PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Barbara A. King	**Organization:**	Corrective Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Denver Field Office
Field Office Director:	Jeffrey D. Lynch
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	12445 E. Caley Avenue, Centennial, CO 80111
Mailing address: *(if different from above)*	N/A

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Aurora ICE Processing Center		
Physical address:	3130 N. Oakland Street, Aurora, CO 80010		
Mailing address: *(if different from above)*	N/A		
Telephone number:	303-361-6612		
Facility type:	CDF		
Facility Leadership			
Name of Official/Officer in Charge:	Johnny Choate	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	Sandra Minker	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)

AUDIT FINDINGS

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS:

Directions: Discuss the audit process to include the date of the audit, names of all individuals in attendance, audit methodology, description of the sampling of staff and detainees interviewed, description of the areas of the facility toured, and a summary of facility characteristics.

The Prison Rape Elimination Act (PREA) audit of the Aurora ICE Processing Center (Aurora) was conducted on September 11-13, 2018, by lead auditor Barbara King and team member Dudley Kesler, U.S. Department of Homeland Security (DHS) certified PREA Auditors for Creative Corrections, LLC. The purpose of the audit was to determine compliance with the Department of Homeland Security (DHS) PREA Standards. The Aurora facility is operated by GEO Group Inc. (GEO) and contracted by U.S. Immigration and Customs Enforcement (ICE) for the housing of both adult male and female detainees. This was the first DHS ICE PREA audit of the facility. The audit period covered the previous twelve months from September 2017 through August 2018.

About a month prior to the audit, External Review and Analysis Unit (ERAU) Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form and within folders for ease of auditing. The main policies that provide facility direction for PREA is 5.1.2-D-AUR PREA Sexual Abuse Assault Prevention and Intervention (SAAPI) for Immigration Detention Facilities, 5.1.2-E-AUR Investigating Allegations of Sexually Abusive Behavior (PREA), DHS ICE policy 11062.2 Sexual Abuse and Assault Prevention and Intervention, and Evidence Collection, and the SAAPI Coordinated Response Plan. All the documentation, policies, and PAQ was reviewed by the Lead Auditor. The Auditor communicated with the ERAU Team Lead requesting further documentation for clarification and review on September 5, 2018. Responses to the request was provided on September 6, 2018 by the ERAU Team Lead. Facility staff provided additional documentation during the onsite portion of the audit, and the Auditor also received additional audit documentation materials post audit inspection. The Auditor also reviewed the facility's and GEO's websites. A tentative daily time schedule was provided by the ERAU Team Lead for the on-site audit.

Before the start of the audit, the Auditors met with agency and facility staff. The Team Lead opened the entry briefing at 8:00 A.M. on the first day of the on-site visit. In attendance were:

- (b) (6), (b) (7)(C) Management and Program Analyst, Office of Professional Responsibility (OPR)/ERAU, ICE
- (b) (6), (b) (7)(C) Assistant Field Officer Director (AFOD) ICE / ERO PREA Field Coordinator
- Sandra Minker PSA Compliance Manager, GEO
- (b) (6), (b) (7)(C) PREA Investigator, GEO
- (b) (6), (b) (7)(C) PREA Director, GEO Corporate
- (b) (6), (b) (7)(C) Transport Supervisor, GEO
- (b) (6), (b) (7)(C) Management Information System, GEO
- (b) (6), (b) (7)(C) Training Officer, GEO
- Johnny Choate Warden, GEO
- (b) (6), (b) (7)(C) Assistant Warden Operations, GEO
- (b) (6), (b) (7)(C) Health Services Administrator/ RN, GEO
- (b) (6), (b) (7)(C) Assistant Health Services Administrator/ RN, GEO
- (b) (6), (b) (7)(C) Maintenance Supervisor, GEO
- (b) (6), (b) (7)(C) Major, GEO

Brief introductions were made and the detailed schedule for the audit was covered. The Lead Auditor provided an overview of the on-site audit process and methodology used to demonstrate PREA compliance. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to ascertain whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, additional onsite documentation review, and conducting both staff and detainee interviews. It was shared that no correspondence was received from a detainee, outside individual, or staff member. The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific category) including an alpha and housing listing of all detainees housed at the facility, lists of staff by duty position and shifts, lists of detainees for specific categories to be interviewed, list of staff who perform risk assessments, and a list of volunteers/contractors on-site during the audit.

A facility tour was completed by the Auditors with key staff. All housing units were toured, as well as, program areas, service areas, food service, control center, booking/intake, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or provided services was observed by the Auditors. During the tour, the Auditors made visual observations of the program/service areas and housing units including bathrooms, officers post sight lines, and camera locations. Sight lines were closely examined as was the potential for blind-spots throughout the areas where the detainees are housed or have accessibility. The Auditors spoke to random staff and detainees regarding PREA education and facility practices during the tour. Review of the housing unit log books was conducted to verify staff rounds for security staff and supervisors. Key facility staff during the audit included the Warden, GEO's PREA Director, Major, Prevention of Sexual Assault (PSA) Compliance Manager, and Investigator. All facility staff were very cooperative and informative during the audit process.

The facility was constructed in 2010. It replaced an older, smaller facility which operated for over thirty years until replaced with the new facility. The facility is a single-story building. The facility has a design capacity of 1,108 adults. The custody levels range from high, medium high, medium, and low. The facility houses no juveniles. On the first day of the audit, the facility population was 889; 825 ICE detainees and 64 United States Marshal Service (USMS) offenders. The ICE detainees consisted of 732 males and 93 females. The average detainee population for the last twelve months was 665. The average time in custody is 44 days for male detainees and 43 for female detainees. The top three nationalities of detainee population are Mexico, Honduras, and Guatemala.

Entrance in the facility for staff and visitors is through the front entrance. The facility administrative offices and ICE offices are to the right in the administrative section of the facility. To enter the secure section of the building, entrance is through a sally port adjacent to the control center controlled by the control center. (b) (7)(E)

(b) (7)(E). The housing consists of one dorm and four multiple occupancy housing units all under direct supervision. The three multiple occupancy general housing units (A, B, C) each contain four pods. All pods are constructed in the same lay out. Each pod can house up to 80 detainees. These consist mainly of 4-bed housing cells and two 7-bed housing cells in each pod. Each pod has an open design with the officer's post inside the doorway facing the dayroom and housing cells. One pod of Housing Unit B house female detainees. The windows of the pod facing the unit hallway are frosted to eliminate any viewing into or out of the pod.

The dorm houses 48 low custody female detainees. The officer's post is located inside the doorway facing the beds. There are (b) (7)(E) cameras that cover the dorm (b) (7)(E). The five showers and six toilets all have privacy curtains. Adjacent to the dorm, is a two-cell restricted housing area for female detainees. For this restricted housing area, a phone on a mobile unit is brought to the cell for the detainee to utilize. All the PREA information and phone numbers are attached for easy reference.

The restricted housing unit (E) consists of 48 ICE and 48 USMS single occupancy housing cells. Rounds are verified through a rounds pipe system. Each pipe location must be checked by the officer making rounds. The pipe location is on the farthest wall to ensure staff enter and observe the whole housing unit. There are three showers all with privacy curtains.

There is a sign posted on each housing unit door that states "Opposite Gender Must Announce When Entering." Within each housing area there are cameras, telephones, televisions, shower area, and PREA information on bulletin boards. In each housing areas (pods and dorm), there are two cameras that cover the whole unit that are monitored by the control center. All showers have privacy curtains. Phones are available for the detainees which allows reporting accessibility. Signs are posted above the phones that state "Phone calls are subject to monitoring at all times." PREA information posters/brochures posted on the bulletin boards include the PREA posters, information on correspondence including addresses and numbers, how to report outside the facility, victim services through Blue Bench, and foreign consulates with addresses and phone numbers.

Other holding areas include the intake/processing area and medical. The intake/processing area has five holding cells. There are two large holding cells with a capacity of 77. There are three smaller holding cells with capacity of ten. The holding cells have toilets with privacy curtains, call buttons to the intake desk, benches for seating, and a camera. (b) (7)(E). Detainees do not remain in holding cells longer than 12 hours. The medical area contains nine medical housing cells with one for suicide watch. There are five negative pressure cells. The toilet in each cell, except two, had privacy curtains. Each cell has call buttons. (b) (7)(E) (b) (7)(E) The area is monitored by 24-hour medical staff and an officer.

Areas where detainees work are the kitchen, laundry area, and warehouse. The kitchen is staffed with (b) (7)(E) staff members and about 10-12 detainees. Meals are prepared in the kitchen and delivered to the dayrooms. The coolers and freezers are always locked and opened only by staff. Detainees are directly supervised while in these areas. The kitchen contains (b) (7)(E) cameras and (b) (7)(E) mirrors to assist with the observation of detainees. The laundry area is an open area with no blind spots. The area is usually staffed by (b) (7)(E) staff members with a work force of about eight detainees. There are (b) (7)(E) cameras in the area. The warehouse is staffed with (b) (7)(E) staff member. If a detainee worker is needed, there is authorization for one worker which will be directly supervised. There are (b) (7)(E) cameras in the area.

During the tour, the Auditors identified sight line concerns in two areas of the facility, medical and the female dorm recreation area. Two cells (523 and 527) in the medical area had visible viewing of the toilets within the cells. During the on-site audit, the facility installed a curtain for the toilet in cell 523. For cell 527 which is utilized for suicide watches, a mobile screen was provided to eliminate the chance for cross gender viewing and the practice is to have only the same sex staff member monitor the detainee while on watch. The facility installed a mirror in the recreation area of the female dorm which eliminated the blind spot at the rear of the recreation area. All the concerns were corrected while the Auditors were on site. (b) (5) The facility ordered the mirrors while the Auditors were still on-site and provided a copy of the purchase order.

The facility had a video management system upgrade in October 2017. (b) (7)(E). All housing units have (b) (7)(E) cameras that provide full coverage of the area. (b) (7)(E) (b) (7)(E) The Auditor observed the camera monitoring displays (b) (7)(E). Cameras are placed that allows privacy to the detainees for showering, changing clothes, and performing bodily functions (b) (7)(E)

All required facility staff and detainee interviews were conducted on-site during the three-day audit. Forty-one formal detainee interviews were conducted, and 20 detainees were informally interviewed during the facility tours, (7.4% of the 825 detainee population). Random detainee interviews from different housing units (29), Limited English Proficient (10), and Reported Sexual Abuse History (2) were interviewed. Two detainees refused interviews. Detainees were selected randomly by the Auditor from each housing unit and from the lists provided for the specialized interviews. The detainees with Limited English Proficient were also interviewed utilizing the random questions but are not included in the random interview numbers above. The Auditors utilized Language Services Associates (LSA) through the Creative Corrections LLC contract for translation services for all limited proficient detainees interviewed. The language line was utilized for detainees that spoke Spanish, Hindi, Vietnamese, and Bangladesh.

Interviews were not conducted for Detainees with Disabilities, Who Filed a Grievance, Placed in Segregation Housing for Risk, Transgender/Intersex, and Who Reported Sexual Abuse. The facility did not have any detainees housed that were in these categories. The facility is an adult facility only and does not house juvenile detainees. There were no detainees placed or housed in segregation housing for risk during the audit period. There were no identified transgender/intersex detainees at the time of the on-site audit. All detainees that had reported sexual abuse had been transferred. And no detainee had filed a grievance was still housed.

A total of (b) (7)(E) staff were formally interviewed and additional (b) (7)(E) informal staff interviews were also conducted during the facility tours (38.2% of the (b) (7)(E) staff who may have contact with detainees). Staff were randomly selected from each of the three shift rosters: security staff (b) (7)(E), non-security department staff (b) (7)(E), and an SDDO officer (b) (7)(E) A total of (b) (7)(E) ICE officers interviewed; (b) (7)(E) as random staff interviews and an SDDO officer. Additionally, specialized staff were interviewed including the Warden (1), PSA Compliance Manager (1), First Line Supervisors (b) (7)(E), Medical and Mental

Health (b) (7)(E) Administrative/Human Resources (b) (7)(E) Non-Security Volunteers/Contractors (b) (7)(E) Investigator (b) (7)(E) Training Supervisor (b) (7)(E) Grievance Coordinator (b) (7)(E) Classification Supervisor (b) (7)(E) and Intake staff (b) (7)(E)

There were four allegations reported during the audit period. Of the four allegations, one was staff-on-detainee sexual misconduct and three were detainee-on-detainee sexual abuse. The staff-on-detainee allegation of sexual misconduct was found to be unsubstantiated. The ICE OPR investigated and closed the case. Of the three detainee-on-detainee sexual abuse allegations, two were found unsubstantiated and one substantiated. Two of the allegations were conducted by the facility investigator and one by OPR. All allegations were reported to the Aurora City Police Department (APD) and ICE OPR. The APD did not investigate an allegation but provided case numbers to each allegation. There were no cases referred for prosecution. A review of all four investigations was conducted.

The Auditors also reviewed staff personnel records, staff training records, and detainee files. A detainee intake, risk screening, and classification was observed by the Lead Auditor in the intake/processing area for a new detainee intake. A reclassification process was also observed of another detainee.

