigate these observations and the auditor determined there was an acceptable level of monitoring and supervision. This observation was discussed at the close-out meeting. It was also noted that numerous video cameras and mirrors supplement staff monitoring of detainees.

The standards used for this audit became effective in March 2014. There were 40 PREA standards assessed for this Subpart A audit. One standard was found to be not-applicable and thirty-six standards were determined to be "Meets Standard". Three standards were assessed as "Does Not Meet Standard" and a corrective action plan is required. The auditor was provided with extensive files containing policies and other documents 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. At the conclusion of the audit, the auditor thanked the staff for their preparation, hard work, and dedication to the PREA audit process.

The auditor concluded through observation, interviews, and review of policies and documentation, that staff and detainees were very knowledgeable concerning their responsibilities involving PREA. However, it is recommended that BFDF policy 2.2.1 (Facility Design) contain specific reference to the protection of detainees from sexual assault, when considering new construction or facility modifications. This revision will provide a more direct compliance link to PREA standard 115.18. Similarly, regarding PREA standard 115.31, to be consistent with the major topics covered in orientation and other periodic training for all categories of staff, it is recommended that a specific reference be made to PREA in the listing of subjects covered in BFDF policy 1.4.3 (General Training Standards and Methods). All other BFDF/ICE directives contained guidance consistent with PREA standards (see notes section). Staff and detainees acknowledged awareness of the facility's zero tolerance policy against sexual abuse. PREA informational posters were prominently displayed in all housing units throughout the facility. The posters provide detainees contact information and the types of advocacy services provided. Audit notifications were also located in the same areas. There were no letters received by the auditor as a result of the audit notifications. All contract security staff were aware of the agency's zero tolerance policy, their responsibilities to protect detainees from all forms of sexual abuse and their duties as first responders, as part of a coordinated response. All interviewed ICE and contractor staff demonstrated an understanding of PREA and their responsibilities under the program, relative to their position in the organization and employment status. All detainees interviewed demonstrated a good understanding of PREA, and its prevention, protection, and reporting mechanisms.

Sufficient staffing resources are monitored to ensure PREA compliance. The tour of the facility revealed all housing units and ancillary departments maintained a high level of physical staff supervision. The auditor noted that there was sufficient staffing to ensure a safe environment for detainees and staff. During a tour of housing units, it was noted that the security officer working in the unit control center makes an audible announcement only in English over the public address system to alert detainees that opposite gender staff are entering the unit. Staff of the opposite gender are required to announce their presence before entering the housing units. Cameras are used extensively in an effort to prevent sexual abuse. Security staff documentation of unannounced security inspections are noted in unit log books.

Current limits to cross-gender viewing are not adequate. PREA standard 115.15(g) requires corrective action. Several shower areas and adjacent dressing areas in the housing units do not have barriers to obstruct cross-gender viewing of the detainees' genitals and buttocks that is not incidental to routine viewing during security inspections. There are, however, adequate limits to cross-gender pat and strip searches.

The facility has adaptive measures in place to ensure disabled and LEP detainees can participate in or benefit from all aspects of PREA. Hiring and promotion practices are consistent with sexual abuse safety measures. The facility has appropriate medical and advocacy networks in place and available if needed. PREA education and training is documented, particularly first responder duties or actions to take in the event of a report of a PREA related incident. During interviews, detainees acknowledged admissions screening regarding a history of sexual abuse or victimization, but approximately two of twenty did not recall whether they were asked if they would like to identify a sexual preference. Intake, classification, and medical/mental health processes are efficient and evaluate detainees based on victimization or abusiveness screening data, as well as abuse allegations while in custody. Related documentation is organized and stored in information systems available on a need-to-know basis. However, reassessments of each detainee's risk of victimization or sexual abusiveness conducted between 60-90 days did not include input from the detainees; there is only a record review conducted without the detainees' own perception of safety considered. PREA standard 115.41(e) requires corrective action.

Available detainee reporting mechanisms are conveyed in a conspicuous manner and staff are aware of reporting processes available to them. Systems are in place for coordinated responses to incidents of sexual abuse if needed. The Office of Professional Responsibility (OPR) has recently trained investigative personnel to handle local administrative investigations. BFDF has access to local law enforcement and ICE investigative resources as needed. The facility does not document efforts to monitor potential retaliation following a report of sexual abuse. As a result, the auditor could not verify retaliation monitoring occurs at BFDF. A PREA tracking log or other mechanism should be used to track retaliation against any person/detainee who reports, complains about, or participates in an investigation into allegations of sexual abuse/harassment. As such, retaliation monitoring is not documented, indicating when monitoring occurred and which retaliation variable was assessed. PREA standard 115.67(c) requires corrective action.

