U.S. Department of Homeland Security
U.S. Immigration and Customs Enforcement
Office of Professional Responsibility
Inspections and Detention Oversight Division
Washington, DC 20536-5501

Office of Detention Oversight
Follow-Up Compliance Inspection

Enforcement and Removal Operations
ERO Chicago Field Office

Kay County Justice Facility
Newkirk, Oklahoma

August 17-19, 2021

FOLLOW-UP COMPLIANCE INSPECTION
of the
KAY COUNTY JUSTICE FACILITY
Newkirk, Oklahoma

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FOLLOW-UP COMPLIANCE INSPECTION TEAM MEMBERS

[redacted]	Team Lead	ODO
	Inspections and Compliance Specialist	ODO
	Inspections and Compliance Specialist	ODO
	Contractor	Creative Corrections
	Contractor	Creative Corrections
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FACILITY OVERVIEW

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR) Office of Detention Oversight (ODO) conducted a follow-up compliance inspection of the Kay County Justice Facility (KCJF) in Newkirk, Oklahoma, from August 17 to 19, 2021.[1] This inspection focused on the standards found deficient during ODO's last inspection of KCJF from March 8 to 12, 2021. The facility opened in 2010 and is owned and operated by the Kay County Justice Authority. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at KCJF in 2019 under the oversight of ERO's Field Office Director in Chicago (ERO Chicago). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2011 (Revised 2016).

ERO has not assigned deportation officers nor a detention services manager to the facility. A KCJF director handles daily facility operations and oversees [redacted] personnel. KCJF provides food services, Turn-Key Health provides medical care, and Tiger Commissary provides commissary services at the facility. The facility does not hold any national accreditations from any outside entities.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	[redacted]
Average ICE Detainee Population[3]	[redacted]
Male Detainee Population (as of August 17, 2021)	[redacted]
Female Detainee Population (as of August 17, 2021)	[redacted]

During its last inspection, in Fiscal Year (FY) 2021, ODO found 35 deficiencies in the following areas: Environmental Health and Safety (4); Admission and Release (1); Custody Classification System (1); Sexual Abuse and Assault Prevention and Intervention (8); Staff-Detainee Communication (1); Hunger Strikes (1); Medical Care (4); Disability Identification, Assessment, and Accommodation (6); Telephone Access (2); Grievance System (3); and Law Libraries and Legal Material (4).

[1] This facility holds male and female detainees with low, medium-low, medium-high, and high security classification levels for periods longer than 72 hours.
[2] Data Source: ERO Facility List Report as of August 16, 2021.
[3] *Ibid.*

FOLLOW-UP COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population of 10 or more detainees, and where detainees are housed for longer than 72 hours, to assess compliance with ICE National Detention Standards. These inspections focus solely on facility compliance with detention standards that directly affect detainee life, health, safety, and/or well-being. In FY 2021, to meet congressional requirements, ODO began conducting follow-up inspections at all ICE ERO detention facilities, which ODO inspected earlier in the FY.

While follow-up inspections are intended to focus on previously identified deficiencies, ODO will conduct a complete review of several core standards, which include but are not limited to Medical Care, Hunger Strikes, Suicide Prevention, Food Service, Environmental Health and Safety, Emergency Plans, Use of Force and Restraints/Use of Physical Control Measures and Restraints, Admission and Release, Classification, and Funds and Personal Property. ODO may decide to conduct a second full inspection of a facility in the same FY based on additional information obtained prior to ODO's arrival on-site. Factors ODO will consider when deciding to conduct a second full inspection will include the total number of deficiencies cited during the first inspection, the number of deficient standards found during the first inspection, the completion status of the first inspection's UCAP, and other information ODO obtains from internal and external sources ahead of the follow-up compliance inspection. Conditions found during the inspection may also lead ODO to assess new areas and identify new deficiencies or areas of concern should facility practices run contrary to ICE standards. Any areas found non-compliant during both inspections are annotated as "Repeat Deficiencies" in this report.

FINDINGS BY PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 2011 (REVISED 2016) MAJOR CATEGORIES

PBNDS 2011 (Revised 2016) Standards Inspected[4]	Deficiencies
Part 1 – Safety	
Emergency Plans	0
Environmental Health and Safety	4
Sub-Total	**4**
Part 2 – Security	
Admission and Release	1
Custody Classification System	0
Funds and Personal Property	1
Sexual Abuse and Assault Prevention and Intervention	1
Special Management Units	3
Staff-Detainee Communication	1
Use of Force and Restraints	0
Sub-Total	**7**
Part 4 – Care	
Food Service	1
Hunger Strikes	1
Medical Care	5
Medical Care (Women)	0
Significant Self-harm and Suicide Prevention and Intervention	6
Disability Identification, Assessment, and Accommodation	1
Sub-Total	**14**
Part 5 – Activities	
Telephone Access	0
Sub-Total	**0**
Part 6 – Justice	
Grievance Systems	0
Law Libraries and Legal Material	2
Sub-Total	**2**
Total Deficiencies	**27**

[4] For greater detail on ODO's findings, see the *Follow-Up Compliance Inspection Findings* section of this report.