An exit briefing was conducted by the Auditors at the completion of the on-site audit. The following participants were in attendance:

- (b) (6), (b) (7)(C) Management and Program Analyst, Office of Professional Responsibility (OPR)/ERAU, ICE
- (b) (6), (b) (7)(C) Assistant Field Officer Director (AFOD) ICE / ERO PREA Field Coordinator
- Sandra Minker PSA Compliance Manager, GEO
- (b) (6), (b) (7)(C) PREA Investigator, GEO
- (b) (6), (b) (7)(C) PREA Director, GEO Corporate
- (b) (6), (b) (7)(C) Training Officer, GEO
- Johnny Choate Warden, GEO
- (b) (6), (b) (7)(C) Assistant Warden Operations, GEO
- (b) (6), (b) (7)(C) Health Services Administrator/ RN, GEO
- (b) (6), (b) (7)(C) Major, GEO
- (b) (6), (b) (7)(C) Programs Manager, GEO
- (b) (6), (b) (7)(C) Regional Manager, GEO Corporate

While the Auditors could not give the facility a final finding per standard, the Auditors did provide a preliminary status of their findings. There were no outstanding issues at the end of the site visit. The Auditors made a few recommendations to the facility administration. A recommendation was to lower the Blue Bench poster on the bulletin boards for easier reading by the detainees. To expand the policy to include the procedural details practiced of how to provide communication options for detainees with disabilities. To place a notice by the telephones that the phone calls to Blue Bench and other reporting agencies are not recorded. The Auditor suggests the facility continue to expand their operating policies and procedures to provide in writing and detail the outstanding procedures demonstrated throughout the audit, which would also provide further written procedural directives for staff. The policies are more policy statements of the standards than procedures.

The Auditors shared with those in attendance the appreciation of the hospitality received and for the professionalism provided by all staff during the visit. The Auditors observed constant interactions between staff and detainees in a positive manner throughout the on-site audit. Those interviewed clearly understood PREA and knew the methods in place to report incidents of sexual abuse/misconduct, if needed. The Auditors shared with the Warden and the facility's administration the positive feedback received from the detainee population regarding the facility's operations, the positive interviews with staff, and the professionalism demonstrated by staff during the audit. The Auditors thanked the Aurora ICE Processing Center, Warden Choate, PSA Compliance Manager, and all the facility staff for their hard work and commitment to the Prison Rape Elimination Act.

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.

Exceeds Standard:

115.11 Zero Tolerance of Sexual Abuse
115.31 Staff Training
115.32 Other Training
115.35 Specialized Training: Medical and Mental Health Care
115.51 Detainee Reporting
115.67 Agency Protection Against Retaliation
115.86 Sexual Abuse Incident Reviews

Meets Standard:

115.13 Detainee Supervision and Monitoring
115.15 Limited to Cross-Gender Viewing and Searches
115.16 Accommodating Detainees with Disabilities and Detainees Who Are Limited English Proficient
115.17 Hiring and Promotion Decisions
115.21 Evidence Protocols and Forensic Medical Examinations
115.22 Policies to Ensure Investigation of Allegations and Appropriate Agency Oversight
115.33 Detainee Training
115.34 Specialized Training: Investigations
115.41 Assessment for Risk of Victimization and Abusiveness
115.42 Use of Assessment Information
115.43 Protective Custody
115.52 Grievances
115.53 Detainee Access to Outside Confidential Support Services
115.54 Third Party Reporting
115.61 Staff Reporting Duties
115.62 Protective Duties
115.63 Reporting to Other Confinement Facilities
115.64 Responder Duties
115.65 Coordinated Response
115.66 Protection of Detainees from Contact with Alleged Abusers
115.68 Post-Allegation Protective Custody
115.71 Criminal and Administrative Investigations
115.72 Evidentiary Standard for Administrative Investigations
115.73 Reporting to Detainees
115.76 Disciplinary Sanctions for Staff
115.77 Corrective Action for Contractors and Volunteers
115.78 Disciplinary Sanctions for Detainees
115.81 Medical and Mental Health Assessments, History of Sexual Abuse
115.82 Access to Emergency Medical and Mental Health Services
115.83 Ongoing Medical and Mental Health Care for Sexual Abuse
115.87 Data Collection
115.201 Scope of Audit

Does Not Meet Standard:

N/A

Not Applicable Standard:

115.14 Juvenile and Family Detainees

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	7
Number of standards met:	32
Number of standards not met:	0
Number of standards N/A:	1

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.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(c): The facility has a written policy 5.1.2-D-AUR PREA Sexual Abuse Assault Prevention and Intervention (SAAPI) for Immigration Detention Facilities mandating zero tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and harassment. The policy provides definitions of sexual abuse and general PREA definitions. Through observation of bulletin boards, posters, educational handouts and materials, review of detainee handbooks, and interviews with staff and detainees it was apparent that the agency and the facility is committed to zero tolerance of sexual abuse, sexual assault, and sexual harassment. Each staff member also carries an informational card that outlines staff responsibilities, zero tolerance, and the first responder requirements. The zero-tolerance policy is publicly posted on the GEO/facility's website.

(d): The facility exceeds the standard with the staff who are responsible to oversee the sexual abuse prevention and intervention policies, procedures, and practices. GEO employs a corporate level PREA Director that oversees the company's PREA compliance throughout all company facilities. Under the PREA Director supervision are three regional PREA Coordinators for the East, West, and Central regions. Their roles are to assist facilities with any PREA technical assistance visits and conduct mock audits. The corporate PREA office also contains one PREA Senior Contract Compliance Manager and two PREA Contract Compliance Managers, and one Data Specialist. The Data Specialist is responsible for collecting and analyzing PREA data and preparing required reports. At the facility level, the PSA Compliance Manager is responsible to oversee that policies and procedures relative to the PREA and ensure facility compliance. The PSA Compliance Manager stated most of her time is related to PREA including making rounds, communication with staff and detainees, reviewing policies and procedures, incident review team duties, and assuring facility compliance of PREA practices. During the interview with the PSA Compliance Manager, she was knowledgeable of the facility's PREA policies and procedures and her responsibilities for coordinating the facility's efforts to comply with the PREA standards. She indicated she coordinates the facility's efforts by reviewing cases, reviewing policy and procedures, and identifying and discussing any PREA concerns. The PSA Compliance Manager was very knowledgeable and active in the audit process. The Auditor determined compliance through the interview with the PSA Compliance Manager, review of facility policy 5.1.2-D-AUR, facility organizational chart indicating the PSA Compliance Manager's position, and the GEO's organizational chart for the corporate PREA Department.

§115.13 – Detainee supervision and monitoring.

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

Notes:

(a): The facility has developed a staffing plan that is supported through policy 5.1.2-D-AUR and staffing rosters. A review of the PAQ indicated the facility's staffing levels is (b) (7)(E) staff that may have recurring contact with detainees. The facility's security staff is comprised of (b) (7)(E) GEO staff; (b) (7) males and (b) (7) females. Security staff work three 8-hour shifts. Sufficient supervision of detainees was observed through on-site observations of security, program, and medical staff supervising and interacting with detainees. The Auditor reviewed daily security shift rosters/assignments for all shifts and determined the facility is ensuring staffing levels are being maintained in accordance with the standard. There is at least (b) (7)(E) assigned officer to each housing unit who provides direct supervision of detainees. The Warden indicated that all posts are filled daily. If there is a staff shortage, coverage is provided through mandatory or volunteer call in overtime. Video cameras operate 24 hours a day, 7 days a week (b) (7)(E). Through the review of the sexual abuse incident reviews, the incident review team reviews staffing levels and were found adequate in all reviews.

(b): Policy 5.1.2-D-AUR and post orders outline the comprehensive detainee supervision guidelines to meet detainee supervision needs. The post orders outline the responsibilities of detainee supervision including random (b) (7)(E) security inspections that are logged in the housing unit assigned logbook by housing unit staff. The duty supervisor is also required to make a round into each housing area at least once per shift which is also logged into the specific housing unit logbook. The Auditor reviewed housing unit logbooks to confirm the practice of rounds and found compliance. The female housing units are staffed only with female staff. The supervision guidelines (post orders) are distributed on an annual basis. The annual review was completed on February 28, 2018 with approval by the Chief of Security and the ICE AFOD. All post orders reviewed by the Auditor have been reviewed and approved within the previous year. During the review of the sexual abuse incident reviews, the incident review team reviews staffing supervision requirements. In one of the incident reviews, it was noted that staff were not making proper rounds that was verified through video viewing. It was addressed through discussion at staff briefing and department head meetings. The practice is monitored through the review of housing unit logbooks by security supervisors, administrative staff, and the PSA Compliance Manager.

(c): The facility has developed a staffing plan that is based on the seven criteria of the standard to include generally accepted detention and correctional practices; any judicial finding of inadequacy; the physical layout, composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the findings and recommendations of sexual abuse incident review reports, and any other relevant factors including but not limited to the length of time detainees spend in facility custody. This process is outlined in policy 5.1.2-D-AUR. The staffing plan was developed by the leadership of the facility including the Warden, Chief of Security, Assistant Warden of Operations, and the facility PSA Compliance Manager with input from the corporate PREA Director. It was noted in the interview with the PSA Compliance Manager that the female detainee population is increasing which requires additional female staff for supervision. The Warden indicated in his interview that the staffing plan is reviewed on a daily basis by the Major, Lieutenants, and Assistant Warden to ensure the safety and security of staff and detainees is maintained. The Warden stated the staffing plan must be contractually approved by ICE and GEO corporate. All posts are filled daily. If there is a staff shortage, coverage is provided through overtime (mandatory or volunteer call in) or utilize part time staff to fill in for a partial shift or whole shift. The last Annual PREA Facility Assessment was completed August 29, 2018. The facility has no

judicial findings of inadequacy. The review indicated the staffing plan was completed; stating no changes were needed and there were no staff deviations. The previous year's review was on September 16, 2017. Based on the review of the staffing plan, staffing rosters, and interviews with the Warden and PSA Compliance Manager the Auditors found compliance.

(d): (b) (7)(E). Housing unit staff make security rounds with no more than (b) (7)(E) between security checks. The Duty Supervisor is required to make a security round at least once per shift. Senior staff and department heads must make security rounds (b) (7)(E) per week. Rounds are made on all three shifts. All rounds are documented in housing unit logbooks in red ink. Through reviews of housing unit logbooks and interviews with staff and detainees, it was confirmed that (b) (7)(E) are done (b) (7)(E). (b) (7)(E) The facility's policy 5.1.2-D-AUR and post orders prohibits staff from alerting other staff members that supervisory staff rounds are occurring. Supervisors also indicated in the interviews that if a staff member was alerting other staff, training would be conducted immediately with the staff member and progressive discipline action could be started on the employee.

§115.14 – Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The Aurora ICE Processing Center does not house juvenile and family detainees. At the time of the audit, there were no individuals housed under the age of 18, all were adults. Review of the PAQ and interviews with the Warden and PSA Compliance Manager confirm the facility does not house juveniles nor family detainee units. If the facility receives a detainee that they determine may be a juvenile; the detainee would be placed in protective custody until ICE conducts an investigation into the actual identity and age of the detainee. The detainee would be transferred to appropriate housing at another ICE facility. This is supported by the facility policy 5.1.2-D-AUR.

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

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

Notes:

(b/c/d) Policy 5.1.2-D-AUR states cross-gender pat searches of male detainees shall not be conducted unless after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Cross-gender pat-down searches of female detainees are prohibited absent exigent circumstances. When exigent circumstances are present, a supervisor will be contacted prior to the search and an incident report will be filed regarding all cross-gender searches. The search will be documented using the Cross-Gender Pat Search Log. Post and shift assignments are completed to ensure that there is always female staff on duty on all three shifts. This was confirmed through review of the shift rosters. Staff interviewed indicated that they had not conducted or were aware of any cross-gender pat-down searches conducted. They indicated that female staff are always present to pat down a female detainee. During the audit year, there were no cross-gender pat-searches conducted. This was supported by a memo to file, PAQ, and interviews. Pat-down searches observed during the audit were conducted by the same sex staff member.

(e/f) Policy 5.1.2.D-AUR outlines cross-gender strip searches or cross-gender body cavity searches shall not be conducted except in exigent circumstances including consideration of officer safety or when performed by medical practitioners. Body cavity searches will only be conducted by medical staff. Interviews with medical staff and security staff confirmed staff are aware of facility protocols for conducting strip or body cavity searches, and if performed shall be approved by a supervisor and documented by incident reports and on the Cross-Gender Pat Search Log. During the audit year no cross-gender strip or body cavity searches were conducted. This was documented through memo to file and interviews. The facility does not house juveniles.

(g) The facility's policy 5.1.2-D-AUR states policy and procedures will allow detainees to shower, perform bodily functions and change clothing without employees of the opposite gender viewing them. Detainees interviewed indicated they felt they had enough privacy to change their clothes, shower, and perform bodily functions. They were not observed by staff of the opposite gender. Staff also confirmed the detainees have privacy for these functions. In the housing units, there are shower curtains in front of all showers and the toilets in the medical housing cells and the intake holding cells observed during the tour. The policy also requires staff of the opposite gender announce their presence when entering detainee housing areas; this was observed during the audit. Announcements are made in English and Spanish. There is a sign posted on each housing unit door that states "Opposite Gender Must Announce When Entering." Detainees interviewed stated that staff of the opposite gender announce when entering the housing unit by loudly stating "male/female in the unit/pod". The detainees also indicated if the staff member does not make the announcement, the housing unit officer makes the announcement. Staff are also provided training on unannounced rounds to help assure compliance with the standard that limits cross-gender viewing. Staff indicated that announcements are made upon entering the housing units.