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	0
Number of standards met:	36
Number of standards not met:	3

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:

Sexual Abuse and Assault Prevention and Intervention (BFDF 4.5.12) addresses the requirements identified in the standard. The agency has appointed a Prevention of Sexual Assault Coordinator. BFDF has appointed a PSA Compliance Manager. Based on an interview with the PSA Compliance Manager has sufficient time and authority to coordinate efforts to comply with PREA standards. The agency and facility directives outline a zero-tolerance policy for all forms of sexual abuse and sexual harassment. Policy requires detainees to be informed about the PREA zero-tolerance during in-processing procedures. (Continued)

§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:

A review of the staffing plans, organizational chart, post orders, as well as interviews with the AOIC, and the Acting PSA Compliance Manager confirmed the facility has a staffing plan which provides adequate staff to ensure a safe and secure environment for staff and detainees. A comprehensive analysis of staffing is completed annually. The facility is staffed by (b)(7)(E) employees who have contact with detainees. This includes ICE and IHSC, as well as contracted security, maintenance, and other staff. The facility's security staff complement is (b)(7)(E) Staff supervision and monitoring is supplemented by (b)(7)(E) video cameras. Post orders are reviewed annually. The audit included an examination of the video monitoring systems, housing unit log books, and staff/detainee interviews. (Continued)

§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. BFDF 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:

The policy on "Searches" (BFDF Policy 3.1.18), addresses the requirements of this standard. In accordance with BFDF policy and Section 2.10 of the ICE Performance Based National Detention Standards, cross-gender pat-down searches, strip searches or cross-gender visual body cavity searches are not permitted, 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 last twelve months. When conducted, the search is required to be documented. Security Staff Post Orders for Sub Control Officers require announcements to be made when opposite gender staff enter units. (Continued)

§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

Special Needs Detainees (BFDF 4.2.5), Special Health Care Programs (BFDF 4.5.8), and Detainee Discipline (BFDF 3.3.1) address the requirements of this standard. BFDF takes appropriate steps to ensure detainees with disabilities or LEP have an opportunity to participate in and benefit from the facility's efforts to prevent, detect and respond to any form of sexual abuse. PREA pamphlets, PREA posters and detainee handbooks are in both English and Spanish. The facility has a contract with an interpretation service to provide services for detainees who are LEP. ERO Language Services is used to provide language interpretation. Staff have access to interpretive services during the disciplinary process. Detainee PREA education material is available in accessible formats. Interviews with LEP detainees confirm that they received PREA information in a language they understand. There are also accommodations for the hearing impaired. (Continued)

§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:

The policy on Employee Recruitment, Selection, and Promotion (BFDF 1.3.5) addresses the requirements of this standard. The facility hires and promotes in accordance with the ICE Directive 6-7.0 (Personnel Security and Suitability Program). BFDF refrains from hiring, promoting or enlisting the services of anyone who has engaged or has been convicted of sexual abuse. The Human Resource Manager was interviewed and stated that all components of this standard have been met. All employees, contractors and volunteers have had background checks completed. Employees and unescorted contractors who have detainee contact have backgrounds re-investigated every five years.

§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 policy on Facility Design (BFDF 2.2.1) addresses the requirements of this standard. BFDF considers the effects of the design, expansion or modification of existing facility buildings, upon the facility's ability to protect detainees from sexual abuse. An expansion of the facility was completed in 2015 by adding a 32 bed Special Housing Unit. Video monitoring is prevalent in the new expansion and the design promotes staff detainee interaction to the greatest degree possible. However, the governing policy could be improved by including a specific reference to PREA objectives when considering expanding or modifying 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:

Sexual Assault Intervention and Prevention (ICE Directive 11062.2) and BFDF 4.5.12 address the requirements of this standard. ICE, IHSC, and contract security 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. All forensic medical examinations are conducted at Erie County Medical Center by qualified health care professionals. However, there were no forensic medical exams conducted during the last 12 months. The facility follows a uniform evidence protocol which maximizes the potential for obtaining usable physical evidence for administrative and criminal proceedings. If applicable, victims of sexual assault are referred to health services for initial examination and treatment. (Continued)

§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:

