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Office of Professional Responsibility
Inspections and Detention Oversight Division
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Office of Detention Oversight Compliance Inspection

Enforcement and Removal Operations ERO El Paso Field Office

Otero County Processing Center Chaparral, New Mexico

February 1-5, 2021

COMPLIANCE INSPECTION
of the
OTERO COUNTY PROCESSING CENTER
Chaparral, New Mexico

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COMPLIANCE INSPECTION TEAM MEMBERS

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	Inspections and Compliance Specialist	ODO
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	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 compliance inspection of the Otero County Processing Center (OCPC) in Chaparral, New Mexico, from February 1 to 5, 2021.[1] The facility opened in 2008 and is owned by Otero County and operated by Management and Training Corporation. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at OCPC in 2008 under the oversight of ERO's Field Office Director in El Paso (ERO El Paso). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2011 (Revised 2016).

ERO has assigned deportation officers and a detention services manager to the facility. An OCPC warden handles daily facility operations and is supported by [redacted] personnel. Management and Training Corporation provides food services and medical care and Keefe Commissary Network provides commissary services at the facility. The facility was accredited by the American Correctional Association in January 2019, and the National Commission on Correctional Health Care in February 2019. In April 2018, OCPC was audited for the Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) and was DHS PREA certified in February 2019.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	311
Average ICE Detainee Population[3]	[redacted]
Male Detainee Population (as of 2/1/2021)	[redacted]
Female Detainee Population (as of 2/1/2021)	N/A

During its last inspection, in Fiscal Year (FY) 2020, ODO found 32 deficiencies in the following areas: Environmental Health and Safety (1), Admission and Release (2); Custody Classification System (4); Funds and Personal Property (10); Use of Force and Restraints (2); Food Service (6); Medical Care (5); Significant Self-harm and Suicide Prevention and Intervention (1); and Recreation (1).

[1] This facility holds male 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 January 19, 2021.
[3] *Ibid.*

COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population greater than ten, 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.[4]

ODO identifies violations of ICE detention standards, ICE policies, or operational procedures as "deficiencies." ODO also highlights instances in which the facility resolves deficiencies prior to completion of the ODO inspection. Where applicable, these corrective actions are annotated with "C" under the *Compliance Inspection Findings* section of this report.

Upon completion of each inspection, ODO conducts a closeout briefing with facility and local ERO officials to discuss preliminary findings. A summary of these findings is shared with ERO management officials. Thereafter, ODO provides ICE leadership with a final compliance inspection report to: (i) assist ERO in developing and initiating corrective action plans; and (ii) provide senior executives with an independent assessment of facility operations. ODO's findings inform ICE executive management in their decision-making to better allocate resources across the agency's entire detention inventory.

ODO was unable to conduct an on-site inspection of this facility, as a result of the COVID-19 pandemic, and instead, conducted a remote inspection of the facility. During this remote inspection, ODO interviewed facility staff, ERO field office staff, and detainees, reviewed files and detention records, and was able to assess compliance for at least 90 percent or more of the ICE national detention standards reviewed during the inspection.

[4] ODO reviews the facility's compliance with selected standards in their entirety.

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

PBNDS 2011 (Revised 2016) Standards Inspected[5]	Deficiencies
Part 1 – Safety	
Emergency Plans	0
Environmental Health and Safety	0
Sub-Total	**0**
Part 2 – Security	
Admission and Release	0
Custody Classification System	0
Facility Security and Control	0
Funds and Personal Property	1
Population Counts	0
Sexual Abuse and Assault Prevention and Intervention	0
Special Management Units	2
Staff-Detainee Communication	0
Use of Force and Restraints	0
Sub-Total	**3**
Part 4 – Care	
Food Service	0
Hunger Strikes	0
Medical Care	12
Significant Self-harm and Suicide Prevention and Intervention	1
Disability Identification, Assessment, and Accommodation	0
Sub-Total	**13**
Part 5 – Activities	
Religious Practices	0
Telephone Access	0
Sub-Total	**0**
Part 6 – Justice	
Grievance Systems	0
Law Libraries and Legal Material	0
Sub-Total	**0**
Total Deficiencies	**16**

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

DETAINEE RELATIONS

ODO interviewed 12 detainees, who each voluntarily agreed to participate. None of the detainees made allegations of discrimination, mistreatment, or abuse. Most detainees reported satisfaction with facility services except for the concerns listed below. ODO conducted detainee interviews via video teleconference.

Medical Care: One detainee stated he received poor medical attention for gallbladder pain prior to his January 12, 2021, hospitalization for the issue. Furthermore, he stated when he was discharged from the hospital, he was prescribed a facility medical diet, which he did not receive.