(h) This section is non-applicable. The facility is not a Family Residential Facility.

(i) Detainees will not be searched for the sole purpose of determining the detainee's genital status. Policy 5.1.2-D-AUR prohibits staff from searching or physically examine a detainee for the purpose of determining genitalia status. The review of the training lesson plans, PREA ICE Facilities and Pre-Service Prison Rape Elimination Act ICE 2017, documented these policies are covered in annual training. During interviews with staff, they were aware of the policy and indicated only medical could conduct such search. No searches have occurred in the audit period per documentation memo and interview with PSA Compliance Manager. There were no transgender or intersex detainees housed during the audit to interview.

(j) Policy 5.1.2-D-AUR states that security staff shall be trained in conducting pat-down searches, cross-gender pat-down searches, searches of transgender and intersex offenders in a professional and respectful manner. Other than annual training, this training is also part of the initial pre-service training and covered in shift briefings. Interviews with the Training Supervisor and staff confirmed these practices, as well as the review of the training lesson plans reinforcing these policies in the annual training, and review of staff training records. A computer print-out provided indicated that (b)(7)(E) staff had completed the required training. When staff were randomly asked how a transgender pat down search would be completed, they indicated the transgender/intersex detainee could request the gender of the officer to conduct the pat-down search and the pat-down would be conducted using the back or blade of the hand.

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

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

Notes:

(a) The facility's policy 5.1.2-D-AUR ensures procedures to provide disabled detainees have equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Staff during interviews explained the steps that would be taken to effectively communicate with disabled detainees when necessary. Detainees who are deaf or hard of hearing would be provided the facility and the ICE Detainee handbooks and access to interpreters who can interpret effectively, accurately, and impartially. The Intake Staff interviewed stated a sign language translator would be utilized through a video conference line. Detainees who have limited reading skills or blind would have staff read the materials to them. They would also be able to listen to the PREA Video. The facility also provides written materials in formats or through other methods for effective communication with detainees with intellectual disabilities and mental health staff would explain and ensure that the detainee comprehends the information. The orientation video is available in Spanish and English. The ICE Detainee Handbook is available in English and Spanish. The facility has a contract with Language Line Services Inc. for interpretation services. A copy of the contract was provided for documentation. The facility also has bilingual staff on all three shifts. There were no detainees identified that had disabilities during the on-site audit to interview. The Auditor recommended to expand the policy to include the procedural details practiced of how to provide communication options for detainees with disabilities.

(b) DHS/ICE PREA posters in English and foreign languages, containing the name of the facility PSA Compliance Manager are posted throughout the facility, including on all bulletin boards in the housing units. Also, posted in the housing units are ICE ERO Language Line posters and contact information for victim advocacy services through the local rape crisis center, Blue Bench. The PREA Educational video is available in Spanish and English. The ICE National Detainee Handbook includes a section (language identification guide) in the front of the handbook which outlines multiple languages to assist detainees who do not speak English or Spanish. During the audit, ten interviews were conducted with limited English proficient detainees. The language line was utilized for detainees that spoke Spanish (7), Hindi (1), Vietnamese (1), and Bangladesh (1). The detainees indicated they were provided information through interpreters, the ICE Detainee Handbook, and facility postings; except for the Hindi detainee indicated he did not receive a handbook. He did receive PREA information through the interpretation line. They also indicated they knew how to report and indicated they would report to an officer or the hotline. These detainees indicated they received PREA education through written materials (handbook and posters) in their language, they know how to report, and staff was able to assist when requested. In most cases, they would go to an officer for assistance if needed. Those limited English proficient detainees formally interviewed and others interviewed during the facility tour, all indicated they have received the PREA information and knew how to report if needed. The Intake Staff interviewed stated the detainees are provided written materials in a language they understand through handbooks, the language line when needed for interpretation, and the video played in two languages. The Auditor observed a detainee intake where a staff interpreter and the language line were utilized to communicate PREA education material and conduct the risk screening. The detainee was provided the ICE Detainee Handbook in Spanish. The Auditor recommended to expand the accessibility to handbooks in other languages than English and Spanish to detainees in their language of choice, including Hindi. The facility indicated they would print a handbook in Hindi for the detainee. The Auditor finds the standard compliant through interviews with limited English proficient detainees, the handbooks available in multiple languages and the facility availability to print in languages not readily accessible, and the use of the language line for interpretation services.

(c) The policy 5.1.2.D-AUR states that minors, alleged abusers, detainees who witnessed the alleged abuse and detainees who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of sexual abuse. The facility has a contract with Language Line Services Inc. for translation services effective February 1, 2011. A copy of the contract was provided for documentation. The facility also has bilingual staff on all three shifts. This allows multiple methods that allow detainees to communicate by someone other than another detainee. Staff interviewed indicated a detainee would request a staff member for translation or the use of the language line. The detainees interviewed with limited English proficiency indicated they would communicate with a staff member for the need of a translation services or have another detainee that spoke English tell an officer the need for the services.

§115.17 – Hiring and promotion decisions.

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

Notes:

(a/b/d) Through review of policy 5.1.2-D-AUR, it was determined that the facility has established a system of conducting criminal background checks for new employees, contractors, and volunteers who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The job application form requires the employee to answer questions of: have not engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution and have not been civilly or administratively adjudicated or convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to refuse. The form was updated in March 2018 with the three questions. These forms are utilized for new hires and promotions. The Human Resources staff interviewed indicated this information is also checked on all applicants as part of the hiring process during the background stage. The facility will contact prior institutional employers to obtain information on substantiated allegations of sexual abuse or any resignation during an investigation. The facility utilizes a third-party company, Career Builder, for background checks. Background checks are also conducted through ICE prior to an employee or contractor being approved for hire or a volunteer approved to provide services. During a training session on September 25, 2018, the Unit Chief – OPR Personnel Security Unit (PSU) explained that all ICE and contract employees must clear a background investigation through PSU before hiring or promoting any staff or contractor who may have contact with detainees. The contractor or staff complete an e-QIP and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE; if it is a contract employee, the office informs the contractor that the employee cannot perform work on behalf of ICE. The Unit Chief explained the sexual misconduct questions are asked of the potential employee as part of the e-QIP. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a supervisor. The continuing affirmative duty to report is also accomplished annually during the annual performance review of employees. They must complete an acknowledgement form containing the questions prior to the completion of the evaluation. The Auditors randomly selected (b) (7 employee files to review for the administrative adjudication check (the three questions) on the application form or as part of the hiring process paperwork and the background check prior to hiring. The employee files were in compliance.

(c) Policy 5.1.2-D-AUR requires a background investigation and criminal background record check for all new hires to ensure the candidate is suitable for hiring. A background and criminal background record check will be repeated for all employees at least every five years. The Human Resource staff interviewed indicated the facility utilizes a third-party company, Career Builder, for background checks. Background checks are also conducted through ICE prior to an employee being approved for hire and again within five years. The Auditors randomly selected (b) (7) employee files to review for the criminal background checks prior to hiring; all were completed prior to the hiring date. The Auditor provided (b) (7)(E)t employee names (b) (7) GEO and (b) (7) ICE) to OPR the Personnel Security Unit (PSU) to verify background checks were completed within five years. All were completed within the five-year period except for (b) (7)(E). These employees were hired prior to the PREA standards effective date; however, background checks have been completed since the effective date of the standard just not within the five years of the original background check. During a training session on September 25, 2108, the Unit Chief – OPR Personnel Security Unit (PSU) explained that all ICE and contract employees must clear a background investigation and as part of the continuous evaluation program a background check will be conducted every five years to ensure an employee's retention is clearly consistent with the interests of the agency and national security.

(e) The employment application contains a statement indicating the applicant agrees not to falsify or omit information. If the applicant does falsify or omit information, employment can be denied, or the person will be subject to immediate termination. The Human Resource staff interviewed confirmed the wording on the application and that a person would not be hired or terminated for falsifying information. During the review of the employee personnel files, the wording was verified on the employee application forms. The policy 5.1.2-D-AUR also states and supports the practice.

(f) Policy 5.1.2-D-AUR indicated the facility shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work, unless prohibited by law. The Human Resource staff interviewed stated all information requests, internal and external, are forward to corporate for response. The information will be provided through the corporate office.

§115.18 – Upgrades to facilities and technologies.

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

Notes:

(a) The facility was constructed in 2010, no expansions or modifications have occurred at the facility. A memo to file and the interview with the Warden confirms no expansions or modifications have occurred. Policy 5.1.2-D-AUR indicates the facility will take into effect any design planning, modifications or expansions to protect detainees from sexual abuse.

(b) The facility had a video management system upgrade in October 2017. (b) (7)(E) (b) (7)(E). All housing units have (b) (7)(E) cameras that provide full coverage of the area. (b) (7)(E). The cameras are monitored through (b) (7)(E). (b) (7)(E) An interview with the Chief of Security provided the information regarding the video system upgrade. The Chief of Security and Warden indicated PREA was considered during the planning process for the upgrade consideration. The administrative staff walked the facility to identify blind spots. Consideration was then given to identified blind spots and areas that may have high risk for additional camera coverage. A copy of the contract was provided for documentation.

§115.21 – Evidence protocols and forensic medical examinations.

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

Notes:

(a) The facility begins investigations immediately following an allegation. The allegations are also reported to the APD and ICE, including to the AFOD and ICE staff at the facility for investigation and further action. If the investigation is not conducted by the APD or ICE, the facility will complete the investigation by a specialized trained investigator. Staff indicated that almost all of the PREA allegations are investigated through OPR or Office of Inspector General (OIG). Of the four allegations, two were investigated by ICE OPR. Policy 5.1.2-D-AUR outlines the facility's evidence and investigation protocols of the allegation. Agency policy 11062.2 outlines the agency's evidence and investigation protocols. The facility utilizes the Department of Justice (DOJ's) National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents 2nd Edition for the uniform evidence protocol as indicated by the PSA Compliance Manager. The protocols are incorporated into the facility's SAAPI Coordinated Response Plan. The SAAPI Coordinated Response Plan provides an extensive guideline for staff to follow for investigations and/or referring an allegation for investigation. The protocols are approved by GEO Corporate and ICE as part of the annual policy review. The facility does not house juvenile detainees. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel in accordance with OPR policies and procedures. The OPR will coordinate with the FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation.

(b/d) The facility has a memorandum of understanding (MOU) agreement with Blue Bench, the community rape crisis center and victim advocacy services. The MOU outlines that Blue Bench will provide immediate advocacy, support and crisis intervention via a published hotline; have a qualified advocate respond in person to the facility or other locations as requested to provide additional advocacy, emotional support, and information to victims; provide up to three follow-up visits and continued individual advocacy and support to victims at the facility; inform the victim of the option for a victim advocate to be present during the medical examination and investigative interviews; answer victims' questions about the forensic exam and accompany the victim during the exam if desired; provide all of the above specified services without cost to the facility; and communicate any questions or concerns to designated PREA Compliance Manager and facility office. The MOU was executed on March 30, 2018 with annual renewals. The interview with the PSA Compliance Manager indicated that the services are free of charge to the detainee and the hotline is available 24-hours a day for the detainees. The hotline number and victim advocacy services are provided to the detainees on a poster on the housing units bulletin boards. The PSA Compliance Manager also indicated that each alleged victim is provided a Blue Bench pamphlet and the Sexual Abuse and Assault Awareness brochure and must sign acknowledging receiving the information. The Auditor interviewed a Blue Bench staff member after the on-site audit. The staff member confirmed the services provided by the center, the staff member could not provide the number of instances services were provided to the facility. The facility also has a MOU with the Denver Health Medical Center executed October 24, 2013 for sexual assault emergency services that includes medical and forensic nursing services, counseling, and other appropriate care deemed necessary.

(c) All alleged victims of sexual assault who require a forensic exam are taken to Denver Health Medical Center for completion of the forensic exam and emergency medical healthcare with no cost to the detainee. The facility has an MOU with the hospital for SANE services and agrees to comply with the provisions set forth in the Prison Rape Elimination Act of 2003. The services are available through the emergency department 24-hours a day 7 days a week. The medical staff interviewed indicated all detainee victims would be transported to Denver Health Medical Center where a SANE staff are on-call. The Auditor interviewed the Correctional Care Coordinator at Denver Health Medical Center after the on-site audit. The Coordinator confirmed the medical services including forensic exams provided by the hospital. It was noted that if a SANE nurse is not on duty, a SANE nurse on-call would report. There were no alleged victims from the four allegations that required forensic or emergency medical services.

(e) All allegations are reported to the APD and ICE, including to the AFOD and ICE staff at the facility for investigation and further action as indicated by interviews with the PSA Compliance Manager and the Investigator. The facility does have a MOU with the APD. The MOU outlines all the requirements of the standard. The PSA Compliance Manager stated that APD always assigns the incident a case number. To date, the APD has not investigated a case. Upon review of the investigation files, notifications were made to the APD and case numbers were assigned. Notifications were also to the AFOD and ICE OPR. Two investigations were completed by ICE OPR.