BFDF 4.5.12 and ICE Directive 11062.2 address the requirements of this standard. The policies establish facility and agency protocols to ensure each allegation of sexual abuse is investigated or referred to an appropriate investigative authority. There were no closed cases applicable for this audit period. When required, all allegations of sexual abuse are reported immediately to the Genessee County Sheriff's Office and the New York State Police. The facility also notifies the Joint Intake Center (JIC), OPR, the DHS OIG, and FOD as dictated by the status of the alleged perpetrator and victim. The facility coordinates with ICE and other appropriate investigative entities to (Continued)

§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:

The policy on General Training Standard and Methods (BFDF 1.4.3) addresses the requirements of this standard. The review of training documents/curriculum, training logs and interviews with staff and the Senior Field Training Officer confirmed that all ICE employees, contract staff and volunteers received PREA training that includes each element of the standard. Staff receive initial training when hired and receive annual refresher training.

§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:

BFDF 1.4.3 addresses the requirements of this standard. Based on a sampling of files, all contractors and volunteers providing services to the detainees at the facility on a non-recurring basis have received PREA training. A review of the training records 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. Interviews with contract staff and volunteers confirmed they receive PREA training annually.

§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:

The BFDF Facility Handbook addresses the requirements of this standard. The handbook contains a section called "Sexual Abuse and Assault Awareness". During intake, each detainee receives a Sexual Abuse and Assault Awareness pamphlet, the ICE National Detainee Handbook and the BFDF Handbook. The pamphlet and handbooks are available in English and Spanish. 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)

§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:

A BFDF staff member received a certificate of training for "OPR Management Inquiry Training Program (OPR MIT-702)." The training was provided by the DHS U.S. Immigration and Customs Enforcement Academy, OPR Training Program. The certificate of training was presented on May 12, 2017. The training was described as the combining of what was previously known as separate Administrative Inquiry (AI) and Management Referral (MR) processes into a newly formed Management Inquiry (MI) process. The OPR PSAC will continue to review any MI closing reports involving detainee sexual abuse allegations. The open cases applicable during this audit were not affected by this reorganization.

§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:

ICE Directive 11062.2 addresses the requirements of this standard. Section 5.2 covers the requirements for IHSC medical and mental health staff. All mental health and medical staff at BFDF have received the specialized medical and mental health PREA training. The training includes how to detect and assess signs of sexual abuse and harassment, how to preserve physical evidence, how to respond effectively and professionally to victims of sexual abuse and how to report allegations of sexual abuse. The training plan and course material were reviewed by the auditor. Forensic exams are conducted at an outside hospital. Compliance with this standard was confirmed by staff interviews and the review of training documents.

§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:

The policies on Detainee Admission Procedures (BFDF 4.4.1), and Detainee Classification (4.2.2) address the requirements of this standard. All detainees are assessed at intake immediately upon arrival. Documents and electronic information available upon admission are reviewed and the detainee is interviewed and assessed in accordance with several classification and security variables. Several potential victimization variables are also reviewed. Based on this process, which includes a scoring mechanism, a security/supervision level is assigned. This process occurs within 12 hours of admission in order to assign appropriate housing. (Continued)

§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:

BFDF policies 5.1.2 and 4.1.1 address the requirements of this standard. These policies require the facility to use the established classification system to determine proper housing and vulnerability risk. Classification and security variables are evaluated to determine general population placement or specialized housing placement. As stated above, an identified vulnerability risk is not identified and marked as such of the classification document. However, sufficient information is reviewed in order to inform proper initial housing placement. The above policies require housing and program assignments to be made on an individual basis. No transgender detainees were housed during the time of the audit. However, facility policy requires staff to consider the detainee's self-identification and base housing placements on the transgender detainee's mental health and well being.

§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:

The policy on Protective Custody Operations (BFDF 3.4.4) addresses the requirements of this standard. Policy states detainees at high risk for sexual victimization shall not be placed in restricted 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 within 72 hours and reassessed every seven days, thereafter, while in restricted housing. During the last twelve months, no detainees were placed in a protective custody unit on the basis of their vulnerability to sexual abuse or assault.

§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:

BFDF 4.5.12 addresses the requirements of this standard. A review of documentation, and staff and detainee interviews indicated that there are multiple reporting mechanisms available to detainees for reporting allegations of sexual abuse (i.e., verbally in writing via a letter to ICE, to the DHS OIG or consulate; by telephone call to a hot line; anonymously; privately and from a third party). 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.