- Action Taken: ODO reviewed the detainee's medical record and spoke with the facility medical staff. The detainee arrived at the facility on December 9, 2020, with a history of diabetes, high cholesterol, and allergies. He was on a number of medications and they were prescribed for him during the intake screening process. The detainee also reported a history of gallstones but was not experiencing symptoms at the time. On December 10, 2020, the detainee submitted a sick call request claiming he received the wrong pill and was feeling bad. The next day, the facility's licensed vocational nurse (LVN) triaged the detainee's sick call request and scheduled the detainee for a same day appointment with the facility's nurse practitioner (NP). The NP saw him for a chronic care appointment and explained to the detainee that he received the correct medication, but it was a different color because the facility used a different manufacture. Although the detainee complained of mild upper abdominal pain and constipation, his abdomen was soft but not distended. All other assessment findings and his vital signs were within normal limits.

  Additionally, the detainee reported a history of three emergency room visits in April 2020 (prior to his detention) and he was told he had gallstones and needed surgery; however, the detainee never followed-up. As such, the NP ordered laboratory studies and submitted an outside consultation for an ultrasound of the detainee's gallbladder. The NP also ordered milk of magnesia to be taken by the detainee twice daily as needed for constipation, Tylenol, twice daily as needed for pain, and Bentyl, twice daily for abdominal spasms. On December 12, 2020, the detainee was brought to the facility's health services for complaints of abdominal pain. He was evaluated by the facility's LVN, given his previously prescribed medications, and placed on medical observation. The following morning, the detainee's symptoms subsided, and he was released back to his housing unit. On December 15, 2020, his blood was drawn, and the results were received two days later. On December 23, 2020, the detainee saw the NP to review his laboratory studies and his liver enzymes and glucose were slightly elevated. Additionally, the detainee complained of constipation and felt depressed. The NP told him an ultrasound was scheduled, a referral to mental health was submitted, and a fiber tablet to be taken twice daily was added to his treatment regimen. The NP also ordered a diabetic and healthy heart diet for the detainee. On December 29, 2020, the detainee was seen by the facility's registered nurse (RN) for complaints of abdominal pain, constipation, nausea, and vomiting; however, his vital signs were stable. The NP was consulted and ordered an injection for nausea to be given for two days, a nonsteroidal

anti-inflammatory (NSAID) injection for pain was to be administered, and noted his ultrasound was scheduled on January 4, 2021.

On January 8, 2021, the NP reviewed the ultrasound report, which confirmed the detainee had gallstones, and discussed the case with the clinical director (CD), who advised to admit the detainee to the hospital on January 11, 2021, for elective surgery. The detainee had his gallbladder removed on January 13, 2021, and had another surgical procedure the next day, to remove another gallstone that developed. He returned to the facility on January 17, 2021 and was placed in the medical housing unit under the COVID-19 protocol. On January 18, 2021, the detainee was evaluated by the CD and he denied any complaints. The health service administrator (HSA) confirmed with the food service administrator that the detainee had been receiving a diabetic, healthy heart diet. During the pandemic, all meals, including specialized diets, were delivered to the housing units.

Medical Care: One detainee stated he could not lift his left arm because of a recent fall and had been given pain medication by the facility's medical staff, but he felt he needed additional treatment.

- Action Taken: ODO reviewed the detainee's medical record and spoke with the facility's medical staff. The detainee arrived at the facility on October 3, 2020. During the facility's intake process, the detainee reported a one-month history of left shoulder pain due to a fall; however. he was not taking any medications. On November 3, 2020, the detainee submitted a sick call request complaining of left shoulder pain. Two days later, he was evaluated by the facility's LVN using a standardized nursing protocol. The detainee was provided an over-the-counter dose of NSAID medication and the encounter was co-signed by the CD. The detainee was seen by the NP and noted mild tenderness to the detainee's left shoulder and limited range of motion. On November 10, 2020, the NP ordered a stronger dose of the NSAID medication, an x-ray, and advised the detainee to avoid heavy lifting. On December 9, 2020, the detainee had an x-ray, which showed normal findings and nine days later the detainee was seen by the NP to discuss the x-ray findings. The detainee reported his pain was well controlled, which he was advised by the NP to follow-up by submitting a sick call request if needed. On January 16, 2021, he submitted a sick call request for shoulder pain and was evaluated by the facility's RN. The assessment results showed the detainee had minimal findings to his shoulder, so the RN contacted the CD for orders. The CD prescribed a different NSAID medication and the detainee was advised to return to the facility's medical clinic if his condition worsened. On January 28, 2021, the detainee was seen by the RN for an unrelated complaint and his shoulder pain was not mentioned during the encounter. The detainee was seen by the NP on February 3, 2021, when he reported good pain control with his current medication regimen; however, he had limited range of motion to his shoulder, decreased strength, but had a good hand grip. The detainee was advised to follow-up through sick call if his condition changed or worsened. According to the medication administration records, the detainee had been compliant with his medications.