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

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

Notes:

(a/d) Policies 5.1.2-D-AUR and 5.1.2-E Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection state all allegations are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations. A staff member will report the allegation to a supervisor who will make the required notifications which begins the investigation process. The facility will document all investigation referrals. The allegations are referred to the APD and ICE, including to the AFOD and ICE staff at the facility for investigation and further action. The Investigator stated that OPR will review all cases to determine if an investigation is required by the agency. All allegations involving staff are investigated by OPR. Agency policy 11062.2 outlines the agency's evidence and investigation protocols. Once the investigation allegation is reviewed and accepted by the agency OPR investigator, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If the investigation is not conducted by the APD or ICE, the facility will complete the investigation by a specialized trained investigator. The facility does have a MOU with the APD. The MOU outlines all the requirements of the investigation. Upon review of the investigation files, notifications were made to the APD and case numbers were assigned. Notifications were also made to the AFOD and ICE OPR. Of the four allegations, two investigations were completed by ICE OPR and the other two by the facility. The Warden stated the facility follows the SAAPI Coordinated Response Plan which includes the notification to the PSA Compliance Manager and Investigator who start the administrative investigation immediately. They will continue the investigation until another agency begins the investigation. If the investigation is completed by an outside entity, the facility will conduct their own administrative investigation at the conclusion of a criminal investigation where the allegation was substantiated.

(b) The SAAPI Coordinated Response Plan outlines the responsibility of the facility and other investigative agencies. Policy 5.1.2-D-AUR addresses the responsibilities and requirements for investigation. The PSA Compliance Manager indicated that her role and the Investigator's is to assist as requested during an investigation as requested by an outside investigative entity. Contact would occur at least monthly to remain informed of the progress of the investigation. The policy also states that all data including investigations shall be securely retained for at least ten years or longer. The PSA Compliance Manager indicated that all investigations are maintained for at least five years in hard copy, also stored electronically. An older case was reviewed to ensure compliance with the required time frame.

(c) On the GEO website, www.geogroup.com/PREA, is a webpage dedicated to PREA. The webpage contains the company's policies 5.1.2-D and 5.1.2-E for public information. The page also contains the zero-tolerance policy, how to report sexual abuse or sexual harassment, and how an employee may report sexual abuse or sexual harassment. There is a paragraph that explains the investigation process that states if the allegation potentially involves criminal behavior, GEO will ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations. The policy 5.1.2-E-AUR also provides the protocols for sexual abuse investigations. The ICE website, www.ice.gov/prea includes information on the agency's PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE Detainee Handbook, ICE PREA poster and ICE PREA pamphlet.

(e/f) Policies 5.1.2-D-AUR and 5.1.2-E-AUR require that all incidents are promptly reported to the Joint Intake Center (JIC), ICE OPR, and/or DHS OIG, as well as, the appropriate ICE Field Office Director (FOD) if the incident is potentially criminal and a staff member, contractor, volunteer or detainee is alleged to be the perpetrator of sexual abuse. The SAAPI Coordinated Response Plan has a list of required notifications that includes the ICE after Hours Duty Office who will make the required notifications to the agency. The Investigator stated all notifications are made to the agency, APD, and GEO Corporate. The review of the four investigation cases confirmed that notifications are made to the appropriate agency and facility staff.

§115.31 – Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a/b/c) The facility's policy 5.1.2-D-AUR and training curriculum Sexual Abuse and Assault Prevention and Intervention (PREA) address all the PREA requirements and outlines the training requirements. Training records, staff interviews, and the training curriculum review indicated the training includes the zero tolerance policy; definitions and examples of prohibited and illegal sexual behavior; right of detainees and staff to be free from sexual abuse and from retaliation for reporting of prohibited and illegal sexual behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional signs of sexual abuse and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees; and requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. The initial training occurs at the academy, each staff member attends the academy pre-service training prior to being assigned to the facility. The training is also provided annually through the annual in-service training for all staff. Each employee is required to attend in-service annually. Additional training occurs during staff briefing with different PREA topics refreshers. Staff during interviews acknowledged the numerous methods they received training. The Pre-Audit Questionnaire indicated all staff had completed training. After interviews with the PSA Compliance Manager, the Warden, and the Training Supervisor, it was determined all facility staff have received training. A selection of staff training records was reviewed; all had completed the pre-service training and annual in-service. The Training Supervisor also provided electronic training Completion Status Detail Report for the annual PREA ICE Facilities

and PREA Cross-Gender Searches classes documenting all staff completion of required training. All training is maintained in the facility's training database, Learning Management System, for each employee. Staff document the completion of training through a signature on the Basic Training Acknowledgement Form. Each staff member is provided and must carry the PREA Staff Responsibility Card; that outlines general PREA information and first responder duties. The facility exceeds the training standard by requiring all staff to complete annual training instead of the standard's two-year requirement, refresher training at staff briefing, and the PREA informational card carried by staff.

§115.32 – Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) All contractors and volunteers who have contact with detainees receive PREA training prior to assuming their responsibilities. The commissary, mental health, and telephone services are provided by contractors. Volunteers are utilized for religious services, life skills instructors, victim advocates, and English as Second Language instructors. Policy 5.1.2-D-AUR and lesson plan ICE Prison Rape Elimination Act (PREA) Training for Contractors and Volunteers cover the PREA training requirements of volunteers and contractors. This training includes the agency's policy and procedures regarding sexual abuse and sexual harassment prevention, detention, and response; their roles and responsibilities in sexual abuse prevention, detection, and intervention; reasons why and situations where sexual abuse and/or assault may occur; examples of barriers to detainee reporting; zero tolerance; first responder requirements; reporting methods and requirements; and PREA definitions. Interviews were conducted with (b) (7)(E) contractor and (b) (7)(E) volunteers when interviewed stated the training is conducted in a classroom setting with the use of a power point presentation, video, and discussion. They were knowledgeable on PREA, their responsibilities for reporting, the reporting process, who to report to, and the agency's zero tolerance policy. They indicated they would report to a security officer, security supervisor, and their direct supervisor immediately. The training is conducted by the facility's training officer and Lieutenant. Training records were reviewed and confirmed the training.

(b) Policy 5.1.2-D-AUR states training for volunteers and contractors will be held annually. The annual training was conducted on April 12, 2018. This was confirmed through the interviews with the volunteers and contractors and review of the training files. (b) (7)(E) volunteer indicated that training sometimes occurs twice a year and when changes occur refresher training is provided. The facility exceeds the standard by providing annual training and refresher training as needed to all volunteers and contractors.

(c) Policy 5.1.2-D-AUR states that all staff document through signature the understanding of the training received. Volunteers and contractors document the completion of training through a signature on the Basic Training Acknowledgement Form. Training records are maintained by the Training Supervisor. Training records of four contractors and volunteers were reviewed and documented compliance.

§115.33 – Detainee education.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a/e/f) The facility provides a comprehensive PREA education to the detainee population beginning at intake into the facility. The facility policy 5.1.2-D-AUR address the PREA education requirements for detainees at intake. At intake into the facility, staff provide detainees information through the facility's Detainee Handbook, ICE Detainee Handbook (readily available in English and Spanish; other languages are obtainable if needed); PREA pamphlet Sexual Abuse and Assault Awareness, the Detainee Orientation Video, and verbally explained by the intake staff during processing. During the intake process, the Detainee Orientation Video is playing that includes PREA information. The Intake Staff interviewed indicated the video is played on a loop in each of the holding cells. The video and handbooks include information on sexual abuse prevention, sexual abuse reporting, sexual abuse treatment and counseling, and the grievance process. The video is available in English and Spanish. The PREA pamphlet Sexual Abuse and Assault Awareness is available in Spanish and English. The auditor observed the education provided to a detainee during the intake process. Intake staff utilized a staff interpreter and the language line to communicate the PREA education to the detainee with the detainee signing acknowledging receiving the handbooks and pamphlet. During the audit period, 4,551 detainees were booked at the facility. Based on the intake process the auditor observed, all detainees receive the PREA information during the intake process. The random detainees interviewed acknowledged receiving education on the same day as intake into the facility through the video, handbook, and postings on the walls. The Auditors also during the tour viewed DHS/ICE PREA posters in English and foreign languages, containing the name of the facility PSA Compliance Manager posted throughout the facility, including on all bulletin boards in the housing units. Also, posted in the housing units are ICE ERO Language Line posters and contact information for victim advocacy services through the local rape crisis center, Blue Bench.

(b/d) The ICE Detainee Handbook is available in English and Spanish. Staff during interviews explained the steps that would be taken to effectively communicate with disabled detainees when necessary. Detainees who are deaf or hard of hearing would be provided the handbook and access to interpreters who can interpret effectively, accurately, and impartially. The Intake Staff interviewed stated a sign language translator would be utilized through a video conference line. Detainees who have limited reading skills or blind would have staff read the materials to them. They would also be able to listen to the PREA Video. The facility also provides the written materials and video to detainees with intellectual disabilities and mental health staff would explain and ensure that the detainee comprehends the information. The orientation video is available in Spanish and English. The facility has a contract with Language Line Services Inc. for translation services. DHS/ICE PREA posters in English and foreign languages, containing the name of the facility PSA Compliance Manager posted throughout the facility, including on all bulletin boards in the housing units. Also, posted in the housing units are ICE ERO Language Line posters and contact information for victim advocacy services through the local rape crisis center, Blue Bench. During the audit, ten interviews were conducted with limited English proficient detainees. The detainees indicated they were provided information through interpreters, ICE Detainee Handbook, facility postings, and peers. They also indicated they knew how to report, and they would report to an officer or the hotline. These detainees indicated they received PREA education through written materials in their language, they know how to report, and staff was able to assist when requested. In most cases, they would go to an officer for assistance if needed. Those limited English proficient detainees formally interviewed and others interviewed during the facility tour, all indicated they have received the PREA information and knew how to report if needed. The Intake Staff interviewed stated the detainees are provided written materials in a language they understand through handbooks, the language line when needed for translation, and the video played in two languages. The Auditor observed a detainee intake where a staff interpreter and the language line were utilized to communicate PREA education material and conduct the risk screening. The detainee was provided a handbook in Spanish.

(c) The detainees sign acknowledging the receipt of the handbooks and PREA pamphlet during the intake process. Nineteen detainee files were reviewed for documentation of PREA information provided during the intake process and showed compliance. All orientation was conducted on

the day of intake and documented through signature of the detainee. Policy 5.1.2-D-AUR also outlines the requirement of maintaining documentation of detainee participation.

§115.34 – Specialized training: Investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a/b) The facility's policy and lesson plan PREA Specialized Training Investigating Sexual Abuse in Adult/Juvenile Correctional Settings reflects that investigators are to be trained in conducting sexual abuse investigations in confinement settings. The specialized training lesson plan including sections on identifying how trauma can affect a victim's cooperation in an investigation; forensic medical exam process; role of the victim advocates; best practice and policy requirements on evidence collection in confinement settings; understanding of Miranda and Garrity; techniques for interviewing and interrogating during investigations of sexual abuse; criteria required for administrative action and prosecutorial referral; and what a final investigative report should contain. The facility has (b) (7)(E) specialized trained investigators who have completed the general PREA training and the required specialized training for investigators. The specialized training is a four-hour training block. The training was conducted on February 13, 2018. The specialty training was verified through the interviews with the PSA Compliance Manager and the Investigator and review of the training records including training certificates and training attendance record form with signatures. The agency provides investigation training through the Lesson Plan Investigating Incidents of Sexual Abuse and Assault Training. The OPR Criminal Investigator who completed an investigation had completed the training on May 21, 2014 as documented through an agency training spreadsheet of all trained investigators. The spreadsheet lists the specialized trained investigators with the completion date of the training.

§115.35 – Specialized training: Medical and mental health care.
Outcome: Exceeds Standard (substantially exceeds requirement of standard)
Notes:

(a) There are no ICE Health Services Corps. (IHSC) staff working at the facility making this section non-applicable. The medical staff are employees of the facility and the mental health staff are contractors. The healthcare staff receive specialized training for sexual abuse and sexual assault, lesson plan Specialized Medical and Mental Health PREA Training. As required by policy 5.1.2-D-AUR which states all full-time medical and mental health practitioners who work regularly in the facility shall receive specialized training in addition to the general training mandated for employees. The facility exceeds the standard by providing specialized training to the healthcare staff which is not required by the standard for facility employees.

(b/c) Although the facility does not have IHSC staff or required to comply with section B of the standard, the facility is in compliance with the specialized trained full-time medical and medical health staff that are employees of the facility. The policy 5.1.2-D-AUR and training lesson plan Specialized Medical and Mental Health PREA Training outline that training will include detecting signs of sexual abuse and assault; preserving physical evidence of sexual abuse; responding professionally to victims of sexual abuse; and proper reporting of allegations or suspicions of sexual abuse and assault. Training records were reviewed showing compliance of health care staff completing specialized training and the general PREA training. The Training Supervisor also provided a Completion Status Detail Report for the specialized training showing the completion of training of all healthcare staff. The interviews with mental health and medical staff stated staff must complete PREA pre-service training when hired and then complete annual in-service. The specialized training is an on-line course. Healthcare staff do not conduct forensic exams. All alleged victims of sexual assault who require a forensic exam are taken to Denver Health Medical Center for completion of the forensic exam and emergency medical healthcare with no cost to the offender. The facility has an MOU with the hospital for SANE services and agrees to comply with the provisions set forth in the Prison Rape Elimination Act of 2003. The services are available through the emergency department 24-hours a day 7 days a week. The medical staff interviewed indicated all detainee victims would be transported to Denver Health Medical Center where SANE staff are on-call. Policy 5.1.2-E-AUR has been reviewed and approved by the Chief of Security and ICE FOD as part of the annual policy review noted on the front page of the policy.