§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:

BFDF policies on Detainee Grievance Procedures (3.5.6), 4.5.12, and the BFDF Detainee Handbook address the requirements of this standard. Detainees may file a grievance at any time without use of an informal resolution process. All allegations of sexual abuse or sexual assault, when received by staff, would immediately result in an administrative or criminal investigation. 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. In the last 12 months the facility received one grievance alleging sexual abuse. The Grievance Officer was interviewed and confirmed compliance with this standard. (Continued)

§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:

BFDF 4.5.12 and the BFDF Detainee Handbook address the requirements of this standard. Policy requires staff to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse. Detainees are offered crisis intervention services via the RESTORE hot line. The facility's local resource for detainee reporting and victim advocate services is RESTORE, a component of Planned Parenthood of Western NY. Interviews with staff, a RESTORE staff member, and detainees support the facility's 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:

Procedures for third-party reporting are listed in the Sexual Abuse and Assault Awareness Pamphlet, the BFDF detainee handbook and posters which include the ICE and DHS OIG telephone number and mailing address. This information is also available on the Detention Reporting and Information Line Web page and the OIG Web page. Staff and detainees interviewed were aware of the procedures for third-party reporting. The facility also has signs in the 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:

BFDF 4.5.12 addresses the requirements of this standard. Staff confirmed during interviews they know they are responsible 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. Staff may report sexual misconduct inside or outside of their chain of command.
The DHS OIG hot line is available for third party reporting. Policy requires the information concerning the identity of the alleged detainee victim and the specific facts of the case be limited to staff with a need-to-know.

§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:

BFDF policies 4.5.12, and 4.2.2 address the requirements of this standard. Policy requires special consideration to be given to any factor that would raise the risk of vulnerability, victimization or assault. Policy requires staff members to take immediate action to protect a detainee when there is a reasonable belief that the detainee is subject to a substantial risk of imminent sexual abuse. Interviewed staff were well aware of their duties and responsibilities, as they relate to a detainee being at imminent risk for being sexually abused. All staff indicated they would act immediately to protect the detainee and then call their supervisor. Interviews with staff and an examination of established policy confirm compliance with this standard.

§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:

BFDF 4.5.12 requires that upon receiving an allegation that a detainee was sexually abused while confined at another facility, the facility whose staff received the allegation must notify the administrator of the facility where the alleged abuse occurred. The notification must be completed as soon as possible, but no later than 72 hours after receiving the allegation, and the notification must be documented. An interview with the PSAM confirmed their awareness of the requirement. During the applicable audit period, BFDF reports that no allegations of detainee sexual abuse while confined at another facility were received.

§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:

BFDF policy 4.5.12 addresses the requirements of this standard. All security staff interviewed were knowledgeable concerning their first responder responsibilities, when learning of an allegation of sexual abuse. They also stated they would separate the alleged victim and abuser, preserve and protect the scene, not allow detainees to destroy possible evidence and contact their supervisor. Non-security staff stated that their main duties would be to ensure the alleged victim does not destroy any physical evidence and then notify security staff. BFDF did not report any actual first responder cases during the audit period. Interviews with security/non-security staff and an examination of policies confirm compliance with this standard.

§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:

BFDF 4.5.12 addresses the requirements of this standard. The Sexual Abuse Response Team (SART) has been established to ensure coordinated actions of staff in response to sexual abuse incidents. Policy establishes written procedures for a coordinated, multidisciplinary team approach. In addition to first responders, the team consists of a medical practitioner, a mental health provider, a security staff member, an investigator from the assigned entity, and representatives from outside entities that provide relevant services and expertise. Staff interviews confirmed that they were knowledgeable regarding their responsibilities in the coordinated response. BFDF reported no need to coordinate medical or social services for sexual abuse cases requiring transfer to other facilities.

§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:

BFDF 4.5.12 addresses the requirements of this standard. Staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation. When a contractor is alleged to be the perpetrator, the contractor's firm will be notified of the incident. 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 (A) OIC and PSA Compliance Manager confirmed 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:

BFDF 4.5.12 addresses the requirements of this standard. Policy prohibits any type of retaliation against any person or detainee who has reported, complains about, or participates in an investigation into an allegation of sexual abuse. BFDF policy requires at least a 90 day period of monitoring to determine if there are facts that may suggest possible retaliation by detainees or staff. Monitoring areas are to include any detainee disciplinary reports, housing or program changes, or staff negative performance reviews or reassignments. The facility reports that there have been no instances of detainees or staff reporting retaliation during this audit period. However, there is no evidence of retaliation tracking to determine the time period of monitoring, or the intervals at which retaliation variables were assessed. (Continued)

§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:

BFDF policies 4.5.12 and Administrative Segregation (3.4.2) address the requirements of this standard. Facility policy states that vulnerable detainees shall be housed in a supportive environment that represents the least restrictive housing option possible. The facility will allow the victim, to the extent possible, the same level of privileges permitted immediately prior to any sexual assault. Facility policy states placement in administrative segregation due to a special vulnerability is to be used as a last resort. Based on a review of documentation during the applicable audit period, one detainee was placed in protective custody due to a vulnerability issue. The case was administered appropriately. The detainee was reassessed and returned to general population the same day.

