

# PREA Audit: Subpart A DHS Immigration Detention Facilities Audit Report



# Homeland Security

AUDITOR INFORMATION			
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AGENCY INFORMATION			
<b>Name of agency:</b>	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
<b>Name of Field Office:</b>	San Antonio		
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<b>ERO PREA Field Coordinator:</b>			
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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
<b>Name of facility:</b>	Karnes County Residential Center		
<b>Physical address:</b>	409 FM 1144, Karnes City, TX 78118		
<b>Mailing address: (if different from above)</b>			
<b>Telephone number:</b>	830-254-2000		
<b>Facility type:</b>	<input type="checkbox"/> SPC <input type="checkbox"/> CDF <input type="checkbox"/> DIGSA <input checked="" type="checkbox"/> IGSA <input type="checkbox"/> FRC <input type="checkbox"/> Other, <b>Describe:</b>		
Facility Leadership			
<b>Name of Official/Officer in Charge:</b>	Rose Thompson	<b>Title:</b>	Program Director
<b>Email address:</b>	(b)(6), (b)(7)(C)	<b>Telephone number:</b>	830-254-2005
Facility PSA Compliance Manager			
<b>Name of PSA Compliance Manager:</b>	Laura Guerrero	<b>Title:</b>	PSA Compliance Manager
<b>Email address:</b>	(b)(6), (b)(7)(C)	<b>Telephone number:</b>	(830-254-2002

## 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 Karnes County Residential Center (KCRC) in Karnes City, Texas was conducted on May 9-10, 2017. The audit was completed by David R. Andraska, a certified PREA auditor with the Nakamoto Group, Inc. 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 The GEO Group, Inc. (GEO) and KCRC 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: U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Review & Analysis Unit (ERAU) Team Lead (b)(6), (b)(7); GEO staff to include: Program Director (b)(6), (b)(7), Prevention of Sexual Assault (PSA) Compliance Manager (b)(6), (b)(7), and GEO PREA Director (b)(6), (b)(7); ICE Enforcement and Removal Operations (ERO) staff to include: Assistant Field Office Director (AFOD) (b)(6), (b)(7), Supervisory Detainee Deportation Officer (SDDO) (b)(6), (b)(7), ICE Health Service Corps (IHSC) Health Services Administrator (HSA) (b)(6); as well as other ICE and facility support staff.

There were 185 residents housed in the facility during the audit which included 92 female adults and 93 juveniles. A comprehensive tour of the facility was completed. The tour included the intake processing area, all housing units, the medical services department, school, recreation, food service, the library, visiting room, chapel, multipurpose rooms and the control center. During the tour, it was noted that there was sufficient staffing to ensure a safe environment for residents and staff. It was observed during the tour that residents are able to shower, dress and use the toilet facilities without exposing themselves to employees of the opposite gender. Staff is required to knock and announce their presence in English and Spanish before opening the door of a resident's suite.

Informal and formal conversations with employees and residents regarding the PREA standards were conducted. PREA information reporting sheets in English and Spanish are posted by the telephone in all resident suites, which provide information on how to report PREA incidents and include phone numbers for the PSA Manager, OIG hotline, Rape Crisis hotline and a Child Abuse hotline. ICE PREA zero tolerance posters were displayed in all common areas and throughout the facility. The posters encourage reporting and provide information on confidential reporting and victim services. Audit notifications were also located in the same areas.

A total of thirty-one staff interviews were conducted during the audit. The interviews included security staff on all shifts. All were aware of the agency's zero tolerance policy and knew their responsibilities to protect residents from sexual abuse/harassment and their duties as first responders as part of a coordinated response. Specialized staff were also interviewed, specifically the Program Director, GEO PREA Director, PSA Compliance Manager, HSA, Case worker, Nurse, Psychologist, Investigators, Human Resource Specialist, Intake staff, Classification staff, Training Administrator, Chief of Security, supervisory staff, a volunteer and grievance staff. All interviewed staff demonstrated an understanding of the PREA and their responsibilities under this the program, relative to their position in the organization and employment status.