DETAINEE RELATIONS

ODO interviewed 15 detainees, who each voluntarily agreed to participate. None of the detainees made allegations of discrimination, mistreatment, or abuse. All detainees reported satisfaction with facility services.

FOLLOW-UP COMPLIANCE INSPECTION FINDINGS

SAFETY

ENVIRONMENTAL HEALTH AND SAFETY (EHS)

ODO interviewed the facility's maintenance staff and found staff did not conduct monthly fire and safety inspections **(Deficiency EHS-102[5])**.

ODO found facility staff did not forward written reports of inspections nor any necessary corrective action determinations to the facility administrator for review **(Deficiency EHS-103[6])**.

ODO interviewed the facility's maintenance supervisor and found the supervisor did not maintain inspection reports nor records of corrective actions in the safety office **(Deficiency EHS-104[7])**.

ODO reviewed the facility's fire drill documentation and found facility staff did not conduct nor document fire drills at least quarterly in all facility locations including administrative areas **(Deficiency EHS-107[8])**. **This is a repeat deficiency**.

SECURITY

ADMISSION AND RELEASE (AR)

ODO interviewed the facility's intake supervisor and found ERO Chicago did not approve the facility's orientation procedures in advance **(Deficiency AR-61[9])**.

CUSTODY CLASSIFICATION SYSTEM (CCS)

ODO interviewed the classification supervisor, toured the laundry room, and found facility staff issued tan uniforms to low and medium-low custody detainees; however, they also issued those detainees green t-shirts, which could cause confusion in distinguishing the low and medium-low custody detainees from high-level custody detainees who wear green uniforms. ODO noted this

[5] "Facility maintenance (safety) staff shall conduct monthly inspections." *See* ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(C)(2)(b).
[6] "Written reports of the inspections shall be forwarded to the facility administrator for review and, if necessary, corrective action determinations." *See* ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(C)(2)(c).
[7] "The maintenance supervisor shall maintain inspection reports and records of corrective action in the safety office." *See* ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(C)(2)(c).
[8] "Fire drills shall be conducted and documented at least quarterly in all facility locations including administrative areas." *See* ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(C)(4).
[9] "Orientation procedures in CDFs and IGSAs must be approved in advance by the local ICE/ERO Field Office." *See* ICE PBNDS 2011 (Revised 2016), Standard, Admission and Release, Section (V)(F).

practice as an **Area of Concern**.

FUNDS AND PERSONAL PROPERTY (FPP)

ODO reviewed [redacted] detainee detention files and found in [redacted] files, facility staff did not make separate documentation for each kind of currency or negotiable instrument **(Deficiency FPP-46[10])**.

SEXUAL ABUSE AND ASSAULT PREVENTION AND INTERVENTION (SAAPI)

ODO interviewed the facility's Prison Rape Elimination Act coordinator and found the facility did not post its SAAPI protocols on its website, or otherwise made them available to the public **(Deficiency SAAPI-16[11])**. **This is a repeat deficiency**.

SPECIAL MANAGEMENT UNITS (SMU)

ODO reviewed one detainee's administrative segregation (AS) file and found no documentation indicating a supervisor conducted a 72-hour review of the detainee's placement in AS **(Deficiency SMU-44[12])**.

ODO reviewed one detainee's AS file and found no documentation indicating the 72-hour review included an interview with the detainee **(Deficiency SMU-45[13])**.

ODO reviewed one detainee's AS file and found no documentation indicating facility staff conducted 30-minute rounds on an irregular basis. Specifically, 30-minute rounds were missing for [redacted] days the facility housed the detainee in their SMU **(Deficiency SMU-126[14])**.

STAFF-DETAINEE COMMUNICATION (SDC)

ODO reviewed the facility's detainee request logbook and found the logbook did not record the staff response nor action of detainee requests **(Deficiency SDC-20[15])**.

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[10] "Separate documentation should be made for each kind of currency and negotiable instrument and should include detainee identification information and a description of the amount and type of currency or other negotiable instrument inventoried." *See* ICE PBNDS 2011 (Revised 2016), Standard, Funds and Personal Property, Section (V)(G)(1).

[11] "Each facility shall also post its protocols on its website, if it has one, or otherwise make the protocol available to the public." *See* ICE PBNDS 2011 (Revised 2016), Standard, Sexual Abuse and Assault Prevention and Intervention, Section (V)(A). *See* ICE PBNDS 2011 (Revised 2016), Standard, Special Management Units, Section (V)(a)(3)(a).