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

(a/b) The screening process for the risk of victimization and abusiveness are outlined in the policy 5.1.2-D-AUR. This screening occurs at intake into the facility with the use of the Aurora ICE Processing Center Processing Risk Assessment Tool developed by GEO. The policy requires that each new arrival will be kept separate from the general population until the detainee is classified and may be housed according. The initial classification process and housing assignment shall be completed within 12-hours of admission. This risk screening is conducted for all detainees during intake into the facility by the classification staff. This screening assists with determining a detainee's vulnerability or tendencies of acting out with sexually aggressive behavior. Random interviews with detainees indicated the screening occurred prior to the placement in general population. Most detainees indicated it was completed within 12-hours from admission. The Auditors reviewed 19 random detainee files selected by the Auditors, including the files of the detainees who indicated the screening was not completed within the proper timeframe. All files documented the risk screening occurring within 12 hours of admission and completed prior to the detainee being transferred to general population housing. Classification staff stated that detainees are asked about housing placement and if they have a concern for their safety. If the detainee is identified at high risk of sexual victimization or a potential sexual abuse victim, the detainee is referred through the PREA Referral Form to the PSA Compliance Manager, medical, and mental health for further screening. The detainee will be seen by a committee for determination of housing placement.

(c/d) The auditor observed the intake process including the classification staff completing the PREA Risk Assessment Tool and intake staff providing PREA orientation information to the detainee. At the arrival to the facility, the classification staff completes the PREA Risk Assessment Tool as part of the intake paperwork process. The PREA Risk Assessment Tool conforms to the PREA standard requirements. The screening forms includes questions regarding mental, physical, and developmental disabilities; age of the detainee; physical build of the detainee; whether the detainee has been previously incarcerated; whether the detainee's criminal history is exclusively nonviolent; whether the detainee has prior convictions against an adult or child; whether or not the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether or not the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concern about his/her physical safety. The tool has 17 questions to assess the detainee's risk for victimization and risk of abusiveness. Information is provided through interview with the detainee and Form I-213 Record of Deportable/Inadmissible Alien provided at intake by ICE staff. (b) (7)(E). (b) (7)(E)

(b) (7)(E) [redacted]

. The detainee signs the tool acknowledging the answers are correct. A detainee that scores at risk are referred to mental health. There are also targeted questions that would require a referral to mental health if there is a yes response. The Classification Supervisor indicated that if a detainee self-identifies as transgender or intersex, a referral to medical is made. The detainee is housed in medical until the Transgender Care Committee reviews for safety concerns and housing placements. During the random detainee interviews, most detainees indicated they remember being asked these questions on the day of their arrival. The Auditors reviewed the PREA Risk Assessment Tools within the detainee files and found all files compliant and risk assessments completed within the appropriate timeframes.

(e) A classification officer will reassess the detainee's risks of victimization and abusiveness between 60-90 days from the date of the initial assessment and any other time when warranted based on any additional, relevant information or following an incident of abuse or victimization as stated in policy 5.1.2-D-AUR. The reassessment is conducted using the GEO PREA Vulnerability Reassessment Questionnaire. The average time in custody is 44 days for male detainees and 43 for female detainees. Of the 19 detainees' files reviewed, four detainees were held for a timeframe that required a reassessment. The reassessments were completed within the appropriate timeframes.

(f) Through review of policy 5.1.2-D-AUR and confirmed through staff interviews, disciplining detainees for refusing to answer or not providing complete information in response to certain screening questions is prohibited. The Classification Supervisor and PSA Compliance Manager stated the detainee does not have to answer questions and can refuse. Information from Form I-213 Record of Deportable/Inadmissible Alien would be utilized for information as much as possible. The detainee would be housed in medical until a further review is completed. If not completed the day of arrival, it would occur the next day.

(g) Policy 5.1.2-D-AUR and staff interviews confirmed appropriate controls have been implemented to ensure that sensitive information is not exploited by staff or other detainees. The Classification Supervisor indicated the Risk Screening Tool is in the detainee's medical file which are maintained in a lock cabinet in the administrative area for active files and files of released detainees are secured in the property room. Other than classification staff, the only other staff with access is the intake staff, medical, mental health, and PSA Compliance Manager. Information is shared with appropriate staff (medical, mental health, and supervisors) on a need-to-know basis to make security and management decisions.

§115.42 – Use of assessment information.

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

Notes:

(a) The facility's policy 5.1.2-D-AUR address the assessment process and the use of the screening information to determine housing, recreation, voluntary work, and other activities to ensure the safety of the detainee. If the detainee is identified at high risk of sexual victimization or a potential sexual abuse victim, the detainee is referred through the PREA Referral Form to the PSA Compliance Manager, medical, and mental health for further screening. The detainee will be seen by a committee for determination of housing placement. The PSA Compliance Manager maintains an At Risk Log of potential victims and potential abusers determined from the Intake PREA Risk Screening Tool. The PSA Compliance Manager stated the log will include current housing locations and will be used to assist in making housing placements. During the site visit, the auditor observed the classification officer completing the risk assessment process with a detainee, the detainee score did not identify the detainee at risk and general housing was assigned. The interviews with the Classification Supervisor and PSA Compliance Manager indicated that housing and program assignments are made on a case by case basis with consideration of custody level and PREA risk factors. In review of completed risk assessments in the detainees files, the Auditor determined the facility is utilizing collected data, such as the detainees physical characteristics (build and appearance), age, whether the detainee has mental, physical or development disability, previous assignment in specialized housing, alleged offense and criminal history, whether the detainee is perceived to be Lesbian/Gay/Bi-Sexual/Transgender/Intersex (LGBTI) or is gender non-conforming to determine housing, recreation, work, and other activity decisions. Through staff interviews and observing a classification, it was determined that the facility addresses the needs of the detainee consistent with the security and safety of the individual detainee.

(b) The facility's policy 5.1.2-D-AUR indicates that staff shall consider the detainee's gender self-identification and make housing assignments for a transgender and/or intersex detainee on a case-by-case basis based on the detainee's health and safety. When a detainee self-identifies during the intake process, the detainee is housed in medical until the Transgender Care Committee meets with the detainee and reviews any concerns. A referral is also made to medical and mental health. The detainee may be housed up to 72 hours in medical until an appropriate housing determination is made by the Transgender Care Committee. The Transgender Care Committee meeting will occur within 72 hours, but staff stated it is usually within 24 hours. The Committee considers the detainee's criminal history and past/present behavior; physical, mental, medical, and special needs; self-assessment of the detainee's safety need; privacy issues including showering and housing; and all records and assessment including medical and mental health. The Committee will complete the Transgender Care Committee Summary Form which provides housing placement decisions and lists any safety concerns. The Transgender Care Committee is comprised of the Warden or Assistant Warden, Classification or Case Management, Medical, Mental Health, and PSA Compliance Manager. The Committee may consult with the PREA Coordinator at GEO Corporate. The Classification Supervisor indicated the committee will meet with and reassess the transgender detainee every 60 days utilizing the PREA Vulnerability Reassessment Questionnaire. At the time of the on-site audit, there were no transgender or intersex detainees housed. The Auditor reviewed a transgender detainee file of a detainee that was released. The file contained the risk assessment, notes from the Transgender Care Committee, housing placement, and the reassessment of the detainee within the appropriate timeframe.

(c) Transgender and intersex detainees have the opportunity to shower separate from other detainees. Interviews with the Classification Supervisor and PSA Compliance noted that transgender/intersex detainees may shower in the housing unit or medical based on the detainee's option. If the dorm or housing unit is selected, the detainee is placed in the shower area with no other detainee around, this is usually at a scheduled time. The Auditor noted during the tour all showers have privacy curtains, which would provide privacy to the detainee. The detainee may opt to go to medical for showering which is an individual shower stall with a curtain. Policy 5.1.2-D-AUR supports this practice.

§115.43 – Protective custody.

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

Notes:

(a/b) Policy 5.1.2-D-AUR outlines the written procedures for protecting a detainee that is vulnerable to sexual abuse or assault. This policy was approved by the Chief of Security and ICE FOD during the annual policy review. The policy indicates that a detainee shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exists, as a last resort. All such placements are documented on DHS Sexual Assault/Abuse Available Alternatives Assessment Form, detailing the reasons for placement of a detainee in administrative segregation on the basis of vulnerability to sexual abuse or assault. The Warden stated a detainee would not be placed in administrative segregation unless there was no other option. The detainee would be moved as soon as possible and within 72 hours, although the policy states up to 30 days. He also noted that there were no placements in the past year. A memo to file and the PAQ also reflected there were no instances within the audit period. There were no detainees that were placed in segregation housing for risk of sexual victimization to interview.

(c) The policy 5.1.2-D-AUR direct that if a detainee is placed in segregation housing for protective custody, the detainee would have access to programs, visitation, counsel, and other services to the extent possible. The Warden and Chief of Security indicated detainees maintain all program, privileges, and services available to the general population detainees; unless warranted through a disciplinary case. If a restriction would occur, it would be based on a discipline case and would be documented through that an incident report and disciplinary process.

(d) Policy 5.1.2-D-AUR states a supervisory staff member will conduct a review within 72 hours of the detainee's placement into administrative segregation to determine whether segregation is still warranted. The review includes an interview with the detainee. The review will be documented on the DHS Sexual Assault/Abuse Available Alternatives Assessment Form indicating the decision made and the justification. A supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in administrative segregation, and seven days thereafter for the first two months and every ten days thereafter. The Chief of Security indicated each review will include an interview and a completed DHS Sexual Assault/Abuse Available Alternatives Assessment Form. The DHS Sexual Assault/Abuse Available Alternatives Assessment Form will be reviewed and signed by the Facility Administrator or Assistant Facility Administrator upon completion. There were no instances to review.

(e) Per policy 5.1.2-D-AUR the facility is required to notify the appropriate ICE FOD no later than 72-hours after the initial placement into administrative segregation on the basis of a vulnerability to sexual abuse or assault for review and approval of the placement. The PAQ indicated and the Warden stated, the facility has not had an instance where a detainee was placed into administrative segregation. The Warden was knowledgeable on the procedures for placing a vulnerable detainee into administrative segregation for protection and the notification process to ICE.

§115.51 – Detainee reporting.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) The facility has established procedures allowing for multiple internal and external ways for detainees to report sexual abuse, retaliation, staff neglect, and violations of responsibilities that may have contributed to such incidents. PREA reporting methods are shared with detainees at intake including through the facility's Detainee Handbook, ICE Detainee Handbook, PREA pamphlet Sexual Abuse and Assault Awareness, the Detainee Orientation Video, and verbally explained by the intake staff during processing. Reporting information is also available on the DHS/ICE PREA posters in English and foreign languages, containing the name of the facility's PREA Compliance Manager posted throughout the facility, including on all bulletin boards in the housing units. The Auditors during the tour viewed information on reporting methods posted on the bulletin boards in the housing units. Detainees can report verbally and in writing to facility staff; report through the grievance process; utilize third party reporting; through a Detainee Request Form or Medical Request for Services; call the DHS OIG toll-free hotline; verbally and in writing to ICE/ERO staff member; request and submit grievance to ICE/ERO; call the facility reporting line 9116#; letter to the Office of Inspector General; call to the Blue Bench victim advocate group; and call or write a Consular Official. The Warden also showed the Auditors tablets in the housing units that detainees may use to email staff including reporting an incident. The facility's Detainee Handbook, ICE Detainee Handbook, PREA pamphlet Sexual Abuse and Assault Awareness, and posters outline the reporting methods available to the detainee population. During the formal detainee interviews the detainees acknowledged receiving information on how to report at intake, in the handbooks, and on posters. They were able to identify reporting methods including telling a staff member, call the DHS OIG toll-free hotline writing a grievance, and/or telling family or friend. Also, during the informal interviews with detainees while touring the facility, they indicated they knew the reporting process and felt comfortable reporting to a staff member. There were four allegations during the audit time frame; two were reported to security staff, one through a grievance, and one through a kite to mental health. An Auditor tested the hotline during the tour. These reporting methods were demonstrated through review of policies and procedures, detainee handbooks, posters throughout the facility, review of investigation files, and interviews with detainees and staff. The facility exceeds the standard in the numerous methods the detainees can report internal and external.

(b) Detainees may report outside the facility to an entity that is not part of the facility by calling the DHS OIG toll-free hotline, write a letter to DHS Joint Intake Center, or call the Blue Bench victim advocate group. The facility's Detainee Handbook, ICE Detainee Handbook, PREA pamphlet Sexual Abuse and Assault Awareness and posters provide information to the detainee on how to report anonymous. There is a poster posted by the phone that provides toll-free phone numbers to numerous outside agencies including Consulates, ICE, community organizations, national rape crisis line, advocacy organizations, and the American Bar Association. The DHS OIG PREA poster provides a hotline and states calls can be made anonymously and confidentially. The detainee may report anonymously by phone by pressing 9 on the telephone and entering 000000# as the pin number. This number would not identify a detainee. The PSA Compliance Manager indicated anonymous reports could be made through the phone system, by writing a kite to staff or medical, and by third party. During the interview with a Blue Bench representative, it was stated any information regarding an allegation would be reported to the facility unless the victim has requested to stay anonymous. Upon review of the investigation files, no allegations were reported outside the facility.

