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

Office of Detention Oversight Compliance Inspection

Enforcement and Removal Operations ERO Los Angeles Field Office

Desert View Modified Community Correctional Facility Adelanto, California

May 3-5, 2022

COMPLIANCE INSPECTION
of the
DESERT VIEW MODIFIED COMMUNITY CORRECTIONAL FACILITY
Adelanto, California

TABLE OF CONTENTS

COMPLIANCE INSPECTION TEAM MEMBERS

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

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 Desert View Modified Community Correctional Facility (DVA) in Adelanto, California, from May 3 to 5, 2022.[1] The facility opened in 2021 and is owned by the city of Adelanto and operated by the GEO Group, Inc. (GEO). The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at DVA in 2021 under the oversight of ERO's Field Office Director in Los Angeles (ERO Los Angeles). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2011 (Revised 2016).

ERO has assigned a deportation officer and a detention services manager. A GEO supervisor oversees daily facility operations and manages [redacted] support personnel. GEO provides food services and medical care, and Keefe provides commissary services at the facility. The facility does not hold any accreditations from any outside entities.

Capacity and Population Statistics	Quantity
ICE Bed Capacity[2]	[redacted]
Average ICE Population[3]	[redacted]
Adult Male Population (as of May 3, 2022)	[redacted]
Adult Female Population (as of May 3, 2022)	[redacted]

This was ODO's first compliance inspection of DVA.

[1] This facility holds male and female detainees with [redacted] security classification levels for periods greater than 72 hours.
[2] Data Source: ERO Facility List as of April 25, 2022.
[3] *Ibid.*

COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population greater than 10, and where detainees are housed for over 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 highlights instances when 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 its decision-making to better allocate resources across the agency's entire detention inventory.

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

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

PBNDS 2011 (Revised 2016) Standards Inspected[5,6]	Deficiencies
Part 1 - Safety	
Emergency Plans	1
Environmental Health and Safety	0
Sub-Total	**1**
Part 2 - Security	
Admission and Release	1
Custody Classification System	2
Funds and Personal Property	0
Post Orders	0
Searches of Detainees	0
Sexual Abuse and Assault Prevention and Intervention	0
Special Management Units	0
Use of Force and Restraints	3
Sub-Total	**6**
Part 4 - Care	
Food Service	0
Hunger Strikes	0
Medical Care	0
Medical Care (Women)	0
Personal Hygiene	0
Significant Self-harm and Suicide Prevention and Intervention	0
Sub-Total	**0**
Part 5 - Activities	
Correspondence and Other Mail	0
Trips for Non-Medical Emergencies	0
Marriage Requests	0
Voluntary Work Program	0
Sub-Total	**0**
Part 6 - Justice	
Legal Rights Group Presentations	0
Sub-Total	**0**
Part 7 - Administration and Management	
Detention Files	0

[5] For greater detail on ODO's findings, see the *Compliance Inspection Findings* section of this report.
[6] Beginning in FY 2022, ODO instituted a process of rotating all standards on a 3-year basis. As a result, some standard components may not be present in all standards.

Interview and Tours	0
Detainee Transfers	0
Sub-Total	**0**
Total Deficiencies	**7**

DETAINEE RELATIONS

ODO interviewed 19 detainees, who each voluntarily agreed to participate. None of the detainees made allegations of discrimination, mistreatment, nor abuse. Most detainees reported satisfaction with facility services except for the concerns listed below.

Medical Care: One detainee stated his concern for an operation on his shoulder as recommended by a medical doctor. The detainee also stated his pain remains constant and more than a month has passed since his last doctor's appointment.

- Action Taken: ODO reviewed the detainee's medical file and found the detainee arrived at the facility on November 11, 2021. Medical staff screened the detainee upon his arrival to DVA, issued him pain medication for his shoulder, and referred him to the clinical medical authority (CMA). The CMA evaluated the detainee on November 7, 2021, and the detainee never mentioned his shoulder pain. Medical staff subsequently examined the detainee's shoulder and referred him to an orthopedic specialist for further evaluation. On March 5, 2022, an X-ray of the detainee's right shoulder indicated mild degenerative joint disease. On April 5, 2022, magnetic resonance imaging of the detainee's shoulder revealed a near complete tear of the infraspinatus and partial tear of the supraspinatus. On April 13, 2022, the detainee started a 15-day physical therapy treatment. On April 20, 2022, an orthopedic specialist evaluated the detainee's shoulder and recommended continued physical therapy and a possible surgical repair of the torn rotator cuff. The CMA reevaluated the detainee on May 3, 2022, and ordered an additional week of physical therapy and pain medication. The CMA informed the detainee he would be reevaluated in a week to determine the need for surgery.

Medical Care: One detainee stated he has not received his new pair of dentures from the previous facility.

- Action Taken: ODO reviewed the detainee's medical file and found the detainee arrived at the facility in November 2021. Facility medical staff screened the detainee upon his arrival and noted his partial implant. The previous facility coordinated his denture fitting with the understanding it would be forwarded to the detainee at DVA. On May 3, 2022, the CMA reevaluated the detainee and confirmed the partial implant but did not have the denture from the previous facility on inventory. The CMA scheduled a priority dental appointment for the detainee on May 5, 2022, to fit him for a new set of partial implants.

Medical Care: One detainee stated his concern over treatment of his open leg wound. Additionally, he stated a facility specialist said the wound needed to be cleaned twice a day, but the facility allowed only one cleaning per day.

- Action Taken: On May 4, 2022, ODO reviewed the detainee's medical file and confirmed an outside hospital's recommendation to clean the wound twice per day. However, a facility medical doctor ordered cleaning the wound only once a day because too much cleaning would cause more harm than good. On May 5, 2022, the facility doctor found visible evidence of healing and ordered to continue cleaning the wound only once per day. ODO confirmed the facility medical staff advised the detainee of the doctor's decision.

