



**U.S. Department of Homeland Security**  
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Office of Professional Responsibility  
ICE Inspections  
Washington, DC 20536-5501

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**Office of Detention Oversight  
Follow-Up Compliance Inspection**

**Enforcement and Removal Operations  
ERO Phoenix Field Office**

**CCA Florence Correctional Center  
Florence, Arizona**

**June 28-30, 2022**

**FOLLOW-UP COMPLIANCE INSPECTION**  
**of the**  
**CCA FLORENCE CORRECTIONAL CENTER**  
Florence, Arizona

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## **FOLLOW-UP COMPLIANCE INSPECTION TEAM MEMBERS**



Acting 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
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 follow-up compliance inspection of the CCA Florence Correctional Center (CCA FCC) in Florence, Arizona, from June 28 to 30, 2022.<sup>1</sup> This inspection focused on the standards found deficient during ODO’s last inspection of CCA FCC from December 6 to 9, 2021. The facility opened in 1999 and is owned and operated by CoreCivic. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at CCA FCC in 1987 under the oversight of ERO’s Field Office Director in Phoenix (ERO Phoenix). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2008.

ERO has assigned a supervisory detention officer, deportation officers, and a detention services manager (DSM) to the facility. A CCA FCC warden oversees daily facility operations and manages █████ support personnel. Trinity Service Group provides food services, CoreCivic provides medical care, and Keefe provides commissary services at the facility. The facility was accredited by the American Correctional Association in August 2019 and by the National Commission on Correctional Health Care in April 2019. In March 2021, CCA FCC was audited for the Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) and was DHS PREA certified.

Capacity and Population Statistics	Quantity
ICE Bed Capacity <sup>2</sup>	█████
Average ICE Population <sup>3</sup>	█████
Adult Male Population (as of June 28, 2022)	█████
Adult Female Population (as of June 28, 2022)	█████

During its last inspection, in Fiscal Year (FY) 2022, ODO found five deficiencies in the following areas: Classification System (1); Food Service (1); Hunger Strikes (1); and Medical Care (2).

<sup>1</sup> This facility holds male and female detainees with low, medium-low, medium-high, and high security classification levels for periods greater than 72 hours.

<sup>2</sup> Data Source: ERO Facility List as of June 27, 2022.

<sup>3</sup> *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 uniform corrective action plan (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 2008 MAJOR CATEGORIES

PBNDs 2008 Standards Inspected <sup>4,5</sup>	Deficiencies
<b>Part 1 - Safety</b>	
Emergency Plans	0
Environmental Health and Safety	2
<b>Sub-Total</b>	<b>2</b>
<b>Part 2 - Security</b>	
Admission and Release	7
Classification System	3
Facility Security and Control	0
Funds and Personal Property	4
Special Management Units	9
Staff-Detainee Communication	0
Use of Force and Restraints	2
<b>Sub-Total</b>	<b>25</b>
<b>Part 4 - Care</b>	
Food Service	5
Hunger Strikes	1
Medical Care	3
Personal Hygiene	1
Suicide Prevention and Intervention	2
<b>Sub-Total</b>	<b>12</b>
<b>Part 5 - Activities</b>	
Recreation	0
Telephone Access	1
<b>Sub-Total</b>	<b>1</b>
<b>Part 6 - Justice</b>	
Grievance System	0
<b>Sub-Total</b>	<b>0</b>
<b>Total Deficiencies</b>	<b>40</b>

<sup>4</sup> For greater detail on ODO's findings, see the *Follow-up Inspection Findings* section of this report.

<sup>5</sup> 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.

## DETAINEE RELATIONS

ODO interviewed 19 detainees, who each voluntarily agreed to participate. Due to COVID-19 considerations and restrictions within the facility, ODO was able to interview only 19 out of the 319 detainees. None of the detainees made allegations of discrimination, mistreatment, or abuse. Most detainees reported satisfaction with the facility services except for the concerns listed below.

*Food Service:* Three detainees stated their concern over meals with small portions, cold servings, and repetitive meals within the week.