(c) Staff indicated through interviews they were aware of the methods available to them to report sexual abuse allegations. Staff were also knowledgeable on the methods the detainees could report to staff and their responsibility in the process. Staff acknowledged through interviews that they would report immediately any allegation to a supervisor and document it through an incident report. Policy 5.1.2-D-AUR indicates that staff shall be allowed to privately report sexual abuse to the Chief of Security or upper level executive if requested. The reporting requirements and process is provided to staff through training, policy 5.1.2-D-AUR, and the PREA Staff Responsibility Card. During the audit time frame, two allegations were reported to security staff who reported it immediately as documented in the investigation files.

§115.52 – Grievances.

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

Notes:

(a/b) The facility's policy 5.1.2-D-AUR and Detainee Handbook addresses the administrative procedure for detainee grievances regarding sexual abuse. The facility does not impose a time limit for the submission of a grievance regarding an allegation of sexual abuse. A detainee can file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or compliant. The Grievance Coordinator stated there were no time limits for a grievance regarding an allegation of sexual abuse. The handbook states there is no time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. There is a locked grievance mailbox in each housing unit.

(c) The facility's policy 5.1.2-D-AUR and Detainee Handbook provides written procedures and timeframes for handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. If the grievance is a substantial risk of imminent sexual abuse to the detainee, it is handled as an emergency grievance. The grievance is forwarded to the Warden or designee for immediate corrective action to protect the alleged victim. An initial response to the emergency grievance is required within 48 hours and a final decision within five calendar days. Although the Grievance Coordinator indicated there were no grievances within the audit time period and the PAQ indicated two, there was only one grievance regarding an allegation of sexual abuse. This grievance was received on November 7, 2017 and referred for investigation on the same day. The detainee housing unit was changed, and referral was made to mental health. There were no detainees available to interview, the detainee who submitted the grievance was no longer housed at the facility. The Grievance Coordinator indicated that an emergency grievance would be handled as soon as possible and within 24-hours.

(d) Policy 5.1.2-D-AUR states staff will take grievances regarding an allegation of sexual abuse and medical emergencies to the immediate attention of proper medical staff for further assessment. The Grievance Coordinator indicated in the interview that first contact would be to the PSA Compliance Manager and Shift Commander; then medical would be contacted. The Detainee Handbook indicates the detainee will be offered protection, receive a medical examination, and offered mental health counseling. One grievance regarding an allegation of sexual abuse was received during the audit period. The detainee was seen by medical and mental health the same day the grievance was received. This was documented in the investigation file.

(e) The facility's policy 5.1.2-D-AUR and Detainee Handbook provides written procedures and timeframes for handling grievances. The facility shall issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. The policy also indicates that the facility shall send all grievances related to sexual abuse and the facility's decisions to the appropriate ICE FOD. The one grievance was forwarded to ICE FOD. ICE OPR investigated and closed the case on February 2, 2018 with an unsubstantiated disposition. The Auditor reviewed the process within the investigation file.

(f) The facility's policy 5.1.2-D-AUR and Detainee Handbook indicates that detainees may obtain assistance in preparing a grievance including from another detainee, staff, family members, attorneys, and outside advocates. The random detainees interviewed were not aware that assistance could be utilized or requested. This information is provided to the detainees in the handbook. The random staff interviews were inconsistent in their responses. Of the (b) (7) random staff interviews, (b) (7)(E) staff were aware of assisting detainees and indicated they would contact their supervisor, case manager, or PSA Compliance Manager for direction. The other (b) (7)(E) staff (56%) were not sure if assistance was allowed or how to provide assistance. The Auditor suggests that the facility provide a refresher on this section of the standard to staff.

§115.53 – Detainee access to outside confidential support services.

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

Notes:

(a/b) The facility's policy, 5.1.2-D-AUR states the facility shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to most appropriately address victim's needs. The facility has accomplished this with a partnership documented through a MOU with Blue Bench for victim advocacy services. The MOU outlines that Blue Bench will provide immediate advocacy, support, and crisis intervention via a published hotline; have a qualified advocate respond in person to the facility or other locations as requested to provide additional advocacy, emotional support, and information to victims; provide up to three follow-up visits and continued individual advocacy and support to victims at the facility; inform the victim of the option for a victim advocate to be present during the medical examination and investigative interviews; answer victims' questions about the forensic exam and accompany the victim during the exam if desired; provide all of the above specified services without cost to the facility; and communicate any questions or concerns to designated PSA Compliance Manager and facility office. The MOU was executed on March 30, 2018 with annual renewals. The interview with the PSA Compliance Manager indicated that the services are free of charge to the detainee and the hotline is available 24-hours a day for the detainee. The Auditor interviewed a Blue Bench staff member after the on-site audit. The staff member confirmed the services provided by the center. The facility also has a MOU with the APD for investigations. The PSA Compliance Manager indicated that the APD would refer a case to the Adams County Prosecutor's Office for prosecution if warranted. The PSA Compliance Manager is the contact for both MOUs. The role would be the liaison for the facility to remain informed of the progress of the case being investigated.

(c) The facility provides detainees information about local and national organizations that can assist detainees who have been victims of sexual abuse. Victim advocacy service information is provided to the detainees on posters on the housing units bulletin boards and in the Detainee Handbook. There is a poster posted by the phone that provides toll-free phone numbers to numerous outside agencies including the national rape crisis line and advocacy organizations. The Blue Bench poster provides the continuum of care services available through the agency, 24-hour hotline numbers in English and Spanish, and an address. The Auditors observed the posters during the tour. The PSA Compliance Manager also indicated that each alleged victim is provided a Blue Bench pamphlet and the Sexual Abuse and Assault Awareness brochure and must sign acknowledging receiving the information. Most detainees interviewed were not aware of outside support services available to them. Two female detainees during the tour stated they received emotional support services through the telephone from the person listed on the bulletin board (Blue Bench). However, the facility provides this information in multiple ways to the detainees including the Detainee Handbook and posters throughout the facility. The Auditor suggested to lower the Blue Bench poster on the bulletin boards to an area easier to read.

(d) Policy 5.1.2-D-AUR and the Detainee Handbook address the confidentiality and the extent to communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. There is a posting above the housing unit phones that state all telephone calls at the facility are subject to being recorded. The Detainee Handbook states the calls to the sexual assault advocacy group are not recorded and in accordance with Colorado Revised Statutes (CRS), the victim advocate may report the incident to other

agencies with the consent of the victim. The Blue Bench poster indicates all calls can be anonymous. The detainees may press 9 on the telephone and enter 000000# as the pin number to report anonymous. Also, the handbook informs detainees that staff members are required to keep the reported information confidential and only discuss it with the appropriate officials on a need-to-know basis. The Sexual Abuse and Assault Awareness pamphlet states information concerning your identity and the facts of your report will be limited to only those who need to know. The PSA Compliance Manager stated the hotline numbers are not monitored. The interview with the Blue Bench staff member stated the agency would only report the information to the facility if the detainee consented. The Auditors suggested that a notice be posted that informs the detainees to the extent the phones are monitored including that hotline numbers for sexual abuse reporting are not monitored.

§115.54 – Third-party reporting
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

Policy 5.1.2-D-AUR states that third-party reporting information will be posted publicly on GEO's website. GEO's website provides information regarding reporting sexual abuse. The site states "to report an allegation of Sexual Abuse/Sexual Harassment on behalf of an individual who is or was housed in any GEO facility or program or if you were previously housed in a GEO facility or program and need to report an allegation of sexual abuse/harassment, you may contact the Facility Administrator's Office in the facility where the alleged incident occurred or where the individual is housed. Please see our Locations page for each facility's contact information. Reports can be made over the phone, in person, in writing or anonymously if desired. You can also contact our Corporate PREA Coordinator." A phone number and address are provided. Information is provided in the facility lobby on the DHS OIG, PREA, and GEO Third Party posters with phone numbers to call. Third-party individuals have the option to contact the facility, GEO Corporate, or DHS OIG. There were no third-party reports this audit period.

§115.61 – Staff reporting duties.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a/b) Policy 5.1.2-D-AUR states all employees are required to report immediately in accordance with facility and corporate policy any knowledge, suspicion, or information regarding sexual abuse that occurred in the facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Employees are required to report to designated supervisors or officials. The supervisor will report the incident to ERO. The policy was approved by the Chief of Security and the ICE FOD during the annual policy review. Reporting requirements are covered in the annual in-service training, pre-service training, and shift briefings for all staff. Specialized and random staff interviews confirm that staff are knowledgeable in their reporting duties, the process of reporting, and to whom to report. Random staff interviewed indicated they would report immediately to their supervisor and the PSA Compliance Manager and then write an incident report. This reporting information is provided on the staff's PREA Staff's Responsibility Card also. Staff can report privately outside the chain of command by utilizing the facility's employee hotline, calling the corporate PREA Coordinator, reporting to the Chief of Security, and reporting to upper level executives. During the interviews, most staff indicated they would report privately through the hotline or call the corporate PREA Coordinator.

(c) The policy 5.1.2-D-AUR states that staff are not to reveal any information related to a sexual abuse report to anyone other than the extent necessary to protect the safety of the detainee or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, and other security and management decisions. Reporting requirements including confidentiality are covered in the annual in-service training, pre-service training, and shift briefings for all staff. Staff interviewed indicated information would only be shared with the supervisor and other staff on a need-to-know basis.

(d) Policy 5.1.2-D-AUR addresses the language of the standard stating the facility would report to designated state or local service agencies under applicable reporting laws. The facility does not house juvenile detainees. The PSA Compliance Manager stated if an alleged victim is a vulnerable adult the incident would be reported to APD and any designated state and local agencies under mandatory reporting laws. The Warden indicated that all mandatory reporting laws would be followed and, also would notify ICE and the corporate office.

§115.62 – Protection duties.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

The policy 5.1.2-D-AUR requires that if a staff member has reasonable belief that a detainee is subject to substantial risk of imminent sexual abuse, the staff member will take immediate action to protect the detainee. Staff interviewed indicated they would take immediate action to protect the detainee by separating the detainee from other detainees and maintain in a safe location. Then report the incident to the supervisor for further action and write an incident report. These responsibilities are covered in the annual in-service training, pre-service training, and shift briefings for all staff. The Warden stated a PREA investigation would be assigned, a change in housing may occur, and immediate medical and mental health referrals would be made. All staff interviewed knew the steps to take to protect a detainee at risk for sexual abuse; to immediately separate the detainee from the area to keep the detainee safe and separate from other detainees; notify the supervisor; and write an incident report. Through the review of investigation reports, it appeared that the alleged victims were removed from the area immediately to a safe location and an investigation was started.

§115.63 – Report to other confinement facilities.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a/b) Policy 5.1.2-D-AUR requires upon receiving an allegation that a detainee was sexually abused while confined at another facility, the Facility Administrator or Assistant Facility Administrator (in the absence of the Facility Administrator) will notify the Facility Administrator or designee of the facility where the alleged abuse occurred. Notification will also be made to the ICE FOD. The notifications should take place as soon as possible, but no later than 72 hours after receiving notification. The Warden indicated that the notifications would be made immediately to the other facility and ICE. He also indicated there were no instances this audit period, as noted on the PAQ also. There were no allegations reported at the facility that occurred at another facility during the audit period.

(c) The notifications will be documented. Copies of the notifications are forwarded to the PSA Compliance Manager and Corporate PREA Coordinator. The interview with the PSA confirmed the practice, as well as, policy 5.1.2-D-AUR.

(d) The PSA Compliance Manager interview further indicated, if the facility was to receive notification from another facility of an allegation of sexual abuse that occurred at the facility, an investigation would immediately be initiated. Notification would also be made to the ICE FOD. This is supported by policy 5.1.2-D-AUR.

§115.64 – Responder duties.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) Policy 5.1.2-D-AUR clearly specifies the detailed procedures for security and non-security staff when responding to an allegation of sexual abuse. The first security staff member to respond to the report is required to separate the alleged victim and abuser; immediately notify the on-duty security supervisor and remain on scene until relieved by responding personnel; preserve and protect the crime scene; and ensure the alleged victim and alleged abuser to take no action to destroy evidence. It states the alleged victim and abuser should be placed in separate dry cells or areas to protect evidence. A security staff member of the same sex will be placed outside the cell or area for direct supervision. Through interviews with supervisors and random staff it was demonstrated that staff was knowledgeable in the steps as a first responder: to separate the alleged victim and abuser; preserve and protect the crime scene; and request the alleged victim and alleged abuser to take no action to destroy evidence and contact a supervisor. First responder responsibilities are covered in the annual in-service training, pre-service training, and shift briefings for all staff. The first responder responsibilities are also outlined on the PREA Staff's Responsibility Card carried by all staff. During the review of the investigation files, it documented that staff took the appropriate steps when notified of an allegation. Of the four allegations, two were reported to a security staff member, one through a kite to mental health, and one through a grievance. There were no detainees that reported sexual abuse identified to interview, they were no longer housed in the facility.