§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 and BFDF 4.5.12 address the requirements of this standard. The policies establish facility and agency protocols to ensure each allegation of sexual abuse is investigated or referred to an appropriate investigative authority. There were no closed cases applicable for this audit period. When required, all allegations of sexual abuse are reported immediately to the Genessee County Sheriff's Office and the New York State Police. The facility also notifies the Joint Intake Center (JIC), OPR, the DHS OIG, and FOD as dictated by the status of the alleged perpetrator and victim. Three facility case files were reviewed of sexual abuse allegations investigated during the applicable audit period. All were referred to the DHS OIG or ICE OPR as applicable. Policy requires coordination of investigations to ensure the integrity of criminal investigations as required. As verified in training documentation, the Acting PSA Compliance Manager recently received specialized training to conduct (Management Inquiries). As such, all three applicable administrative investigations during the audit period were referred to the Joint Intake Center and OPR. (Continued)

§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:

ICE Policy 11062.2 and BFDF 4.5.12 address the requirements of this standard. When conducting administrative investigations, the agency and facility impose no standard higher than the preponderance of evidence to substantiate an allegation of sexual abuse or assault. Interviews with the Acting PSA Compliance Manager/Investigator confirm 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:

ICE Directive 11062.2 addresses 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 "Proof of Service" forms and placed in both the detainee A file and the facility investigative file. However, over the last 12 months, there were no closed cases. There were no notifications applicable, as one detainee was no longer in custody and two other cases were still open.

§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:

BFDF policies 4.5.12 and 1.3.5 address the requirements of this 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, unless the activity was clearly not criminal. There were no substantiated allegations of sexual abuse including staff for the audit period. Compliance with this standard was determined by a review of policies and interviews with the Acting PSAM and Acting OIC.

§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:

The policy on Use of Non-Staff (BFDF 1.7.1) addresses the requirements of this 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. During the applicable audit period, there were no sexual abuse allegations lodged against a contractor or volunteer. Compliance with this standard was determined by a review of policies and interviews with the Acting PSAM and Acting OIC.

§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:

BFDF 4.5.12 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 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 when determining what type of sanction should be imposed. (Continued)

§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 Directive 03-01, BFDF 4.5.12 and the BFDF Medical Services policy (BFDF 4.5.3) address 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 pursuant to 115.41, a medical evaluation takes place within two working days. The procedures also allow for detainees who report victimization or abusiveness to be offered a follow-up meeting with mental health staff within 72 hours of referral. Treatment services are offered without financial cost to the detainee. Examples of referrals were reviewed by the auditor.

§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:

BFDF 4.5.3 addresses the requirements of this standard. Policy requires that 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 Erie County Medical Center. Victim advocacy services are offered through RESTORE. There is no financial cost to the detainee for any sexual abuse related incident, related medical or mental health care or advocacy services, regardless of whether the victim names the abuser or cooperates with the incident investigation. There were no facility referrals for emergency care for sexual abuse victims within the last twelve months that required the services of a SAFE/SANE nurse or the community advocacy agency.

§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:

BFDF 4.5.12 addresses 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 victim, regardless of whether the victim names the abuser or cooperates with the investigation. Detainee victims of sexual abuse are offered tests for sexually transmitted infections, in accordance with professionally accepted standards of care, as medically appropriate. Mental health evaluations are conducted on all known detainee-on-detainee abusers within 60 days of learning of such abuse. (Continued)

§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:

BFDF 4.5.12 covers the process for sexual abuse incident reviews. The policy requires an assessment of whether substantiated or un substantiated allegations reveals a need to change policy or practice to better prevent, detect, or respond to sexual abuse; whether the incident or allegation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender or intersex identification; status or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The policy requires the review to be completed within 30 days of the conclusion of the investigation. There were three allegations of sexual abuse during the last twelve months, none of which had a final outcome at the time of the audit. There were no closed investigations for the audit period. (Continued)

§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:

BFDF 4.5.12 addresses the requirements of this standard. BFDF maintains all case records associated with claims of sexual abuse in a secure area, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post release treatment as applicable. The local PSA Manager works with the PSA Coordinator and the DHS OIG to share data regarding effective agency response methods to sexual abuse. Interviews with the Acting PSA Compliance Manager 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 all relevant documents and conducted interviews with staff/detainees. Audit notices were posted in all housing areas, giving the detainees an opportunity to confidentially correspond with the auditor. The auditor did not receive any correspondence from the detainees at BFDF.