- Action Taken: ODO verified that the dietitian-prepared nutritional analysis exceeded the recommended daily allowance for calories per scoop and portion sizes as detailed on the nutritional food preparation worksheet. ODO observed meal preparations and found the facility served portions in accordance with the menu. ODO verified temperatures at multiple points during the food preparation and delivery process and found that all temperatures fell within the requirements of the standard. Furthermore, ODO interviewed the food service director, reviewed the meal calendar, and found no evidence of repetition of meals on the same day or subsequent days.

*Law Libraries and Legal Materials:* One detainee stated his concern over the inaccessibility of the portable LexisNexis on the mobile law library because it froze during an update.

- Action Taken: ODO tested and confirmed unavailability of the LexisNexis on all computers and notified the facility point of contact (POC). ERO Phoenix removed the mobile law library to repair the software issue. ODO followed-up with the facility on July 19, 2022, and the facility warden confirmed the software issue was resolved and the mobile law library was updated with the current version of the LexisNexis software.

*Medical Care:* One detainee stated his personal doctor recommended surgery on his nasal passages to improve breathing, but the facility staff disapproved the recommended surgery.

- Action Taken: ODO interviewed the facility health services administrator (HSA), reviewed the detainee's medical records, and found the detainee submitted a sick call request on June 18, 2022, and a nurse practitioner (NP) examined him on the same day. The NP prescribed nasal spray and determined the detainee's symptoms did not warrant an appointment with an outside physician. On June 25, 2020, the detainee submitted a sick call request for difficulty breathing through his nose, and medical staff approved an appointment with a specialist. On July 19, 2022, ODO followed up the HSA and found the facility released the detainee from ICE custody on July 15, 2022.

*Medical Care:* One detainee stated he dislocated his left shoulder 15 days ago and required surgery. The detainee also stated the strength of his prescribed pain medication proved ineffective for him and requested a stronger dosage.

- Action Taken: ODO interviewed the HSA, reviewed the detainee's medical records, and found the detainee had acromioclavicular joint surgery on June 10, 2022. The

facility's medical staff attempted to conduct a post-surgery follow-up evaluation on June 25, 2022; however, the detainee declined the appointment and the facility's medical staff documented the refusal on a medical refusal form, which the detainee signed. At the request of ODO, the facility's medical staff examined the detainee on June 29, 2022, prescribed pain medication, and scheduled an appointment with the facility provider for July 1, 2022. ODO followed up with the HSA and found the facility provider evaluated the detainee on July 1, 2022, and determined the detainee required an outside consultation. ODO also confirmed that facility staff informed the detainee of his scheduled specialist appointment for August 30, 2022.

*Medical Care:* One detainee stated he submitted a sick call request due to pain in his right arm caused by four herniated disks in his back and 3 weeks passed before a facility provider examined him and prescribed medication that he found to be ineffective.

- Action Taken: ODO interviewed the HSA, reviewed the detainee's medical records, and found medical staff examined the detainee on the same day he submitted his sick call request, June 1, 2022. On June 4 and 9, 2022, the detainee submitted sick call requests and the provider examined him and prescribed pain medication. The facility HSA reported that the detainee refused a follow-up sick call appointment on June 13, 2022, and signed a medical refusal form. However, a facility medical provider examined him on June 18, 2022, after he submitted a sick call request on the previous day. The provider ordered C-spines and X-rays to be completed by June 20, 2022. On June 24, 2022, the provider reviewed the C-spines and X-ray results with the detainee and continued with his treatment plan. ODO followed up with the HSA on July 19, 2022, and confirmed the provider continued the detainee's medical plan of action and another follow-up appointment for July 28, 2022.

*Personal Hygiene:* One detainee stated he submitted a request to replace his sandals 3 months ago and has yet to receive the replacement sandals.

- Action Taken: ODO contacted facility staff regarding the detainee's request for new sandals and found no record of the detainee's request on file. A staff member informed the detainee on how to submit detainee requests and issued the detainee a new pair of sandals.

*Religious Practices:* One detainee stated the facility has times posted for designated religious services, but no clergymen preside over those services.