Twenty residents (17 female adults and 3 juveniles) were randomly selected from the housing units for an interview. The interviewed residents were of various ages, nationalities and ethnic backgrounds. There were no residents on site that were identified as disabled, or who previously reported a history of sexual abuse. No residents self-identified as Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI). Eighteen limited English proficient (LEP) residents were included in the group of residents and were interviewed utilizing a telephonic interpretation service. All residents interviewed demonstrated a good understanding of the PREA program, the prevention, protection, and reporting mechanisms, and stated they felt safe at the facility. No residents refused to be interviewed. No residents verbally requested to speak to the auditor while on-site and no letters were received by the auditor as a result of the audit notifications.

There were no allegations of sexual abuse, assault or harassment during the twelve months preceding the audit.

KCRC is located at 409 FM 1144, Karnes City, TX and is owned and operated by GEO. In December 2010, GEO was selected by Karnes County, Texas, to design, build, finance, and manage a new detention facility under an intergovernmental service agreement with ICE. On July 11, 2014, the contract was modified to convert the facility from a Civil Detention Facility into a Family Residential Unit for females and their children. The modification and expansion of KCRC was completed in early December 2015, and increased the capacity from 608 beds to 1,158 beds. Due to the Texas Department of Family Protective Services guidelines, the capacity was lowered to 830 beds, allowing only five beds per resident suite. KCRC is staffed with (b)(6) GEO employees, (b)(6) ICE employees and has (b)(6) cameras. The center consists of a two-story structure that features three large internal courtyards for recreation, with resident suites (sleeping areas) surrounding the courtyard. Resident suites are individual rooms housing up to five residents, with each room featuring its own bathroom/shower for privacy, individual TVs, and microwaves. The design and location of the 166 resident suites allow for the separation of residents by gender, age groups, and security levels. Multipurpose rooms for social activities and recreation, as well as laundry rooms for personal clothing, are located within each housing wing.

Residents are provided education programming, medical care, recreation, visitation facilities, life skills/chores, study time, group interaction, free time, and access to religious and legal services. All residents of school age are offered educational services through a certified charter school. Each classroom is equipped with state-of-the-art smart-boards which allow children to interactively participate in classroom instruction. Field trips are provided monthly for all children to local parks, libraries, and other community events. Each room is equipped with activity games for use by children, with multipurpose rooms for social activities, laundry facilities, and 24 hour snack refrigerators. Food served at the facility is catered to the resident's local cuisine and served buffet style. The recreation area includes an indoor gymnasium, artificial turf soccer field, covered pavilion, playground and picnic areas.

During the last twelve months, 15,328 residents (7,353 adults and 7,975 children) were booked into the facility.

**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 OPR ERAU Team Lead; ERO SDDO; GEO staff to include: Program Director, Regional Vice President (b)(6), PREA Director, and PSA Compliance Manager; and other staff to discuss audit findings. The facility staff was courteous, cooperative, and professional. The interaction observed between staff and resident was considered appropriate. There were no blind spots observed during the tour and adequate video cameras and mirrors supplement staff monitoring of residents.

The standards used for this audit became effective in March 2014. There are 41 PREA standards for a Subpart A audit. Two standards were found to "Exceed" the requirements and thirty-nine standards were found to "Meet" the mandates of the PREA standards. No standards were found as "Does Not Meet" and a corrective action plan is not required. The auditor was 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 Program Director and the facility staff for their preparation, hard work, and dedication to the PREA audit process. A special thanks to the PSA Compliance Manager for a great job coordinating the staff and resident interviews and for the preparation of the PREA binder documentation.