COMPLIANCE INSPECTION FINDINGS

SECURITY

ADMISSION AND RELEASE (A&R)

ODO interviewed the classification manager and deputy warden, reviewed lesson plans of departmental overviews, and found department heads, as a group, went to each housing dorm weekly to give overviews of their respective departments to the detainees. Detainees were allowed to ask questions and address general concerns with the department heads. This practice gave the detainees access to each department and was reported to have significantly reduced written complaints. ODO cites this as a **Best Practice**.

FUNDS AND PERSONAL PROPERTY (F&PP)

ODO reviewed 17 detainee files and found in 8 out of 17 files the property inventory listed valuables; however, four out of the eight files with valuables did not contain valuable property receipts (Form G-589) **(F&PP-62[6])**.

SPECIAL MANAGEMENT UNITS (SMU)

ODO reviewed the facility's Restrictive Housing Unit (RHU) policy, reviewed nine RHU detainee files, interviewed the captain, and found the facility did have written procedures and documentation for some detainees being placed in segregation. However, three out of nine detainee files indicated 72-hour reviews were not completed by the required deadline to determine whether segregation was warranted. Instead, the documentation indicated the reviews were conducted on the fifth day of the detainee being housed in administrative segregation **(SMU-44[7])**.

ODO reviewed the facility's RHU policy, reviewed nine RHU detainee files, interviewed the captain, and found the facility did have written procedures and documentation for some detainees being placed in segregation. However, four out of nine detainee files indicated 7-day reviews were not completed by the required deadline by a facility supervisor. Instead, the documentation revealed the reviews were conducted on the eleventh day of the detainee being housed in administrative segregation **(SMU-48[8])**.

CARE

MEDICAL CARE (MC)

ODO interviewed the HSA and assistant health services administrator (AHSA) and learned administrative meetings for the second and third quarters in FY 2020, were not held since the

[6] "The Form G-589 or equivalent should be used to describe generally each item of value." *See* ICE PBNDS 2011, Standard, Funds and Personal Property, Section (V)(G)(2).
[7] "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, Standard, Special Management Units, Section (V)(a)(3)(a).
[8] "A supervisor shall conduct an identical review after the detainee has spent seven days in administrative segregation." *See* ICE PBNDS 2011, Standard, Special Management Units, Section (V)(A)(3)(b).

facility experienced a staffing change in their health services administrative and mental health positions in November 2020. Subsequently, the former HSA and full-time mental health professional resigned in November 2020. A part- time licensed mental health counselor (LMHC) was hired on December 7, 2020, and the current AHSA started the position on December 21, 2020, and the HSA started on December 28, 2020 **(MC-284[9])**.

Furthermore, the administrative meeting agenda lacked review and discussion of communicable diseases and infectious control activities **(MC-285[10])**, no infectious disease activities were discussed **(MC-26[11])**, nor were there any meeting minutes to review **(MC-286[12])**. ODO found there were future plans for a meeting to be held on February 15, 2021, reviewed the planned meeting agenda, and noted the agenda included infectious and communicable disease activities and reporting of any actions to be taken.

ODO reviewed 13 detainee medical records and found one detainee was referred to the facility's mental health services during the intake screening process because he had a history of sexual abuse with suicidal thoughts. However, the detainee was evaluated four days later by the NP for his mental health concerns identified on the intake screening form **(MC-119[13]).**

> *Corrective Action:* Effective December 7, 2020, the facility hired a part-time LMHC, who was available to provide mental health services for the detainees and on-call for 24 hours, 7-days a week so mental health services will be provided in the required time frame **(C-1)**.

ODO reviewed 13 detainee medical records and found one detainee was referred to the facility's mental health services during the intake screening process because he had a history of sexual abuse with suicidal thoughts. However, the detainee was not evaluated within 72 hours of the initial referral **(MC-120[14]).**

> *Corrective Action:* Effective December 7, 2020, the facility hired a part-time LMHC, who was available to provide mental health services for the detainees and on-call for 24 hours, 7-days a week so mental health services will be given in the required time frame **(C-2).**

[9] "The HSA shall convene a meeting quarterly at minimum and include other facility and medical staff as appropriate." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(EE)(1).
[10] "The meeting agenda shall include, at minimum, the following:
a. an account of the effectiveness of the facility's health care program;
b. discussions of health environment factors that may need improvement;
c. review and discussion of communicable disease and infectious control activities;
d. changes effected since the previous meetings; and
e. recommended corrective actions, as necessary." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(EE)(1)(a-e).
[11] "Infectious and communicable disease control activities shall be reviewed and discussed in the quarterly administrative meetings as described in Section V.DD of this detention standard." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(C)(1).
[12] "Minutes of each meeting shall be recorded and kept on file." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(EE)(1).
[13] "The CMA, HSA or other qualified licensed health care provider shall ensure a full mental health evaluation, if indicated." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(J).
[14] "Mental health evaluations must be conducted within the timeframes prescribed in "O. Mental Health Program" of this standard." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(J).