- Action Taken: ODO spoke to the chaplain and confirmed the posted worship service hours in the housing units; however, the in-person worship services have not officially begun due to continued COVID-19 restrictions. At the request of ODO, the chaplain informed the detainee of the continued COVID-19 restrictions.



*Staff-Detainee Communication:* Several detainees stated they have yet to see their assigned ICE officers after submitting ICE request forms.

- Action Taken: ODO interviewed the assigned ERO Phoenix ICE officer and confirmed his visits to the housing units twice a week, Tuesdays and Wednesday. The ICE officer stated he routinely informs detainees they can request additional visits via the facility-issued electronic tablets. ODO provided the detainees with the local ICE officer's contact information and requested ERO Phoenix send staff to visit them at the earliest opportunity. ODO confirmed ICE officers met with the detainees on June 29 and June 30, 2022.

*Environmental Health and Safety:* Multiple detainees stated concern over a lack of air conditioning in housing unit Motel Bravo.

- Action Taken: ODO interviewed the facility's maintenance supervisor and confirmed the facility was aware of an unserviceable air conditioner unit in housing unit Motel Bravo and that the facility will make the needed repairs once the facility receives the necessary parts, which could take as long as 1-month due to parts availability. On June 29, 2022, the housing unit manager moved all detainees from housing unit Motel Bravo to housing unit Delta Fox.

*Admission and Release/Medical Care:* One detainee stated facility staff removed him from housing unit Delta Fox on June 12, 2022, and placed him in COVID-19 quarantine for 9 days as retaliation for a verbal altercation with a correctional officer.

- Action Taken: ODO interviewed the HSA, reviewed the detainee's medical records, and found the detainee tested positive for COVID-19 during intake on June 9, 2022, and the facility placed the detainee on COVID-19 quarantine until he cleared the facility's COVID-19 protocols. ODO found no documented evidence for a punitive quarantine of the detainee. At the ODO's request, a facility staff member spoke with the detainee to discuss the COVID-19 protocols.

*Special Management Units:* One detainee stated facility staff placed him in segregation for a month due to a verbal altercation with a correctional officer for touching his groin twice during a pat-down. The detainee stated disciplinary action should have been taken against the officer.

- Action Taken: ODO reviewed the details pertaining to the incident in the facility's institutional panel disciplinary report, dated May 21, 2022, and found no documented grievance from the detainee about inappropriate touching by facility staff. Additionally, ODO learned the facility placed the detainee in segregation for continued violation of facility rules. ODO followed-up with the ICE compliance officer and informed him of the detainee's complaint. At the request of ODO, a staff member met with the detainee to answer any additional questions or concerns the detainee may have had.

*Telephone Access:* One detainee stated facility staff permits him to use the telephone for only 30 minutes on Sundays. The detainee stated he prefers to spread his 30-minute phone call at different times during the week.

- Action Taken: ODO interviewed facility staff and confirmed detainees receive 30 minutes of free telephone service per week, but the facility does not provide detainees the option of breaking up their 30-minute telephone allotment. ODO also found detainees may purchase additional phone credits at the commissary to use at their discretion. At ODO’s request, a staff member met with the detainee and informed him on the facility policy for free telephone usage.

*Telephone Access:* One detainee stated his lawyer does not accept collect calls, but the lawyer may call him at the facility.

- Action Taken: ODO confirmed the facility allows detainees to make telephone call to pro bono legal services at no cost. At ODO’s request, a staff member met with the detainee and informed him on how to contact his lawyer.

## **FOLLOW-UP COMPLIANCE INSPECTION FINDINGS**

### **SAFETY**

#### **ENVIRONMENTAL HEALTH AND SAFETY (EHS)**

ODO observed the facility barber shop operation and found improper cleaning and disinfecting of hair clippers after each detainee visit (**Deficiency EHS-205**<sup>6</sup>).

ODO observed the facility barber shop operation and found the facility did not prohibit the common use of brushes and neck dusters. Specifically, ODO inspected barber shop toolboxes and found brushes and neck dusters in two out of two boxes (**Deficiency EHS-208**<sup>7</sup>).