Significant Self-harm and Suicide Prevention and Intervention: One detainee stated his thoughts of self- harm when he appears before the judge. He said he doesn't have suicidal ideations but just considers hurting himself. His phone calls to his aunt after court appearances help prevent him from such actions. He requested to see a therapist, especially after his appointments with the judge.

- Action Taken: On May 5, 2022, medical staff notified the facility administrator of the detainee's self-harm disclosure. The facility administrator immediately directed the facility psychologist to complete a psychological evaluation of the detainee. The psychologist replied that he had been meeting with the detainee since the detainee's arrival and asserted no need for an evaluation since the detainee never stated thoughts of self-harm. Additionally, the detainee receives follow-up mental health appointments every 2 weeks. On May 5, 2022, the psychologist met with the detainee, placed him on the suicide watch list, and scheduled follow-up appointments for May 6, 2022, and May 11, 2022 (after his court date). ODO contacted ERO on a follow-up call on May 16, 2022, and ERO confirmed no recent indications of self-harm from the detainee and continued evaluations of the detainee by the facility psychologist.

COMPLIANCE INSPECTION FINDINGS

SAFETY

EMERGENCY PLANS (EP)

ODO interviewed the assistant facility administrator and discovered DVA does not have escape-post equipment kits in the command center **(Deficiency EP-82[7])**.

SECURITY

ADMISSION AND RELEASE (AR)

ODO reviewed the facility's admission and release policy, interviewed the intake officer and compliance manager, and found the facility did not screen all detainees with a metal detector at admission **(Deficiency AR-12[8])**.

CUSTODY CLASSIFICATION SYSTEM (CCS)

ODO reviewed the facility custody classification system policy, interviewed the classification officer and compliance manager, and found inadequate training for assigned staff in the facility's classification process. Specifically, ODO found no records verifying staff the facility assigned classification duties received classification process training **(Deficiency CCS-5[9])**.

ODO reviewed the facility custody classification system policy, interviewed the classification officer and compliance manager, and found inadequate training for assigned staff in the facility's classification process. Specifically, ODO found no records verifying staff the facility assigned detainee in-processing duties received the required on-site training **(Deficiency CCS-6[10])**.

---

[7] "Escape-post equipment kits shall be stored in the command center and include, at a minimum:
1) a flashlight;
2) restraints (handcuffs and/or flex-cuffs) and tools necessary for removal;
3) a packet containing post location, map(s), fact sheet highlighting arrest authority, search procedures, apprehension techniques, etc.;
4) a radio; and
5) binoculars (as applicable)."
See ICE PBNDS 2011 (Revised 2016), Standard, Emergency Plans, Section (V)(E)(4)(c)(1-5).

[8] "All detainees shall be screened upon admission; screening shall ordinarily include:
a. screening with a metal detector."
See ICE PBNDS 2011 (Revised 2016), Standard, Admission and Release, Section (V)(B)(2)(a).

[9] "Each facility administrator shall require that the facility's classification system ensures the following: …
2. All facility staff assigned to classification duties shall be adequately trained in the facility's classification process. Each staff member with detainee in-processing responsibilities shall receive on-site training."
See ICE PBNDS 2011 (Revised 2016), Standard, Custody Classification System, Section (V)(A)(2).

[10] "Each facility administrator shall require that the facility's classification system ensures the following: …
2. All facility staff assigned to classification duties shall be adequately trained in the facility's classification process. Each staff member with detainee in-processing responsibilities shall receive on-site training."

USE OF FORCE AND RESTRAINTS (UOFR)

ODO reviewed one detainee's detention file involved in a use-of-force (UOF) incident during the inspection period and found the file did not contain a copy of the UOF report **(Deficiency UOFR-130[11])**.

Additionally, ODO reviewed the detainee's non-citizen file (A-File) and found the UOF report was not included with the A-File **(Deficiency UOFR-135[12])**.

ODO reviewed one UOF after-action review and found the facility administrator and assistant facility administrator did not conduct the after-action review **(Deficiency UOFR-154[13])**.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 24 standards under PBNDS 2011(Revised 2016) and found the facility in compliance with 20 of those standards. ODO found seven deficiencies in the remaining four standards. ODO commends facility staff member for their responsiveness during this inspection. ODO recommends ERO Los Angeles work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. A uniform corrective action plan was not required for DVA as this was ODO's first inspection of DVA.

Compliance Inspection Results Compared	FY 2021	FY 2022 PBNDS 2011 (Revised 2016)
Standards Reviewed	N/A	24
Deficient Standards	N/A	4
Overall Number of Deficiencies	N/A	7
Repeat Deficiencies	N/A	N/A
Areas Of Concern	N/A	0
Corrective Actions	N/A	1
Facility Rating	N/A	Superior

See ICE PBNDS 2011, Standard, Custody Classification System, Section (V)(A)(2).

[11] "A copy of the report shall be placed in the detainee's detention file." *See* ICE PBNDS 2011 (Revised 2016), Standard, Use of Force and Restraints, Section (V)(O).

[12] "Within two working days, copies of the report shall be placed in the detainee's A-File." *See* ICE PBNDS 2011 (Revised 2016), Standard, Use of Force and Restraints, Section (V)(O)(2).

[13] "The facility administrator, the assistant facility administrator, the Field Office Director's designee and the health services administrator (HSA) shall conduct the after-action review." *See* ICE PBNDS 2011 (Revised 2016), Standard, Use of Force and Restraints, Section (V)(P)(3).