[12] "A supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted." *See* ICE PBNDS 2011 (Revised 2016), Standard, Special Management Units, Section (V)(A)(3)(a)(1).

[13] "The review shall include an interview with the detainee." *See* ICE PBNDS 2011 (Revised 2016), Standard, Special Management Units, Section (V)(A)(3)(a)(1).

[14] "Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule." *See* ICE PBNDS 2011 (Revised 2016), Standard, Special Management Units, Section (V)(M).

[15] "At a minimum, the log shall record: …

i. the date the request was forwarded to ICE/ERO and the date it was returned shall also be recorded." *See* ICE PBNDS 2011 (Revised 2016), Standard, Staff-Detainee Communication, Section (V)(B)(2)(i).

CARE

FOOD SERVICE (FS)

ODO interviewed the food service administrator (FSA) and found the FSA did not inspect the food service areas at least weekly. Specifically, the facility did not complete weekly inspections of the food service areas for the months of April through August **(Deficiency FS-415[16])**.

HUNGER STRIKES (HS)

ODO reviewed [redacted] staff training files and found in [redacted] files, staff training records did not document whether staff received training annually to recognize the signs of a hunger strike, nor to implement the procedures for referral for medical assessment and for management of a detainee on a hunger strike **(Deficiency HS-1[17])**.

MEDICAL CARE (MC)

ODO reviewed [redacted] medical care staff credential files and found the professional licenses on file for [redacted] medical care staff members were either not available or had expired. Specifically, three licenses were not available, and three licenses had expired. Although the three expired licenses on file at the facility showed they had expired between [redacted] days ago, the licenses were renewed on time; however, the facility did not have copies of the current, verified licenses **(Deficiency MC-101[18])**.

ODO reviewed [redacted] medical care staff credential files and found the facility did not maintain the professional licenses for [redacted] medical care staff on site nor were they readily available for review **(Deficiency MC-102[19])**.

ODO reviewed [redacted] detainee medical files and found none contained documentation, which showed the chief medical authority (CMA) reviewed the comprehensive health assessments conducted by the registered nurses. Specifically, the nurse practitioner reviewed the comprehensive health assessments instead of the CMA **(Deficiency MC-140[20])**. **This is a repeat deficiency**.

ODO reviewed the training files for [redacted] medical staff and [redacted] non-medical staff and found [redacted] out of [redacted] medical staff members did not have a copy of their current CPR training on file and [redacted] out of [redacted]

[16] "The FSA or CS shall inspect food service areas at least weekly." *See* ICE PBNDS 2011 (Revised 2016), Standard, Food Service, Section (V)(J)(13).
[17] "All staff shall be trained initially and annually thereafter to recognize the signs of a hunger strike, and to implement the procedures for referral for medical assessment and for management of a detainee on a hunger strike." *See* ICE PBNDS 2011 (Revised 2016), Standard, Hunger Strikes, Section (V)(A).
[18] "All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements." *See* ICE PBNDS 2011 (Revised 2016), Standard, Medical Care, Section (V)(I).
[19] "Copies of the documents must be maintained on site and readily available for review. A restricted license does not meet this requirement." *See* ICE PBNDS 2011 (Revised 2016), Standard, Medical Care, Section (V)(I).
[20] "The CMA shall be responsible for review of all comprehensive health assessments to assess the priority for treatment." *See* ICE PBNDS 2011 (Revised 2016), Standard, Medical Care, Section (V)(M).

CPR cards from the medical staff had expired **(Deficiency MC-197[21])**.

ODO inspected the facility's emergency equipment maintenance checklist and the automatic external defibrillator (AED) and found the AED defibrillator pads had expired approximately 30 months ago **(Deficiency MC-201[22])**.

SIGNIFICANT SELF-HARM AND SUICIDE PREVENTION AND INTERVENTION (SSHSPI)

ODO reviewed quarterly multidisciplinary suicide prevention committee meeting minutes and found the committee did not include a representative from the mental health staff **(Deficiency SSHSPI-3[23])**.

ODO reviewed [redacted] staff training files and found in [redacted] files, staff did not receive comprehensive suicide prevention training annually **(Deficiency SSHSPI-8[24])**.

ODO reviewed one medical file for a detainee identified as being at risk for suicide and found the mental health provider did not evaluate the detainee within 24 hours of identification. Specifically, the initial mental health evaluation occurred approximately 42 hours after identifying the risk **(Deficiency SSHSPI-22[25])**.

ODO reviewed the observation security check forms for the one detainee the facility placed on suicide watch since ODO's last inspection and found facility staff did not maintain constant one-on-one visual observation. Specifically, prior to the mental health evaluation, there were periods of [redacted] where the facility security staff members did not record constant one-to-one visual observations **(Deficiency SSHSPI-23[26])**.