<b>SUMMARY OF AUDIT FINDINGS</b>	
<b>Number of standards exceeded:</b>	2
<b>Number of standards met:</b>	39
<b>Number of standards not met:</b>	0

## PROVISIONS

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

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

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

#### Notes:

GEO Policy Sexually Abusive Behavior Prevention and Intervention Program (PREA) (GEO Policy #5.1.2) is a written plan mandating zero tolerance towards all forms of sexual abuse. The policy includes definitions of prohibited behaviors and sanctions for those found to participate in these prohibited behaviors. The KCRC policy 2.1.1 Sexual Abuse/Assault Prevention and Intervention Programs, explains the facility's zero-tolerance policy. Both policies outline the approach to preventing, detecting and responding to all forms of sexual abuse. GEO employs an upper-level, agency-wide facility PREA Director and has the authority to develop, implement, and oversee PREA compliance and indirectly supervise PREA Compliance Managers at all GEO facilities. (Continued on page 10)

### §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:

KCRC Policy #2.1.1 addresses staffing and outlines the requirements of this standard. Policy requires that a comprehensive staffing analysis is completed annually. A review of the staff plan, organizational chart, post orders, as well as interviews with the Program Director and PSA Compliance Manager, confirmed that the facility has a staffing plan which provides adequate staff to ensure a safe and secure environment for staff and residents. The Program Director stated that in the last 12 months, there have been no deviations to the staffing plan. The facility's security staff is composed of 221 GEO staff. The Chief of Security stated post orders are reviewed annually. Supervision is supplemented by video cameras and various ICE and contract on-site staff. (Continued on page 10)

### §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:

KCRC Policy #2.1.1 addresses the requirements of this standard. Juveniles are placed in the least restrictive setting appropriate to the juvenile's age and special needs. At KCRC, all juveniles are housed with their mothers.

### §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 Policy #5.1.2-D and KCRC Policy #2.1.1 and Policy 2.1.9 Searches of Mothers and Children address the requirements of this standard. KCRC does not permit cross-gender pat-down searches, 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 search conducted during the audit period. If conducted, the search must be documented. No pat-down searches are conducted at this facility. Residents have privacy to shower, change clothes and perform bodily function without being seen by staff of the opposite gender. (Continued on Page 10)

**§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 #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. KCRC takes appropriate steps to ensure residents with disabilities and residents who are limited English proficient (LEP) 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 pamphlets, bulletin board postings, and detainee handbooks are printed in both English and Spanish. Staff at the facility has access to the ERO Language Services Resource Flyer when interpretation and/or translation services for detainees who are LEP is required. Staff also has access to the Speak Language Identification Guide. Detainee PREA education material is available in accessible formats. Interviews with LEP residents confirm that they received PREA information in a language they understand.

**§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 #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. KCRC requires all staff to pass a background investigation and refrains from hiring, promoting or enlisting the services of anyone who has engaged in or has been convicted of sexual abuse. The Program Director and Human Resource Specialist were interviewed and stated that all components of this standard have been met. All employees, contractors, and volunteers have had background checks completed. Staff have a continuing duty to report any misconduct. A tracking system is in place to ensure that updated background checks are conducted every five years. (Continued on page 10)

**§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:**

GEO Policy #5.1.2-D addresses the requirements of this standard. GEO considers the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect inmates from sexual abuse. Modification and expansion of KCRC was completed in early December 2015 to increase bed capacity and convert to a family residential center. The number and placement of cameras in the new addition as well as additional cameras in existing areas were based on enhancing the facility's ability to protect residents from sexual abuse.

**§115.21 – Evidence protocols and forensic medical examinations.**

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

**Notes:**

GEO Policy #5.1.2-F and KCRC Policy #2.1.1 addresses the requirements of this standard. ICE and contract staff including Mental Health and Medical Service staff 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 facility investigator conducts investigations relative to sexual abuse allegations. All forensic medical examinations would be conducted at Methodist Hospital by SAFE/SANE staff. The auditor confirmed that the facility has a Memorandum of Understanding (MOU) with Children Alliance of South Texas (CAST) for detainee reporting and victim advocate services. 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 # 5.1.2-F and KCRC Policy #2.1.1 address the requirements of this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/harassment. KCRC investigators and the Karnes County Sheriff's Department conduct investigations at the facility. The facility investigators were interviewed and found to be very knowledgeable concerning their responsibilities in the investigative process. All allegations are reported immediately to the PSA Compliance Manager, Program Director and on-site ICE staff. The on-site ICE staff have the responsibility of notifying the Joint Intake Center, OPR, and the OIG when necessary.