ADDITIONAL NOTES

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

115.11 A video is offered in English and Spanish while the detainee is housed in the intake area of the facility. Detainees are also informed about the program and zero-tolerance via the facility Detainee Handbook, related pamphlets and through postings throughout the facility, which were observed during the tour. All written documents are available in English and Spanish. Other ICE publications are available in Creole, Chinese, and French. Interpretive services are available for detainees who do not speak or read English, Spanish or other languages. All interviews with staff, volunteers, contractors and detainees confirmed that each was aware of the zero-tolerance policy towards all forms of sexual abuse/harassment. The commitment to the enforcement and implementation of PREA meets the required compliance with this standard. An examination of documentation also confirms compliance with this standard.

115.13 There have been no judicial findings of inadequacy, findings of inadequacy from federal investigative agencies or findings of inadequacy from internal or external oversight bodies relevant to this standard. All essential posts are filled each shift and no essential posts are kept open for salary savings. Staffing at BFDF has not adversely impacted the prevalence of substantiated or unsubstantiated sexual abuse allegations, nor has the lack of supervision and monitoring been viewed as causal factors for sexual abuse allegations over the audit period. The review of "unannounced" PREA rounds documentation confirmed that intermediate-level or higher-level supervisors conduct and document security inspections. These inspections are noted in unit log books, but do not distinguish themselves from routine security inspections. Such visits throughout the facility are to be focused on identifying and deterring sexual abuse of detainees. BFDF policy prohibits staff from alerting other employees regarding "unannounced" rounds. Interviews with housing unit officers also confirmed that security inspections are conducted on each shift. It is recommended that "unannounced" rounds focused on PREA initiatives be logged and documented.

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115.15 Additionally, PREA training documentation and staff interviews verify security officers receive training in proper pat-down search procedures. However, 115.15(g) requires a corrective action plan. Detainees do not have reasonable privacy to shower or change clothes without being viewed by staff of the opposite gender, when that viewing is not incidental to routine security inspections. During the tour of the housing units, it was observed that detainees could be viewed showering and changing clothes without adequate visual barriers to conceal the genital and buttock areas of the body. Detainees were viewed showering in their underwear and using makeshift barriers to conceal themselves or enhance privacy while showering. All shower areas should be reviewed to assess whether existing privacy walls should be supplemented by additional partitions or other appropriate visual barriers.

115.16 BFDF attempts to make available sign language interpreters to ensure effective communication with detainees who are deaf or hard of hearing. Policy 4.5.12 states that there are provisions of accommodating hearing impaired detainees during the disciplinary process. The BFDF Detainee Handbook describes provisions for disability- related auxiliary aids such as Text Telephone or TTY.

115.17 The facility does not hire or promote anyone who may have contact with detainees, and does not enlist the services of any contractor who may have contact with detainees, who has engaged in any type of sexual abuse/harassment. Employees have a duty to disclose such misconduct and material omissions regarding such misconduct would be grounds for termination. Submission of false information by any applicant is grounds for not hiring the applicant. The Human Resource Manager was interviewed and confirmed that the agency attempts to contact prior employers for information on substantiated allegations of sexual abuse or resignations which occurred during a pending investigation of sexual abuse. The Human Resource Manager also confirmed that the agency provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. The agency also notifies appropriate licensing/certifying bodies when professional staff are terminated for substantiated allegations of sexual abuse or harassment. A review of documentation also supports compliance with this standard.

115.21 Where evidentiarily or medically appropriate, the alleged victim would be transported to a local hospital for examination and treatment. Only with the alleged detainee victim's consent, a forensic exam would be conducted by a qualified medical professional. All sexual abuse advocacy, examinations, treatment, testing and follow-up care is provided without cost to the victim. The facility has access to a local victim advocacy organization (RESTORE) to provide victim advocacy services. Interviews with staff, a local victim advocate, and an examination of documentation also confirm compliance with this standard.

115.22 Ensure that an administrative or criminal investigation is completed on all allegations of sexual abuse. The policies require that non-federal investigative agencies shall follow the ICE investigative protocols. The policies cover the coordination of criminal, if applicable, and administrative investigations to ensure a criminal investigation is not compromised by a concurrent administrative investigation. Investigative protocols are posted on the ICE public website. At the time of the audit, all three administrative cases were in open status.