Although, the same detainee received a full mental health evaluation by a psychiatric certified nurse practitioner (CNP), the detainee was not seen within the next business day **(MC-151[15]).**

Although, the same detainee received a full mental health evaluation by a psychiatric certified nurse practitioner (CNP), the detainee was not seen within 72-hours after being referred to the CNP by the NP **(MC-150[16]).**

Although, the same detainee received a full mental health evaluation by a psychiatric certified nurse practitioner (CNP), the detainee was not evaluated within 72-hours after being referred to the CNP by the NP **(MC-156[17]).**

Although, the same detainee received a full mental health evaluation by a psychiatric certified nurse practitioner (CNP), the detainee was evaluated not within one business day **(MC-157[18]).**

> *Corrective Action:* Effective December 7, 2020, the facility hired a part-time LMHC, who was available to provide mental health services for the detainees and on-call for 24 hours, 7-days a week **(C-3).**

Lastly, ODO found the RN referred the detainee to mental health services during the intake screening process because he had a history of sexual abuse. However, seven days later, the detainee received a full mental health evaluation by a psychiatric CNP, but not within 72 hours of the initial referral. With the resignation of a full-time mental health professional, who also provided 24 hours 7-days a week on-call services, the facility was without an on-call mental health professional from November 20, 2020, to December 7, 2020. During the interim, the medical director and NP were covering any on-call or urgent mental health services. Additionally, the facility had a tele-medicine contract with mental health providers, but services were only provided one day a week and did not allow for on-call or time sensitive evaluations **(MC-171[19])**.

> *Corrective Action:* Effective December 7, 2020, the facility hired a part-time LMHC, who was available to provide mental health services for the detainees and on-call for 24 hours, 7-days a week **(C-4).**

ODO reviewed three medical records of detainees prescribed psychotropic medications during the

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[15] "If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(O)(3).

[16] "Based on intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(O)(3).

[17] "Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(O)(4).

[18] "If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(O)(4).

[19] "When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(P).

period of June 23, 2020 to February 1, 2021 and found two out of three detainees did not have signed informed consent forms prior to the administration of the psychotropic medication. One detainee signed his consent form 19 days after starting the medications and the other detainee left the facility four days after being prescribed the medications and had not signed a consent form prior to transferring out of the facility **(MC-241[20])**. Obtaining signed consent forms prior to the administration of psychotropic medications were discovered after ODO reviewed the FY 2021 quarterly chart audits and weekly monitoring of the forms was initiated prior to the conclusion of the inspection. In addition, the facility medical staff were educated on the process during facility's staff in-service trainings on December 2, 2020, and December 30, 2020**.**

SIGNIFICANT SELF-HARM AND SUICIDE PREVENTION AND INTERVENTION (SSH&SPI)

ODO interviewed the HSA and AHSA and found the suicide prevention committee did not meet for the second and third quarters for FY 2020 **(SSH&SPI-4[21])**. The facility recently experienced a staffing change in their health services administrative and mental health positions. Additionally, the former HSA and full-time mental health professional resigned in November 2020. A part-time LMHC was hired on December 7, 2020, the current AHSA started on December 21, 2020, and the HSA started on December 28, 2020. ODO found there were future plans for a meeting to be held on February 15, 2021, and reviewed the planned meeting agenda and noted the agenda included infectious and communicable disease activities and reporting of any actions to be taken.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 20 standards under PBNDS 2011 (Revised 2016) and found the facility in compliance with 16 of those standards. ODO found 16 deficiencies in the remaining four standards. ODO commends facility staff for their responsiveness during this inspection and notes there were four instances where the facility's staff initiated immediate corrective action during the inspection. ODO cited a Best Practice in the Admission and Release section. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations.

[20] "Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication's side effects, shall be obtained." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(AA)(4).

[21] "The committee shall meet on at least a quarterly basis to provide input regarding all aspects of the facility's suicide prevention and intervention program, including suicide prevention policies and staff training." *See* ICE PBNDS 2011, Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V).

Compliance Inspection Results Compared	FY 2020 (PBNDS 2011) (Revised 2016)	FY 2021 (PBNDS 2011) (Revised 2016)
Standards Reviewed	18	20
Deficient Standards	9	4
Overall Number of Deficiencies	32	16
Repeat Deficiencies	3	0
Areas of Concern	2	0
Corrective Actions	1	4