**§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:**

KCRC Policy #2.1.1 addresses the requirements of this standard. A review of training documents/curriculum, training logs and staff interviews confirmed that all staff received PREA training and that the training included all the mandatory training objectives outlined in the standard. Medical and mental health staff receive specialized training that includes detecting and assessing signs of sexual assault and abuse, preservation of physical evidence, responding effectively and professionally to victims, and how to report sexual abuse. Staff receive initial pre-service training when they are hired and annually thereafter. In addition, staff receives quarterly training and roll call briefings. All staff are also provided with a Sexual Abuse First Responder Duties pocket guide. (Continued on page 10)

**§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:**

**§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:**

KCRC Policy #2.1.1 addresses the requirements of this standard. All contractors and volunteers providing services to the detainees at the facility 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. An interview with a volunteer confirmed she received initial PREA training and refresher 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:

KCRC Policy #2.1.1 addresses the requirements of this standard. During intake, each adult detainee receives the Sexual Abuse and Assault Awareness pamphlet and each juvenile receives "Keeping Safe!" a bilingual guide for teens in pamphlet form. The pamphlet identifies the key elements of the program and informs detainees of the zero-tolerance policy regarding sexual abuse/harassment and multiple ways to report any such incidents. The pamphlet and handbooks are available in English and Spanish. All detainees watch an "Orientation, PREA and Know Your Rights" video. Detainees sign a form acknowledging receipt of the pamphlet and that they have watched the video. (Continued on page 10)

### §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 Policy #5.1.2-D and KCRC Policy #2.1.1 requires the facility investigator receive specialized training, in addition to the general education provided to all employees. The GEO PREA Director attended the Moss Group "Train the Trainers Specialized Training; Investigating Sexual Abuse in Corrections Setting" sponsored by the PREA Resource Center. She then tailored the program for GEO investigators and is the instructor for all GEO investigator training. The facility investigators attended this specialized PREA training. The auditor reviewed the specialized training curriculum, sign-in sheet and interviewed the trainer and 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:

KCRC Policy #2.1.1 addresses the requirements of this standard. GEO has developed very comprehensive training for its medical and mental health practitioners. All mental health and medical staff at KCRC have received the GEO 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 was 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:

GEO Policy# 5.1.2-D and KCRC Policy #2.1.1 outline the requirements of this standard. All detainees are assessed at intake immediately upon arrival at the facility for their risk of being sexually abused or being sexually abusive towards other detainees. The review of medical intake screening documents, Classification Work Sheets and interviews with staff and residents confirm compliance. All new arrivals are assessed within their first 12 hours. Only two families were at the facility for more than 90 days and a reassessment was completed. 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.

### §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:

GEO Policy # 5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. The facility uses in-processing screening instrument (reviewed by auditor) to determine proper housing and other program assignments, with the goal of keeping residents at high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. There were no LGBTI residents housed at the facility during the audit. The average length of stay for residents is 8 days.



**§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:**

**§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:**

KCRC Policy #2.1.1 addresses the requirements of this standard. Per an interview with the Program Director, because KCRC does not have a restrictive housing unit, residents determined to be at high risk for sexual victimization are placed in Medical observation with one-on-one supervision, until appropriate placement is determined. Reviews would be completed after 72 hours. During the last twelve months, no residents were placed in an observation unit on the bases of being vulnerable 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:

GEO Policy #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. A review of documentation and staff/resident interviews indicated that there are multiple ways (verbally; in writing via a letter to ICE, the DHS OIG, or consulate; or, by telephone call to a hot line, anonymously, privately and from a third party) for residents 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.