ADDITIONAL NOTES

115.33 Detainees also view a comprehensive orientation video that explains the facilities zero-tolerance policy and covers the detainee's right to be free from sexual abuse, sexual harassment and retaliation. Staff interpreters and telephonic interpreter services are available to detainees who are not proficient in English. ERO Language Services provides interpretation services in all applicable languages represented at the facility. Deportation Officers and other staff visit housing units and are available to provide information to address issues that may include PREA information. Detainee interviews confirmed that they received PREA information and they were aware of numerous reporting methods to include anonymous and third party reporting, the zero-tolerance policy and their right to be free from retaliation. The tour of the facility confirmed that PREA education posters were prominently displayed in all housing units, the Visiting Room and common/program areas. Interviews with staff and an examination of documentation also confirm compliance to this standard.

115.41 Documents do not indicate that a re-assessment of the propensity level has been performed at 60-90 days from admission, and this re-assessment process includes actual input from the detainee. Information received during the screening is only available to staff with a need-to-know and never to other detainees. A corrective action plan should be developed which would incorporate the current structure of the ICE classification system, but would contain a notation of a specific propensity for risk of victimization or abusiveness, or lack of such. Additionally, a corrective action plan should document a re-assessment of the detainee's own perception of victimization or sexual safety during the re-classification process.

115.52 There is no prohibition that limits third parties, including fellow detainees, staff members, family members, attorneys and outside advocates, in assisting detainees in filing requests for grievances relating to allegations of sexual abuse and filing such requests on behalf of detainees. Policy addresses the facility will respond to the grievance within 5 days and will respond to an appeal within 30 days; however, the facility immediately opens an investigation of such grievance, therefore complying with the time deadline.

115.67 A corrective action plan is required. The corrective action should indicate how retaliation monitoring is accomplished. A retaliation monitor should be identified. A tracking system should indicate when contact with the detainee or staff member occurred, which retaliation variable was monitored and the result of the assessment.

115.71 As the cases were still open during the audit, the auditor conducted a limited reviewof the available file material (facility investigative file) and this review determined the facility was within the procedural PREA standards. No staff or contractors/volunteers were the subject of any applicable investigations. Files revealed the departure of the alleged abuser or victim from the control of the agency would not provide a basis for terminating an investigation. Interviews with the Acting PSA Compliance Manager confirmed that the facility would fully cooperate with outside investigators. The institution’s investigative staff may conduct administrative investigations within the facility and were interviewed by the auditor. The credibility of an alleged victim, suspect or witness is assessed on an individual basis and is not determined by the person’s status as detainee or staff. The agency does not require a detainee who alleges sexual abuse to submit to a polygraph examination or other truth assessment device as a condition for proceeding with the investigation of such an allegation. Compliance with this standard was determined by a review of policy, documentation and staff interviews.

115.78 BFDF policy does not allow disciplinary action on a detainee for sexual contact with staff, unless there is a finding that the staff member did not consent to such contact. There were no substantiated findings of detainee sexual abuse for the audit period, or disciplinary action for sexual abuse. Interviews with the facility investigator confirmed compliance with this standard.

115.83 The auditor did not review open OPR or AIU cases. The auditor reviewed facility case file documentation on alleged sexual abuse victims follow-ups to mental health and found the issue to be in compliance with PREA requirements. Documentation was reviewed in the medical department relative to the three applicable cases during the audit period.

115.86 Therefore no incident reviews were applicable for the audit period. The auditor reviewed the 2016 annual report for the period ending September 30, 2016.

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.

Don Chadwick — **Auditor’s Signature**

11/09/2017 — **Date**

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Wendy J. Roal Warner	**Organization:**	Creative Corrections, LLC
Email address:	(b) (7)(C), (b) (6)	**Telephone number:**	(309) 241-(b) (7)(C), (b) (6)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Buffalo
Field Office Director:	(b) (7)(C), (b) (6) (Acting)
ERO PREA Field Coordinator:	(b) (7)(C), (b) (6)
Field Office HQ physical address:	250 Delaware Avenue, Buffalo, NY 14202
Mailing address: *(if different from*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Buffalo Federal Detention Facility		
Physical address:	4250 Federal Drive, Batavia, NY 14020		
Mailing address: *(if different from*			
Telephone number:	(585) 344-6500		
Facility type:	SPC		
Facility Leadership			
Name of Officer in Charge:	Jeffrey J. Searls	**Title:**	Assistant Officer in Charge
Email address:	(b) (7)(C), (b) (6)	**Telephone number:**	(585) 344-(b) (7)(C), (b) (6)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	Martin Bermudez	**Title:**	Supervisory Detention and Deportation Off
Email address:	(b) (7)(C), (b) (6)	**Telephone number:**	(585) 344-(b) (7)(C), (b) (6)