ODO reviewed the observation security check forms for the one detainee the facility placed on suicide watch since ODO's last inspection and found facility staff did not document continuous monitoring every 15 minutes or more frequently if necessary. Specifically, there were three periods ranging from [redacted] where facility staff did not record the constant one-

[21] "Training and competency assessment shall include the following areas: a. recognizing of signs of potential health emergencies and the required responses; b. administering first aid, AED and cardiopulmonary resuscitation (CPR)." *See* ICE PBNDS 2011 (Revised 2016), Standard, Medical Care, Section (V)(T)(2)(a-b).

[22] "Medical and safety equipment shall be available and maintained, and staff shall be trained in proper use of the equipment." *See* ICE PBNDS 2011 (Revised 2016), Standard, Medical Care, Section (V)(T)(4).

[23] "The multidisciplinary suicide prevention committee shall, at a minimum, comprise representatives from custody, mental health, and medical staff." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V).

[24] "All facility staff members who interact with and/or are responsible for detainees shall receive comprehensive suicide prevention training, during orientation and at least annually." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(A).

[25] "Detainees who are identified as being "at risk" for significant self-harm or suicide shall immediately be referred to the mental health provider for an evaluation, which shall take place within 24 hours of the identification." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(C).

[26] "Until this evaluation takes place, security staff shall place the detainee in a secure environment on a constant one-to-one visual observation." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(C).

to-one visual observation **(Deficiency SSHSPI-34[27])**.

ODO reviewed one medical file for a detainee the facility placed on suicide watch since ODO's last inspection and noted the evaluation by a mental health professional did not include an assessment for the necessity of a suicide smock (**Deficiency SSHSPI-45[28]**).

DISABILITY IDENTIFICATION, ASSESSMENT, AND ACCOMMODATION (DIAA)

ODO interviewed the facility's staff, reviewed disability-related documents, and determined the facility did not develop disability-accommodation written policy nor procedures. Specifically, the facility had not developed a written policy, which included: reasonable timelines for providing interim accommodations related to disability, reasonable timelines for providing interim accommodations, and reassessments **(Deficiency DIAA-1[29])**. **This is a repeat deficiency**.

JUSTICE

LAW LIBRARIES AND LEGAL MATERIALS (LLLM)

ODO interviewed the facility's staff, toured the facility, and found the facility did not provide a properly equipped law library in a designated, well-lit room that was relatively isolated from noisy areas and large enough to provide reasonable access to all detainees, requesting its use. Specifically, the facility had 4-5 laptops available for detainee use. If needed, the detainees would use them in the housing unit, on their bunk or in the day room, but the facility had no designated area isolated from noise (**Deficiency LLLM-2[30]**). **This is a repeat deficiency**.

ODO interviewed facility staff and found the facility's law library did not include a designated space furnished with tables and chairs to accommodate legal research and writing needs **(Deficiency LLLM-3[31])**. **This is a repeat deficiency**.

[27] "The qualified mental health professional may place the detainee in a special isolation room designed for evaluation and treatment with continuous monitoring that must be documented every 15 minutes or more frequently if necessary." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(F).

[28] "The qualified mental health professional shall assess the detainee to determine whether a suicide smock is necessary." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(F)(2).

[29] "The facility shall develop written policy and procedures, including reasonable timelines, for reviewing detainees' requests for accommodations related to a disability and for providing accommodations (including interim accommodations), modifications, and reassessments. These policies and procedures shall be consistent with the processes outlined in this standard." *See* ICE PBNDS 2011 (Revised 2016), Standard, Disability Identification, Assessment, and Accommodation, Section (V)(B)(1).

[30] "Each facility shall provide a properly equipped law library in a designated, well-lit room that is reasonably isolated from noisy areas and large enough to provide reasonable access to all detainees who request its use." *See* ICE PBNDS 2011 (Revised 2016), Standard, Law Libraries and Legal Materials, Section (V)(A).

[31] "It shall be furnished with a sufficient number of tables and chairs to accommodate detainees' legal research and writing needs." *See* ICE PBNDS 2011 (Revised 2016), Standard, Law Libraries and Legal Materials, Section (V)(A).

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 18 standards under PBNDS 2011 (Revised 2016) and found the facility in compliance with 6 of those standards. ODO found 27 deficiencies in the remaining 12 standards. ODO commends facility staff for their responsiveness during this inspection. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. ODO has not received the uniform corrective action plan for ODO's last inspection of KCJF in March 2021.

Compliance Inspection Results Compared	First FY 2021 (PBNDS 2011) (Revised 2016)	Second FY 2021 (PBNDS 2011) (Revised 2016)
Standards Reviewed	21	18
Deficient Standards	11	12
Overall Number of Deficiencies	35	27
Repeat Deficiencies	11	6
Areas of Concern	0	1
Corrective Actions	0	0