### **SECURITY**

#### **ADMISSION AND RELEASE (AR)**

ODO reviewed the CCA FCC site-specific facility detainee handbooks located in the intake area, interviewed the intake sergeant, reviewed ■ detainee files, and found facility staff issued detainees the handbook, dated March 5, 2018, rather than the current handbook, dated November 16, 2021, and found in ■ out of ■ detainee files, no documentation indicating the facility issued the handbook (**Deficiency AR-7**<sup>8</sup>).

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<sup>6</sup> “After each detainee visit, all hair care tools that come in contact with the detainee shall be cleaned and effectively disinfected.” See ICE PBNDs 2008, Standard, Environmental Health and Safety, Section (IX)(3).

<sup>7</sup> “The common use of brushes, neck duster, shaving mugs and shaving brushes is prohibited.” See ICE PBNDs 2008, Standard, Environmental Health and Safety, Section (IX)(4).

<sup>8</sup> “Each new arrival shall be oriented to facility operations through written material in the form of a handbook.” See ICE PBNDs 2008, Standard, Admission and Release, Section (V)(A).

ODO reviewed [REDACTED] admission staff training records and found in [REDACTED] out of [REDACTED] records, no documentation of training on the admissions process at the facility (**Deficiency AR-10<sup>9</sup>**).

ODO reviewed [REDACTED] detainee detention files converted from United States Marshals Service (USMS) inmate to ICE detainee status, interviewed the intake sergeant, and found staff did not prepare an itemized list of the detainees' baggage and personal property on the personal property inventory form. Specifically, staff secured the detainees' personal property in a supervisor's office until facility staff received clearance to deliver the property to a nearby ICE processing center (**Deficiency AR-38<sup>10</sup>**).

ODO interviewed the facility unit manager, reviewed the facility orientation checklist, and found the facility conducted an in-person interview instead of using an orientation video. ODO also found the orientation did not present an overview of the facility operations that most affect detainees as itemized on the checklist. Specifically, the orientation did not address the following required topics:

- Facility administrator's introduction;
- Typical detention-case chronology (what most detainees can expect);
- Authority, responsibilities, and duties of security officers;
- How the detainee can contact the deportation officer handling his or her docket;
- Availability of pro bono legal services, and how to pursue such services in the facility;
- Standards of conduct, including acceptable and unacceptable detainee behavior, with an overview of other rules and requirements;
- Disciplinary procedures, including criminal prosecution; grievance procedures; and the appeals process;
- Introduction to the individual departments (recreation, medical, etc.); the various housing units; and food services, including availability of diets which satisfy religious requirements;
- Schedule of programs, services and daily activities, including visitation, telephone usage, mail service, religious programs, count procedures, access to and use of the law library and the general library; and sick call procedures;
- Voluntary work program, with specific details including how to volunteer (**Deficiency AR-64<sup>11</sup>**).

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<sup>9</sup> "Staff members shall be provided with adequate training on the admissions process at the facility." *See* ICE PBNDS 2008, Standard, Admission and Release, Section (V)(B)(1).

<sup>10</sup> "In SPCs and CDFs, staff shall prepare an itemized list of the detainee's baggage and personal property, using the Personal Property Inventory Form." *See* ICE PBNDS 2008, Standard, Admission and Release, Section (V)(B)(5).

<sup>11</sup> "The video shall: ...

Present an overview of the facility operations that most affect the detainees.