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 initial audit of the Buffalo Federal Detention Facility (BFDF) was conducted by an auditor from The Nakamoto Group, Inc. The contract for PREA audits for Immigration and Customs Enforcement are now conducted by Creative Corrections, LLC. Wendy Roal Warner, a certified PREA auditor with Creative Corrections, is conducting the Corrective Action Plan (CAP) Final Determination for BFDF. There were three standards in non-compliance as noted below. All three standards have been corrected and are in compliance.

115.15: Information provided in the CAP confirms BFDF added half-mesh shower curtains to all shower areas. A photograph submitted confirms the shower curtain is of sufficient height and width to provide adequate privacy for detainees when showering, while still allowing for proper security monitoring. This standard is now in compliance.

115.41: Information provided in the CAP verifies BFDF revised policy 4.2.3 Classification, revised the classification form, created a reassessment form, and provided training to staff responsible for conducting the initial assessment and reassessment. Document review confirms the revisions clarify the purpose of the initial assessment and reassessment, and the revised reassessment form meets the requirements of the standard. Document review confirms staff have been trained on the revised policy and forms. This standard is now in compliance.

115.67: The information provided in the CAP adequately meets all missing elements of the deficiency. Specifically, BFDF policy 4.5.12, Sexual Abuse and Assault Prevention and Intervention, was updated and designates the PSA Compliance Manager as responsible for tracking/monitoring retaliation. A tracking system was developed that adequately addresses the areas identified to monitor as stated in the standard, and the updated policy and memorandums support the corrections. This standard is now in compliance.

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. 15 - Limits to cross-gender viewing and searches

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

Notes:

At the time of the on-site audit, the tour of the housing units revealed shower areas did not provide adequate visual barriers to conceal the genital and buttock areas of detainees. During the corrective action period, BFDF added half-mesh curtains to all shower areas. A photograph was provided which demonstrates the shower curtain is of sufficient height and width to provide adequate coverage for detainees while showering and still allows for sufficient visual monitoring by staff. This standard is now in compliance.

§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:

At the time of the on-site audit, BFDF's classification process did not include a notation on a detainee's propensity for risk of sexual victimization or abusiveness. Further, reassessments of detainee risk of sexual victimization or abusiveness were not being conducted. The auditor making the CAP Final Determination also noted the classification forms did not assess all nine areas required in section (c) of the standard. During the corrective action period, BFDF revised policy 4.2.3, revised the classification form, created a reassessment form, and provided training to staff responsible for conducting the initial assessment and reassessment. The revised policy and forms now clearly indicate staff are to make an initial assessment of a detainees' risk of sexual victimization/abusiveness through a combined review of file material and intake and medical screening forms. Policy revisions and the reassessment form meet the requirements of the standard and provide clear direction to staff on the time frames for reassessments and the purpose of the form. Document review confirms staff have been trained on the revised policy and forms.

While not noted as a deficiency during the on-site audit, the auditor reviewing the corrective action documents noticed neither of the initial screening forms (medical and classification) assesses if a detainee self-identifies as gay, lesbian, bisexual, intersex or gender non-conforming; there is only a question asking if a detainee is transgender. As the standard requires the initial assessment consider if a detainee self-identifies as gay, lesbian, bisexual, transgender, intersex or gender nonconforming, it is recommended BFDF give consideration to including this question in the initial assessment.

§115. 67 - Agency protection against retaliation

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

Notes:

At the time of the on-site audit, BFDF policy 4.5.12 required monitoring of retaliation against staff or detainees who report sexual abuse with the monitoring required for at least 90 days. However there was not a tracking system in place to monitor the duration of monitoring nor the specific areas monitored, and a retaliation monitor(s) had not been identified. During the corrective action period BFDF revised policy 4.5.12 to designate the PSA Compliance Manager as the Retaliation Monitor. A tracking system was developed to reflect the dates of monitoring for retaliation and the factors evaluated to determine if retaliation is occurring. The revisions now meet the requirements of the standard and it is in compliance.

§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.

Wendy J. Roal Warner April 7, 2018
Auditor's Signature & Date