### §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:

KCRC Policy #2.1.1 addresses the requirements of this standard. Residents are not required to use the informal or formal grievance process to report sexual abuse. Residents also have the option of submitting an emergency grievance. There is no time limit for a resident to submit a grievance regarding sexual abuse. The policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Residents are also able to request assistance from outside sources to complete their grievance. There were no grievances alleging sexual abuse in the last twelve months. The Grievance Officer was interviewed and confirmed compliance with this standard.

### §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 #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. Residents are provided with the Sexual Assault and Abuse Awareness pamphlet and also have access to a poster that provides contact information for local resources that provides support services. The auditor confirmed that the facility has an MOU with the Methodist Hospital and CAST for resident reporting and victim advocate services. Interviews with staff and residents support compliance with this standard.

### §115.54 – Third-party reporting

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

#### Notes:

GEO Policy #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. Procedures for third-party reporting are listed in the Sexual Abuse and Assault Awareness Pamphlet, the Detainee Handbook, and posters which include the OIG telephone number and mailing address. This information is also available on the ICE ERO Detention Reporting and Information Line Web page, OIG Web page, and GEO Web page. Staff and residents 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:

KCRC Policy #2.1.1 addresses the requirements of this standard. Staff interviews confirmed that they were aware of their responsibility to immediately report any knowledge, suspicion, or information about any incident of sexual abuse. They were also aware of the requirement to report retaliation against residents or staff who report or participate in an investigation about sexual abuse, assault or harassment. Staff receive a Sexual Abuse First Responder Duties pocket guide that identifies reporting requirements. Staff may report misconduct outside of their chain of command by calling the OIG or GEO employee hot line. Policy requires the information concerning the identity of the alleged detainee victim and the specific facts of the case be limited to staff who have a need-to-know.

**§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:**

**§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 #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. Staff interviews confirmed that they are aware of their responsibility to immediately take action to protect any resident that they believed is subject to a substantial risk of imminent sexual abuse or harassment. All staff indicated they would act immediately to protect the resident and then call their Supervisor. Security officers are issued a Sexual Abuse First Responder Duties pocket guide outlining all actions to be taken. In the last 12 months, there were no instances in which the facility staff determined that a resident was subject to substantial risk of imminent sexual abuse. Interviews with staff and an examination of policies 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:**

GEO Policy #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. Policy requires that upon receiving an allegation that a resident was sexually abused while confined at another facility, the facility must contact 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 becoming aware of the allegation, and the notification must be documented. An interview with the Program Director and PSA Compliance Manager confirmed their awareness of the requirement. During the audit period, no allegations of sexual abuse were received from a resident while confined at another facility.

**§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 Policy #5.1.2-D addresses 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/abuser, preserve and protect the scene, not allow detainees to destroy possible evidence, and contact their supervisor. The supervisor would continue to protect the detainee by immediately notifying the PSA Compliance Manager. Staff are issued and carry a pocket size Sexual Abuse First Responder Duties card for quick reference and interviewed staff were able to describe all first responder actions if advised that a resident is a victim of sexual abuse. All staff are trained to be first responders. (Continued on page 10)

**§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 Policy #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. Policy establishes written procedures for a coordinated, multidisciplinary team approach to responding to sexual abuse/harassment. In addition to first responders, the team consists of the Program Director, medical and mental health providers, the PSA Compliance Manager, Karnes County Sheriff's Department and, when required, community resources from the local hospital and victim advocacy agency. The facility has established a PREA checklist to aid in their response to allegations of sexual abuse/harassment. Staff interviews confirmed that they were knowledgeable regarding their responsibilities in the coordinated response. No victims of sexual abuse were transferred 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:**

KCRC Policy #2.1.1 addresses the requirements of this standard. Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from their duties requiring detainee contact, pending the outcome of an investigation. Interviews with the Program Director and PSA Compliance Manager 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:**