(b) Policy 5.1.2-D-AUR also outlines that if the first responder is not a security staff member, the staff shall request that the alleged victim not take any actions that could destroy physical evidence, and then notify a security staff member. The random non-security staff interviewed indicated they would contact a security staff member immediately and request the detainee not to destroy any evidence. They also stated they would remain with the alleged victim until a security staff member arrived.

§115.65 – Coordinated response.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a/b) The facility has created a written institutional plan to coordinate actions taken by the multidisciplinary team including first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse, the Aurora Detention Center SAAPI Coordinated Response Plan. The facility also utilizes the PREA Response Checklist for Incidents of Sexual Abuse to document the activities of staff including first responders, medical and mental health, investigator, PSA Compliance Manager, and notifications made including dates and times of all the activities. The PREA Response Checklist covers the activities from when the allegation is reported through retaliation monitoring. Coordination with staff is started through notifications and staff reporting to handle the appropriate activities under their responsibilities. This is supported through policy 5.1.2-D-AUR which also states the PSA Compliance Manger is a required participant and the Corporate PREA Coordinator may be consulted as part of the coordinated response. The Warden indicated the SAAPI Coordinated Response Plan is covered at pre-service, in-service, and staff briefing training. The Auditor reviewed the checklist for the investigations reviewed.

(c/d) Policy 5.1.2-D-AUR addresses the reporting requirements if a victim of sexual abuse is transferred between DHS Immigration Detention Facilities and a non-DHS facility. The facility shall, as permitted by law, inform the receiving facility of the incident and victim's potential need for medical or social services. The only exception is to a non-DHS facility, a victim can request information not be shared. The Warden stated the facility would be informed through email or a call by the PSA Compliance Manager to the facility's PREA staff and followed up with the Notification of PREA Incident Form. He stated the full investigation may be shared if requested at the most and at the minimum details about the incident and the victim's need for medical or social services. There were no instances of transfers during this audit period. The Auditor suggests the facility expand the policy to include ICE Holding and ICE Staging Facilities to encompass all of ICE facilities.

§115.66 – Protection of detainees from contact with alleged abusers.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

Policy 5.1.2-D-AUR states employees, contractor, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any "no contact" orders shall be documented. It also states that GEO shall not enter into or renew any collective bargaining agreement or other agreement that limits the facility's ability to remove alleged employee sexual abusers from contact with any detainee pending the outcome of an investigation or a determination of whether and to what extent discipline is warranted. The Warden stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact detainee post until the investigation is completed. If the case was substantiated, the staff member would be terminated. A volunteer's clearance would be revoked allowing no contact with the facility until the investigation is completed. Also, noted by the Warden and the PAQ there were no instances where a staff member, volunteer or contractor was removed for allegations of sexual abuse. Two staff were terminated for contraband.

§115.67 – Agency protection against retaliation.
Outcome: Exceeds Standard (substantially exceeds requirement of standard)
Notes:

(a) The facility's policy 5.1.2-D-AUR states that that no employees, contractors, volunteers, and detainees shall retaliate against any person, including a detainee who reports, complains about or participates in an investigation into an allegation of sexual abuse. The policy designates the PSA Compliance Manager or Mental Health personnel as the staff member to monitor retaliation. The Warden and PSA Compliance Manager indicated the PSA Compliance Manager is responsible for monitoring detainees. Policy states the facility human resource staff or investigator would monitor staff. Staff is informed of protection from retaliation through training in pre-service and in-service. Of the four cases this audit period, monitoring was conducted on one case. The other three victims were released prior to the beginning of monitoring and the completion of the investigation.

(b) Policy 5.1.2-D-AUR identify protective measures that can be taken including housing changes, removal of alleged staff abusers from contact with victims, and emotional support services for detainees and employees who fear retaliation. The Warden indicated protective measures would be taken immediately and an investigation would be started. The PSA Compliance Manager stated any allegation involving a staff member, the staff member would be moved to a non-detainee post during the investigation for retaliation. She also expanded that emotional support services offered to staff

would be through Employee Assistance Program (EAP) and for detainees through Blue Bench. The one case monitored, the detainee had a housing change as a protective measure. There were no detainees identified for interviews, they were no longer housed at the facility.

(c) Policy 5.1.2-D-AUR outlines the monitoring timeframes. For detainees, the PSA Compliance Manager shall meet weekly with the detainee. The meetings will be documented on the Protection from Retaliation Log with any notes or issues discussed. The detainee/alleged victim must sign the form acknowledging the monitoring contact. Staff will be monitored every 30 days for at least 90 days and documented on the Protection from Retaliation Log. Once completed, the log will be retained in the investigation file. The retaliation monitoring will be for at least 90 days; however, the time frame can be extended if warranted. Monitoring shall terminate if the allegation is determined unfounded. The one monitoring case the detainee was seen weekly until released; with four weeks documented. The facility exceeds the standard with weekly monitoring of detainees and the detailed narrative provided of the monitoring visits. Although the standard does not indicate the frequency of monitoring contacts. The facility conducts the monitoring contacts weekly which exceeds the average contacts conducted in the correctional field as observed by the Auditor. The Warden and PSA Compliance Manager provided the following that would be monitored that may suggest retaliation is occurring: grievances, hotline calls, discipline, housing changes, programs changes, change in detainee behavior, monitoring of phone calls and mail, program participation, and input from staff. The PSA Compliance Manager was very knowledgeable of the monitoring responsibilities. There were no monitoring cases extended beyond the 90 days for this audit period.

§115.68 – Post-allegation protective custody.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) Policy 5.1.2-D-AUR states that detainee victims shall be placed in a supportive environment that represents the least restrictive housing option possible subject to the requirements of 115.43. The PSA Compliance Manager stated if the detainee still feels safe in general population, a housing change would be made with a separation order. If the detainee does not feel safe, the detainee would have to request protective custody. The PSA Compliance Manager and the PAQ noted that the facility has not placed any detainees in protective custody in the past twelve months. There were no detainees identified to interview.

(b) Policy 5.1.2-D-AUR states no detainee shall be held for longer than five days, except in unusual circumstances or at the request of the detainee. The PSA Compliance Manager stated the detainee could be held up to five days, however, the general practice would be to find appropriate housing within 72 hours and transfer the detainee from protective custody. This may be a housing change with a separation order or a facility transfer.

(c) Policy 5.1.2-D-AUR directs that a reassessment shall be completed on a detainee victim in protective custody before returning to general population. The reassessment will take into consideration any increased vulnerability of the detainee as a result of the sexual abuse. The PSA Compliance Manager stated the reassessment would be completed by her and she would also place the detainee on the At Risk Log.

(d) Policy 5.1.2-D-AUR requires the facility to notify the appropriate ICE FOD when a detainee has been held in protective custody for 72 hours. The Warden stated the notification would be made immediately verbally to the FOD followed by an email notification.

§115.71 – Criminal and administrative investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) Policies 5.1.2-D-AUR and 5.1.2-E-AUR Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection state all allegations are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations. The allegations are referred to the APD and ICE, including to the AFOD and ICE staff at the facility for investigation and further action. The Investigator stated that OPR will review all cases to determine if an investigation is required by the agency. All allegations involving staff are investigated by OPR. The facility does have a MOU with the APD. The MOU outlines all the PREA requirements must be followed during an investigation. If the investigation is not conducted by the APD or ICE, the facility will complete the investigation by a specialized trained investigator. The facility has (b) (7)(E) specialized trained staff members, the investigator and the PSA Compliance Manager. The policy states investigations shall be conducted promptly, thoroughly, and objectively for all allegations. The Investigator and PSA Compliance Manager both stated that investigations are started immediately as soon as reported and are objective based on evidence. The Investigator stated the PREA Response Checklist is utilized during the investigation process. The review of the investigations showed that investigations are started promptly; three were started the day reported and the other one the following day.

(b) The Warden stated the facility follows the SAAPI Coordinated Response Plan which includes the notification to the PSA Compliance Manager and Investigator who start the administrative investigation immediately. They will continue the investigation until another agency begins the investigation. The PSA Compliance Manager stated the APD would guide the investigators through the crime scene. If the investigation is completed by an outside entity, the facility will conduct their own administrative investigation at the conclusion of a criminal investigation where the allegation was substantiated. The PSA Compliance Manager stated an administrative investigation would be started with ICE approval. The Investigator shared that the APD is notified of all allegations and to date they have not investigated a case. They provide a case number to the case when notified. Policy 5.1.2-E-AUR states an administrative investigation shall be conducted within 30 days of the conclusion of a criminal investigation where the allegation was substantiated. Within 30 days of the conclusion of a criminal allegation determined unsubstantiated, the facility will review any available investigation reports to determine whether an administrative investigation is necessary or appropriate. The administrative investigations shall be conducted after consultation with the appropriate investigation office within DHS or DOJ and the assigned criminal investigative entity.

(c) Policy 5.1.2-E-AUR contains a section titled Investigative Reports that outline all the items required for investigations as listed in the standard. It also states an investigation report shall be written for all investigations of sexual abuse utilizing the investigative report template, PREA Investigation Report. The template outlines all the requirements as listed in the standard. The template format includes the following sections Executive Digest Summary; Background; Summary of Significant Interviews; Other Investigative Effort/Information/Data; Summary of Investigative Findings; Staff Failure Analysis; and Attachments. The review of investigation files noted that the template format was followed with the required elements of the standard. The PSA Compliance Manager and Investigator shared that the following information and evidence would be collected: statements, interviews, evidence, logbooks, video footage, forensic evidence from the hospital, telephone calls, and review of detainee history. Of the four allegations, two investigations were completed by ICE OPR and the other two by the facility.

(e) Policy 5.1.2-E-AUR states the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. The Warden, PSA Compliance Manager, and Investigator shared that the investigation would continue until completion. Three of the investigations were completed after the alleged victim was released.

(f) Policy 5.1.2-E-AUR states the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. The facility shall request copies of completed investigative reports. Upon receipt, the investigative report will be forwarded to the Corporate PREA Director for review and closure. The PSA Compliance Manager indicated that her role and the Investigator's is to assist as requested by an outside investigative entity during an investigation. The Investigator stated cooperation would include providing copies of reports, interviews, and evidence and would make detainees available for interviews. The PSA Compliance Manager would be the contact with the outside investigative agency to remain informed of the progress of the investigation; the contact would occur at least monthly.

There were four allegations reported during the audit period. Of the four allegations, one was staff-on-detainee sexual misconduct and three were detainee-on-detainee sexual abuse. The staff-on-detainee allegation of sexual misconduct was found to be unsubstantiated. The ICE OPR investigated and closed the case. Of the three detainee-on-detainee sexual abuse allegations, two were found unsubstantiated and one substantiated. Two of the allegations were conducted by the facility investigator and one by OPR. All allegations were reported to the APD and ICE OPR. The APD did not investigate an allegation but provided case numbers to each allegation. There were no cases referred for prosecution. A review of all four investigations was conducted.

§115.72 – Evidentiary standard for administrative investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

The Investigator stated the standard of proof for administrative investigations is a preponderance of evidence, 51%. Policy 5.1.2-E-AUR confirms that no standard higher than a preponderance of evidence will be imposed in determining allegations of sexual abuse as substantiated.

§115.73 – Reporting to detainees.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

Policy 5.1.2-E-AUR outlines the reporting of investigation outcomes to detainees. The detainee is notified whether the allegation was determined substantiated, unsubstantiated, or unfounded through a written notification by the facility administrator or designated staff member on the Notification of Outcome of Allegation Form. The detainee receives the original and a copy is maintained as part of the investigative file. The Warden stated detainees are notified of the investigation outcome if the detainee is still detention. No notifications were made on the investigative cases, the detainees were released prior to the investigation outcome.

§115.76 – Disciplinary sanctions for staff.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) Policy 5.1.2-E-AUR cover that staff shall be subject to disciplinary or adverse action up to and including removal from their position and Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies. The Warden stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact detainee post until the investigation is completed. If the case was substantiated, the staff member would be terminated. The Warden stated an employee would have to go through the disciplinary process before terminated. The Detention Officers are union employees. There was one allegation of sexual misconduct by a staff member. This case was investigated and determined to be unsubstantiated and the case was closed by ICE OPR. No discipline action was required. There were no staff terminations, resignations, other sanctions this audit period per the Warden, memo to file, and PAQ.

(b) Policy 5.1.2-E-AUR has been reviewed and approved by the Chief of Security and ICE FOD as part of the annual policy review noted on the front page of the policy. The policy does indicate that if there is a substantiated allegation, staff removal from their position and federal service is the presumption disciplinary sanction.

(c) Policy 5.1.2-E-AUR directs that the facility shall report all removals or resignations in lieu of removal for violations of agency of facility sexual abuse policies to appropriate law enforcement agencies, unless the activity was clearly not criminal. The Warden stated notifications would be made to ICE and the local law enforcement agency. The information will also be retained in the employee's human resource permanent file.

(d) Policy 5.1.2-E-AUR directs that the facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of agency of facility sexual abuse policies to any relevant licensing bodies, to the extent known. The Warden stated notifications would be made to ICE and all appropriate licensing bodies.