- Facility administrator's introduction;
- Typical detention-case chronology (what most detainees can expect);
- Authority, responsibilities, and duties of security officers (ICE/DRO and contract);
- How the detainee can contact the deportation officer handling his or her docket;
- Availability of pro bono legal services, and how to pursue such services in the facility, including accessing Know Your Rights presentations (location of current listing, etc.);
- Standards of conduct, including acceptable and unacceptable detainee behavior, with an overview of other

ODO interviewed the unit manager, reviewed the facility orientation checklist, and found the facility conducted an in-person interview instead of using an orientation video. ODO also found the orientation did not present an overview of the facility operations that most affect detainees as itemized on the checklist. Specifically, the orientation did not address the following items:

- Facility administrator’s introduction;
- Typical detention-case chronology (what most detainees can expect);
- Authority, responsibilities, and duties of security officers;
- How the detainee can contact the deportation officer handling his or her docket;
- Availability of pro bono legal services, and how to pursue such services in the facility
- Standards of conduct, including acceptable and unacceptable detainee behavior, with an overview of other rules and requirements;
- Disciplinary procedures, including criminal prosecution; grievance procedures; and the appeals process;
- Introduction to the individual departments (recreation, medical, etc.); the various housing units; and food services, including availability of diets which satisfy religious requirements;
- Schedule of programs, services and daily activities, including visitation, telephone usage, mail service, religious programs, count procedures, access to and use of the law library and the general library; and sick call procedures;
- Voluntary work program, with specific details including how to volunteer (**Deficiency AR-65**<sup>12</sup>).

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rules and requirements;

- Disciplinary procedures, including criminal prosecution; grievance procedures; appeals process;
- Introduction to the individual departments (recreation, medical, etc.); the various housing units; and food services, including availability of diets which satisfy religious requirements;
- Schedule of programs, services and daily activities, including visitation, telephone usage, mail service, religious programs, count procedures, access to and use of the law library and the general library; and sick-call procedures;
- Voluntary work program, with specific details including how to volunteer.”

See ICE PBNDS 2008, Standard, Admission and Release, Section (V)(F)(3).

<sup>12</sup> “At a minimum, each video must provide the following material, which may appear in any order as long as the presentation is coherently organized and edited, with smooth transitions between subjects. The facility administrator may supplement the required information with explanations of particular policies, rules, and procedures: ...

- Facility administrator’s introduction;
- Typical detention-case chronology (what most detainees can expect);
- Authority, responsibilities, and duties of security officers (ICE/DRO and contract);
- How the detainee can contact the deportation officer handling his or her docket;
- Availability of pro bono legal services, and how to pursue such services in the facility, including accessing Know Your Rights presentations (location of current listing, etc.);
- Standards of conduct, including acceptable and unacceptable detainee behavior, with an overview of other rules and requirements;
- Disciplinary procedures, including criminal prosecution; grievance procedures; appeals process;
- Introduction to the individual departments (recreation, medical, etc.); the various housing units; and food services, including availability of diets which satisfy religious requirements;
- Schedule of programs, services and daily activities, including visitation, telephone usage, mail service, religious programs, count procedures, access to and use of the law library and the general library; and sick-call procedures;
- Voluntary work program, with specific details including how to volunteer.”

ODO reviewed [REDACTED] detainee files, interviewed the intake sergeant, and found in [REDACTED] out of [REDACTED] files, no documentation for the issue and receipt of the ICE National Detainee Handbook and in [REDACTED] out of [REDACTED] files, and no documentation for the issue of the site-specific facility detainee handbook (**Deficiency AR-68**<sup>13</sup>). **This is a repeat deficiency.**

ODO reviewed [REDACTED] detainee files, interviewed the intake sergeant, and found in [REDACTED] out of [REDACTED] files, no documentation for the acknowledged receipt of the ICE National Detainee Handbook and in [REDACTED] out of [REDACTED] files, and no documentation for the acknowledged receipt of the site-specific facility detainee handbook (**Deficiency AR-73**<sup>14</sup>).

### CLASSIFICATION SYSTEM (CCS)

ODO reviewed [REDACTED] detainee files and associated classification paperwork and found [REDACTED] detainees the facility housed were initially USMS inmates but changed status to ICE detainees while housed at the facility. Additionally, ODO found ERO Phoenix staff had not provided the necessary classification paperwork to facility staff, which delayed the facility staff between 4 and 6 days in completing the classifications of the three ICE detainees (**Deficiency CCS-3**<sup>15</sup>).