**§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:**

GEO Policy #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard. The policy prohibits any type of retaliation against any staff or resident who has reported sexual abuse/harassment or cooperated in any related investigation. The facility PSA Compliance Manager is the designated retaliation monitor. The PSA Compliance Manager stated she would follow up on all potential sexual abuse/harassment cases to ensure that the policy is being enforced. There have been no suspected or actual incidents of retaliation in the last 12 months. Staff interviews confirmed they were aware of the prohibition regarding retaliation. Compliance with this standard was determined by a review of policies and staff interviews.

**§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 Policy #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of the standard. A resident that has been placed in protective custody shall not be returned to general population until a proper reassessment, utilizing an Available Alternative Assessment form, has been completed. The Program Director indicated that the resident would be placed in Medical Observation to ensure a supportive environment that represents the least restrictive housing option for their well-being. The Program Director would be notified of all residents placed in protective custody. There have been no residents 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:**

KCRC Policy #2.1.1 addresses the requirements of this standard. The facility investigator conducts administrative investigations within the facility and refers criminal investigations to the Karnes County Sheriff's Department. There were no criminal prosecutions during this auditing period. Interviews with the Program Director and PSA Compliance Manager confirmed that the facility would fully cooperate with any outside agency who initiates an investigation. The facility PSA Compliance Manager serves as the liaison that provides requested information to the outside agency and provides access to the residents housed at the facility.

**§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 #5.1.2-F addresses the requirements of this standard. Administrative investigations impose no standard higher than the preponderance of evidence to substantiate an allegation of sexual abuse or assault. Interviews with the Program Director and the facility investigator confirmed compliance with this standard.

**§115.73 – Reporting to detainees.**

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

**Notes:**

GEO Policy #5.1.2-F addresses the requirements of this standard. The policy indicates that a detainee shall be notified of the result of the investigation and any responsive action taken as a result of an allegation of sexual abuse. There were no reported allegations of sexual abuse by residents in the last 12 months.

**§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 Policy #5.1.2-F and KCRC Policy #2.1.1 addresses the requirements of the standard. Staff are subject to disciplinary or adverse action up to and including removal from their position for substantiated allegations of sexual abuse or violating agency sexual abuse policies. Policy requires the facility to report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies, 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 policies and interviews with the PSA Compliance Manager and Program Director.

**§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 Policy #5.1.2-F and KCRC Policy #2.1.1 addresses 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 last 12 months, there were no incidents where a contractor or volunteer was accused or found guilty of sexual abuse at KCRC. Compliance with this standard was determined by a review of policies and interviews with the PSA Compliance Manager and Program Director.

**§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:**

**§115.71 Criminal and administrative investigations.** Policy does not permit the discipline of residents who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Residents 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 resident's disciplinary history, mental disabilities and mental illness should be considered in all decision-making. (Continued on page 10)

**Notes:**

**§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:**

KCRC Policy # 2.1.1 addresses 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 will 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. There were no detainees identified during their intake to have experienced prior sexual victimization or perpetrated sexual abuse in the last 12 months. (Continued on page 10)

**§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:**

KCRC Policy #2.1.1 addresses the requirements of this standard. Resident 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. Victim advocacy is offered through an agreement with a community provider. There is no financial cost to the resident for any sexual abuse incident-related medical or mental health care or advocacy service, regardless of whether the victim names the abuser or cooperates with the incident investigation. (Continued on page 10)

**§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:**

**§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 Policy #5.1.2-D and KCRC Policy #2.1.1 addresses the requirements of this standard and identifies the process for sexual abuse incident reviews. The review team consists of upper level management, PSA Compliance Manager, and medical and mental health staff. The review team uses a Sexual Abuse or Assault Incident Review form to document the review process. The review team considers whether the allegation or investigation indicates 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, perceived status, or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.