§115.77 – Corrective action for contractors and volunteers.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a/b) Policies 5.1.2-D-AUR and 5.1.2-E-AUR details the corrective action for contractors and volunteers who have engaged in sexual abuse. Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees and reported, unless the activity was clearly not criminal. Substantiated allegations would be reported to local law enforcement, unless the activity was clearly not criminal. All reasonable efforts would be made to report to any relevant licensing bodies. The Warden noted that a volunteer's clearance would be revoked allowing no contact with the facility until the investigation is completed. If substantiated, the volunteer or contractor shall be removed from all duties and clearance revoked. Also, noted by the Warden and the PAQ there were no instances where a volunteer or contractor was removed for allegations of sexual abuse.

(c) Policy 5.1.2-E-AUR states the facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse; but have violated other provisions within these standards. The Warden

indicated each case would be evaluated and determined if the volunteer or contractor clearance be revoked based on the severity of the violation or prohibit contact with detainees.

§115.78 – Disciplinary sanctions for detainees.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) The facility's policy 5.1.2-E-AUR outlines the detainee disciplinary sanctions. It states a detainee is subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding the detainee engaged in sexual abuse. The Warden stated the detainee discipline would be through the internal disciplinary process. If criminal in nature, the local law enforcement agency would be contacted, and case referred to them.

(b) Policy 5.1.2-E-AUR notes that all steps in the disciplinary process and sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. The abuser in the substantiated case was processed through the disciplinary process and received disciplinary sanctions of disciplinary segregation housing placement. The Warden indicated in the interview that disciplinary sanctions could include restrictions, internal discipline sanctions, disciplinary housing, and prosecution if warranted. The Warden also indicated sanctions are commensurate within the disciplinary process for that the level of prohibited act.

(c) The disciplinary process has progressive levels of review, appeals, procedures, and documentation of the process. Policy 5.1.2-E-AUR documents the standard requirement. The Warden confirmed the disciplinary process has progressive levels of review and appeals and a written report will be maintained in the detainee file.

(d) Policy 5.1.2-E-AUR states that mental capacity, illness, or disability will be taken into consideration when any type of disciplinary sanction, if any, is imposed. The Warden stated that mental health staff will review each case prior to the disciplinary process.

(e) Policy 5.1.2-E-AUR states a detainee shall not be disciplined for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. The Warden stated the detainee would not be disciplined for consensual sexual contact with a staff member. There were no instances to review.

(f) Policy 5.1.2-E-AUR states a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if the investigation does not establish evidence sufficient to substantiate the allegation. The Warden stated a detainee making an allegation in good faith would not be disciplined. There have been no detainees disciplined for falsely reported. There were no detainees who reported sexual abuse identified for interviews, they were no longer housed at the facility.

§115.81 – Medical and mental health assessment; history of sexual abuse.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) Policy 5.1.2-D-AUR directs that an Intake Nurse conducts the medical screening during the intake process prior to a detainee housing placement is made or moved from the intake area. If the detainee is determined at risk for either victimization or abusiveness, has experienced prior victimization or perpetrated sexual abuse, the detainee's assessment form is marked for immediate referral to a medical and/or mental health staff for medical and/or mental health follow-up as appropriate. The Intake Medical and Mental Health Screening Forms are reviewed by the Chronic Care Nurse and/or the Health Service Administrator (HSA) daily for referrals. At the arrival to the facility during the intake process, the classification staff completes the PREA Risk Assessment Tool as part of the intake paperwork. (b) (7)(E) . A detainee that scores at risk are referred to mental health. There are also targeted questions that would require a referral to mental health if there is a yes response. The form has a section that is marked that indicates a referral to mental health was made, date of the referral, and who the notification was made to. The HSA and Psychologist interviewed stated referrals are made immediately by emailing the PSA Compliance Manager, Nurse Scheduler, and HSA. The Auditor observed a classification screening during the intake process. The detainee did not score for a referral.

(b) When a referral for medical follow-up is initiated, the detainee receives a health evaluation no later than two working days from the date of assessment. The HSA stated the detainees from a referral would be seen within 24 hours and noted in the medical progress notes in the detainees medical file per policy 5.1.2-D-AUR. A referral would also be made to mental health if one was not made previously. During the audit period, no detainees were referred for medical follow-up during the intake assessment per memo to file. The Auditor did not note any referrals to medical from the intake assessment while reviewing the detainee files.

(c) When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours per policy 5.1.2-D-AUR. The Auditor selected two detainee files to review based on the random detainee interviews where the detainee stated they had disclosed sexual abuse history. Upon review of these files, the detainee did not report at intake; they reported to the judge at their asylum hearing. They were referred to mental health and were seen within 72 hours. The Auditors also selected five additional medical detainee files to review from referrals made on the PREA Risk Assessment Tools found in the detainee files. Four detainees were seen within the 72 hours, most within 24 hours. One of the detainees refused a follow-up meeting. One of the detainees interviewed stated he was never victimized or reported victimization at intake. Upon review of his health care file, his referral was based on the number of yes responses on the PREA Risk Assessment Tool. The Psychologist stated the detainee from a referral is seen as soon as possible and always within 72 hours. If the detainee had been a victim, the detainee is also scheduled with a mental health provider for additional services if needed.

§115.82 – Access to emergency medical and mental health services.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) Policy 5.1.2-D-AUR states all victims of sexual abuse in custody shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by medical and mental health practitioners. The services would include offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis. Medical and mental services were provided to all the

alleged victims from the four allegations this audit period. All alleged victims were seen the same day of reporting the allegations as noted in the medical and investigation files reviewed. The HSA noted that the Victim Centered Care Checklist is utilized to ensure all services are covered with the victim. The checklists were in the detainees' files and reviewed by the Auditor.

(b) Policy 5.1.2-D-AUR states all services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The HSA and Psychologist interviewed stated healthcare treatment for detainees are free.

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

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

Notes:

(a) The HSA and Psychologist interviewed stated the alleged victims receive medical and mental health evaluations and treatment is provided if needed. There is no cost to the detainee. Medical and mental services were provided to all the alleged victims from the four allegations this audit period. All alleged victims were seen the same day of reporting the allegations as noted in the medical and investigation files reviewed. Policy 5.1.2-D-AUR supports the language of the standard and the practice as stated by the HSA and Psychologist.

(b) Policy 5.1.2-D-AUR language mirrors the standard. The HSA stated the alleged victim is brought to medical immediately for timely medical assessment and treatment. This would include a quick assessment, provide any treatment necessary to stabilize the detainee for transport to the local hospital. If sent to the hospital, follow-up treatment would be offered upon return from the hospital to provide continuum of care. The hospital may complete the sexually transmitted diseases screening and pregnancy testing, if not the services would be provided at the facility upon return. Medical staff would provide emergency contraception and sexually transmitted infections prophylaxis, if needed. None of the alleged victims required outside emergency medical treatment nor emergency contraception and sexually transmitted infections prophylaxis as reviewed in the detainee files. Mental health provided follow-up treatment to the detainees as needed. The Psychologist shared that the mental health department has started creating more detailed treatment plans to document the services and treatments provided and demonstrate compliance with the standards. The HSA and Psychologist interviewed stated that referrals for continued care following transfer to another facility would be completed by healthcare and release from care would be completed through case management.

(c) Policy 5.1.2-D-AUR states services shall be provided in a manner that is consistent with the level of care the individual would receive in the community. The healthcare staff, during their interviews, indicated that the healthcare services are consistent with the community level of care and in most cases better than the community since the detainee has immediate access to services.

(d) Policy 5.1.2-D-AUR mirrors the language of the standard. The HSA confirmed that female detainees would receive timely and comprehensive information and access to pregnancy related information and services as appropriate by the Colorado applicable laws. It was also stated a referral would be made to mental health. There were no alleged female victims during this audit period to interview or complete a file review.

(e) Prophylactic treatment of venereal diseases is offered to victims of sexual abuse and the detainee is scheduled for testing and education. The health care interviews indicated that the initial treatment would be provided by the SANE at the local hospital. The treatment would continue through medical orders by the medical staff. Additional education, follow-up treatment, counseling, and testing are provided as needed stated by the HSA and policy 5.1.2-D-AUR. None of the alleged victims this audit period required prophylactic treatment or testing.

(f) Policy 5.1.2-D-AUR states all services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The HSA and Psychologist both stated there all services are provided without cost to the detainee.

(g) Policy 5.1.2-D-AUR states mental health staff shall attempt to conduct a mental health evaluation on all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by mental health practitioners. The policy notes the definition of known abusers as those detainee abusers in which SAAPI investigation determined either administratively substantiated or substantiated by outside law enforcement. There were no instances where a mental health assessment for a known detainee-on-detainee abuser was conducted per memo to file. This was supported by the review of the investigation file of the one substantiated case. The abuser was released prior to the outcome of the investigation. The Psychologist also confirmed there were no abusers referred. It also stated that mental health would complete a mental health evaluation and offer any basic mental health treatment deemed appropriate. The mental health department does not provide sex offender treatment. The Psychologist shared that usually the abuser does not want to be seen and refuses any treatment services.

§115.86 – Sexual abuse incident reviews.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) Policy 5.1.2-D-AUR outlines the requirement, procedures, and timeframes for sexual abuse incident reviews. Designated staff are required to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including unfounded. The PSA Compliance Manager stated the team consists of the Investigator, Warden, Major, Assistant Warden, medical and mental health staff, classification staff, and PSA Compliance Manager. The review is completed within 30 days of the conclusion of the investigation. The review team utilizes the DHS Sexual Abuse or Assault Incident Review Form to complete and document the review. The form captures any recommendations including a change in policy or practice that could better assist in the prevention, detection, and response to sexual abuse. The DHS Sexual Abuse or Assault Incident Review Form is forwarded to the ERO PREA Field Coordinator and the Corporate PREA Coordinator within ten days after the review. The PSA Compliance Manager is responsible for implementing any recommendation for improvement or document its reasons for not doing so. The Auditor reviewed the sexual abuse incident reviews of the four investigative cases. All reviews were completed within 30 days, with three within 14 days. One review had a recommendation that detainee kitchen workers receive training on horseplay; the training was provided by staff which included a handout for the detainees. Another review recommended refresher training on rounds requirement. Supervisors, department heads, and security staff were reminded to complete rounds through housing units and document them in the logbooks; the refresher was provided through department head meetings and shift briefings. The PSA Compliance Manager is monitoring by reviewing housing unit logbooks. The facility exceeds the standard by completing reviews on all cases including unfounded and the detail of the review with the utilization of the DHS Sexual Abuse or Assault Incident Review Form.

(b) The review team utilizes the DHS Sexual Abuse or Assault Incident Review Form to complete and document the review. The form contains a section of incident review findings which includes group dynamics (including race, ethnicity, gender identity, lesbian, gay, bisexual, transgender; intersex identification, status, or perceived status; or gang affiliation), staffing, physical plant, incident response, general policy and procedures review, and recommendations. All the elements of the standard are addressed within these categories. The PSA Compliance Manager confirmed all the elements are reviewed and documented on the DHS Sexual Abuse or Assault Incident Review Form and is supported through policy 5.1.2-D-AUR.

(c) Policy 5.1.2-D-AUR outlines the procedures for conducting an annual review of all sexual abuse investigations and resulting incident reviews. The 2017 Annual Review of Sexual Abuse Investigations and Corrective Action Plan was completed on October 10, 2017. The document is divided into three sections; comparisons of data from 2016 and 2017, findings, and corrective action plan. As part of the annual review, the PSA Compliance Manager noted that two improvements were completed; the addition of the PREA Investigator position and an upgrade to the camera video system. The 2017 Annual Review of Sexual Abuse Investigations and Corrective Action Plan was forwarded to the ICE FOD and the corporate GEO PREA Director. The PSA Compliance Manager stated the review considers investigations, incident reviews, and trends for the year and comparison to previous years. The Auditor reviewed the annual report. The Corporate GEO PREA office also compiles an annual PREA report for the company which includes breakdowns by facility. This report is available on the GEO website www.geogroup.com/PREA.

§115.87 – Data collection.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

Policy 5.1.2-D-AUR outlines the procedures for data collection. The facility collects and retains data related to sexual abuse as directed by the Corporate PREA Coordinator. This data includes case records associated with claims of sexual abuse including investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary. The PSA Compliance Manager stated the position of the PSA Compliance Manager is responsible for compiling data collected on sexual activity and sexual abuse incidents. The statistical report, DHS Monthly PREA Incident Tracking Log, is forwarded monthly to the Corporate PREA Coordinator. The PSA Compliance Manager will create and update the PREA Survey in the PREA Portal for every allegation of sexual abuse and sexual activity. The data is secured in a locked file cabinet in the PSA Compliance Manager's office, as observed by the Auditor. The established retention schedule is 10 years for these files.

§115.201 – Scope of audits.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(d) During the audit, the facility and agency provided the Auditors full access to all areas of the facility and the Auditors were able to observe practices and tour the facility.

(e) Prior to the audit, during the audit, and after the on-site audit, the agency and facility provided the Auditor requested documents. Policies and documentation were made available through the ICE ERAU SharePoint.

(i) Private interview space was provided to the Auditors for conducting staff and detainee interviews. Staff interviews were held in administrative offices in the administration section of the facility. The detainee interviews were held in private offices located within a secure section of the facility.

(j) Posted signs advised detainees they could send confidential information or correspondence to the Auditor. The Auditor did not receive any correspondence from detainees.

Based on the above information, the agency/facility meets the Standard 115.201 Scope of Audits.

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.

Barbara King December 18, 2018
Auditor's Signature & Date