ODO reviewed [REDACTED] training records of staff members with detainee in-processing responsibilities and found in [REDACTED] out of [REDACTED] records, no documentation of on-site training for techniques to identify and record data from noncitizen files and related records for classification and procedures to prepare and file classification forms (**Deficiency CCS-4**<sup>16</sup>).

ODO reviewed [REDACTED] detainee files, interviewed the classification supervisor, and found ERO Phoenix did not provide the facility with the relevant information for the facility to classify [REDACTED] detainees. Specifically, ERO Phoenix had not provided the classification worksheet for three detainees that converted them from USMS inmate to ICE detainee status (**Deficiency CCS-25**<sup>17</sup>).

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*See ICE PBNDS 2008, Standard, Admission and Release, Section (V)(F)(4).*

<sup>13</sup> “In accordance with the Detention Standard on Detainee Handbook, every facility shall issue to each newly admitted detainee a copy of the ICE National Detainee Handbook and local supplement that fully describes all policies, procedures, and rules in effect at the facility.” *See ICE PBNDS 2008, Standard, Admission and Release, Section (V)(G)(1).*

<sup>14</sup> “As part of the admissions process, the detainee shall acknowledge receipt of the Handbook by signing where indicated on the back of the I-385 (or on a separate form).” *See ICE PBNDS 2008, Standard, Admission and Release, Section (V)(G)(4).*

<sup>17</sup> “Each facility administrator shall require that the facility’s classification system ensures that: ...

- All detainees shall be classified upon arrival and before being admitted into the general population. ICE/DRO staff shall provide CDFs and IGSA facilities the data needed from each detainee’s file to complete the classification process.”

*See ICE PBNDS 2008, Standard, Classification System, Section (V)(A).*

<sup>16</sup> In SPCs and CDFs, every staff member with detainee in-processing responsibilities shall receive on-site training that includes: ...

- Techniques for identifying and recording data from A-files and related records needed for classification purposes and
- Procedures for preparing and filing classification forms.” *See ICE PBNDS 2008, Standard, Classification System, Section (V)(A).*

<sup>17</sup> “As appropriate, ICE/DRO offices shall provide non-ICE/DRO facilities with the relevant information for the facility to classify ICE/DRO detainees.” *See ICE PBNDS 2008, Standard, Classification System, Section (V)(E).*

## FUNDS AND PERSONAL PROPERTY (FPP)

ODO reviewed [REDACTED] detainee detention files converted from USMS inmate to ICE detainee status, interviewed the intake sergeant, and found staff did not search the detainees' personal property for contraband. Specifically, staff secured the detainees' personal property in a supervisor's office until facility staff received clearance to deliver the property to a nearby ICE processing center (**Deficiency FPP-16**<sup>18</sup>).

ODO reviewed [REDACTED] detainee files and found in [REDACTED] out of [REDACTED] files, no forwarding address for lost or forgotten personal property in the facility after a detainee's departure (**Deficiency FPP-19**<sup>19</sup>).

ODO observed the housing units, interviewed the unit manager, and found every housing area did not have lockers or other securable space for detainees to store their authorized personal property. Specifically, the facility provided large duffel bags in the housing units; however, the facility did not have enough duffel bags to issue to each detainee (**Deficiency FPP-26**<sup>20</sup>).

ODO reviewed [REDACTED] detainee detention files converted from USMS inmate to ICE detainee status, interviewed the intake sergeant, and found staff did not use the personal property inventory form to list the detainees' baggage and personal property (separate from funds and valuables) upon conversion to ICE detainee status. Specifically, staff secured the detainees' personal property in a supervisor's office until facility staff received clearance to deliver the property to a nearby ICE processing center (**Deficiency FPP-49**<sup>21</sup>).

## SPECIAL MANAGEMENT UNITS (SMU)

ODO interviewed the chief of security, reviewed [REDACTED] detainee SMU files, and found in [REDACTED] out of [REDACTED] files, no documentation of a security supervisor conducting a review within 72 hours of a detainee's placement into administrative segregation (AS) to determine the necessity of segregation (**Deficiency SMU-109**<sup>22</sup>).