**§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 # 5.1.2- D and KCRC Policy #2.1.1 addresses the requirements of this standard. GEO collects accurate uniform data for every allegation of sexual abuse at facilities under its control using standardized instruments. GEO facilities provide monthly reports and PREA surveys to GEO headquarters. A monthly PREA Incident Tracking log is used to collect and provide the GEO PREA Director data on sexual abuse incidents. All sexual abuse data collected pursuant to these policies is maintained and properly stored and secured. Interviews with the Agency PREA Director and 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 with all relevant documents and conducted private interviews with staff/detainees. Audit notices were posted in all common areas, giving the residents an opportunity to confidentially correspond with the auditor. The auditor did not receive any correspondence from the residents at KCRC.



## ADDITIONAL NOTES

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

115.11 - KCRC has a PSA Compliance Manager who reports to the Warden and has access to the GEO PREA Director. She has sufficient time to complete her duties, was knowledgeable of the PREA standards, and was actively involved in PREA activities. Staff receive initial PREA training and annual refresher training, as well as quarterly training and roll call briefings throughout the year. Security staff are issued a pocket size Sexual Abuse First Responder Duties card to carry for reference. Interviews with staff, volunteers, contractors and residents confirmed that each was aware of the zero-tolerance policy towards all forms of sexual abuse. Review of policies, organization chart, observation of PREA zero tolerance posters during the tour and interviews with staff and residents confirm KCRC is compliant with this standard.

115.13- A PREA Annual Facility Assessment is completed by the PSA Compliance Manager, along with other administrative team members, and forwarded to the GEO PREA Director and Divisional Vice President for review and signature. The audit included an examination of video monitoring systems, unannounced rounds reports, and the PREA Annual Facility Assessment and staff and resident interviews.

115.15 - Staff are required to knock and announce their presence in English and Spanish before opening a door to resident housing rooms. Two staff members are always present when making rounds and only female staff open doors and view inside housing rooms. Staff are not permitted to be in a resident's room with the door closed. The facility does physically search residents for the sole purpose of determining the resident's gender. Based on policy and the design and operation of the facility, the auditor determined that the standard was exceeded.

115.17 - Policy clearly states the submission of false information by any applicant is grounds for termination.

115.31- KCRC is pro-active in informing and stressing the importance of the PREA. Staff are trained to be aware and to not put themselves in a compromising position and, when possible, to work in teams. Based on the frequency of PREA training, the auditor determined, KCRC exceeds this standard's requirements.

115.33 - After the orientation, detainees are asked five questions to ensure they understand the material. The tour of the facility confirmed that PREA posters were prominently displayed in all common areas. Memos are posted identifying the facility's SAAPJ coordinator. A bright orange information sheet regarding PREA reporting is posted by every telephone. Detainees indicated, at the time of arrival, they received information about the PREA, their right to be free from sexual abuse, harassment, retaliation for reporting and multiple ways of how to report abuse. Interviews with staff and detainees, as well as an examination of documentation, confirm compliance with this standard.

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

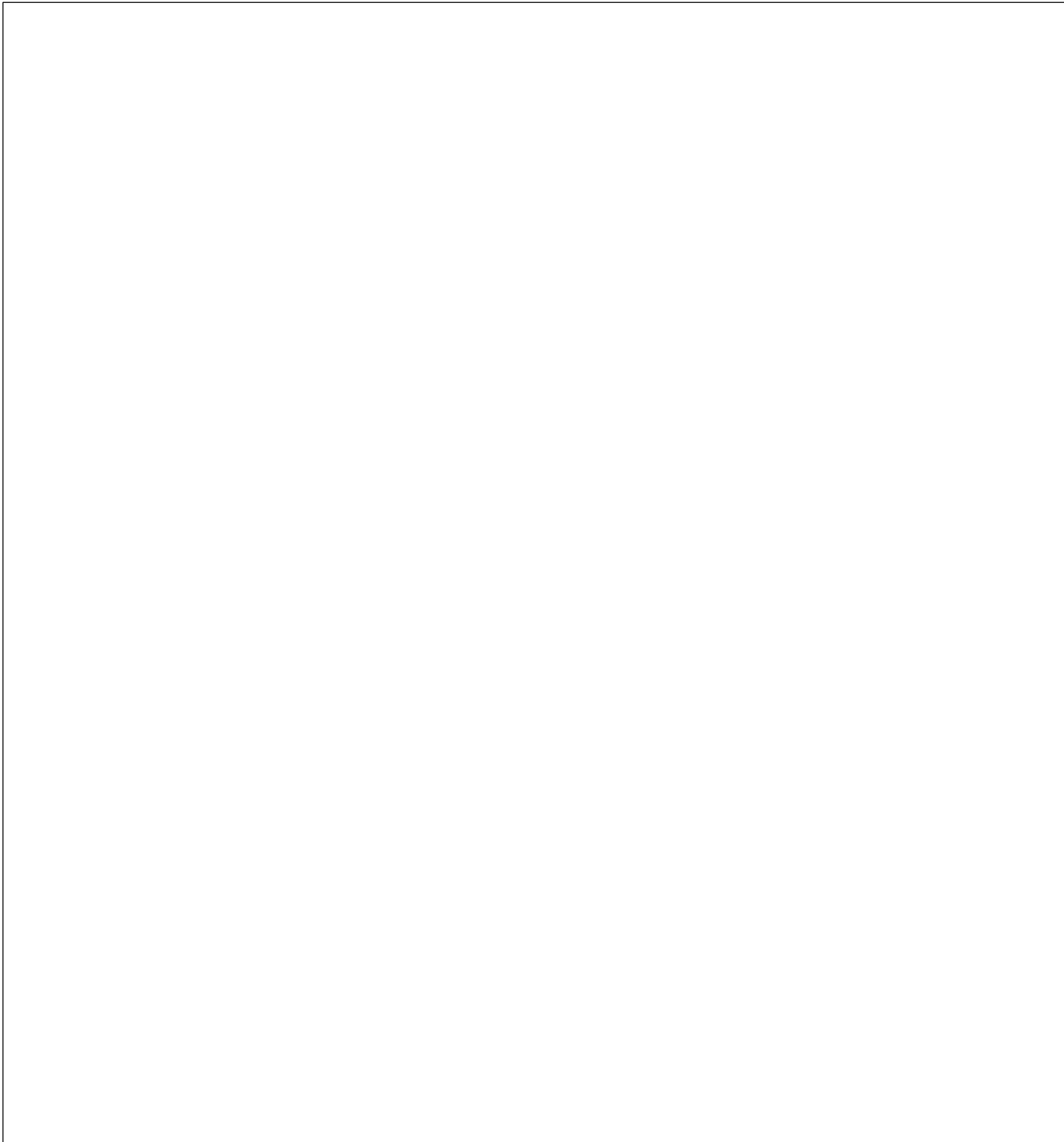
115.78 - Interviews with the Chief of Security and Program Director support a finding that the facility is in compliance with this standard.

115.81 - All information is handled confidentially and interviews with staff support a finding that the facility is in compliance with this standard.

115.82 - Detainee victims of sexual abuse, while detained, are offered timely unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted standards of care. There has been no instance within the last year that required outside services of SAFE/SANE or the community advocacy agency. Compliance with this standard was determined by a review of policy and interviews with medical and mental health staff.

115.83 - There were no allegations of sexual abuse during the audit period and therefore no documents to review. A review of policies and interviews with medical and mental health staff support the finding that this facility is in compliance with this standard.

115.86 - The review is required to be completed within 30 day of the conclusion of the investigation. There were no allegations or investigations of sexual abuse during the audit period and therefore no incident reviews or reports. Interviews with the PSA Compliance Manager and Program Director confirm compliance with this standard.



**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.

*David R. Andraska*  
—  
**Auditor's Signature**

August 17, 2017

**Date**