ODO interviewed the chief of security, reviewed [REDACTED] detainee SMU files, and found in [REDACTED] out of [REDACTED] files, no documentation of a supervisor conducting reviews of detainees within 72 hours of their placement into AS. Specifically, the facility staff did not interview the detainees nor file written records of the decisions and justifications (**Deficiency SMU-110**<sup>23</sup>).

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<sup>18</sup> "Staff shall search all arriving detainees' personal property for contraband." See ICE PBNDS 2008, Standard, Funds and Personal Property, Section (V)(D).

<sup>19</sup> "Standard operating procedure shall include obtaining a forwarding address from every detainee." See ICE PBNDS 2008, Standard, Funds and Personal Property, Section (V)(D).

<sup>20</sup> "Every housing area shall have lockers or other securable space for storing detainees' authorized personal property." See ICE PBNDS 2008, Standard, Funds and Personal Property, Section (V)(E).

<sup>21</sup> "An itemized inventory of all detainee baggage and personal property (separate from funds and valuables) shall be completed during admissions processing using the personal property inventory form." See ICE PBNDS 2008, Standard, Funds and Personal Property, Section (V)(I).

<sup>22</sup> "A security 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 2008, Standard, Special Management Units, Section (V)(C)(3)(a).

<sup>23</sup> "The review shall include an interview with the detainee. A written record shall be made of the decision and the justification." See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(C)(3)(a).

ODO interviewed the chief of security, reviewed [REDACTED] detainee disciplinary segregation (DS) files, and found in [REDACTED] out of [REDACTED] files, no written disciplinary segregation order (DSO), Form I-883 or equivalent, completed and signed by the disciplinary hearing officer (DHO) before facility staff placed a detainee into DS (**Deficiency SMU-131**<sup>24</sup>).

ODO interviewed the chief of security, reviewed [REDACTED] detainee DS files, and found in [REDACTED] out of [REDACTED] files, no DSO completed and signed by the DHO, which prevented the facility staff from giving the detainee a copy of the order within 24 hours (**Deficiency SMU-132**<sup>25</sup>).

ODO interviewed the chief of security, reviewed [REDACTED] detainee DS files, and found in [REDACTED] out of [REDACTED] files, no DSO listing the reasons for placing a detainee in DS before actual placement (**Deficiency SMU-133**<sup>26</sup>).

ODO interviewed the chief of security, reviewed [REDACTED] detainee DS files, and found in [REDACTED] out of [REDACTED] files, no DSO completed and signed by the DHO. Specifically, facility staff did not attach relevant documentation to the order (**Deficiency SMU-134**<sup>27</sup>).

ODO interviewed the chief of security, reviewed 10 detainee DS files, and found [REDACTED] out of [REDACTED] files, no DSO completed and signed by the DHO, detailing the reasons for placing a detainee in DS. Specifically, facility staff did not give a copy of the order to the detainee within 24 hours of placement into DS (**Deficiency SMU-135**<sup>28</sup>).

ODO interviewed the chief of security, reviewed [REDACTED] detainee DS files, and found in [REDACTED] out of [REDACTED] files, no DSO completed and signed by the DHO. Specifically, facility staff did not keep the order on file in the SMU (**Deficiency SMU-136**<sup>29</sup>).

ODO interviewed the chief of security, reviewed [REDACTED] DS files, and found in [REDACTED] out of [REDACTED] files, no DSO completed and signed by the DHO. Specifically, the releasing officer did not indicate the date and time of release on the order (**Deficiency SMU-137**<sup>30</sup>).

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<sup>24</sup> “A written order shall be completed and signed by the chair of the IDP (or disciplinary hearing officer) before a detainee is placed into Disciplinary Segregation.” See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(D)(2).

<sup>25</sup> “A copy of the order shall be given to the detainee within 24 hours, unless delivery would jeopardize the safety, security, or the orderly operation of the facility or the safety of another detainee.” See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(D)(2).

<sup>26</sup> “The IDP chairman shall prepare the Disciplinary Segregation Order (Form I-883 or equivalent), detailing the reasons for placing a detainee in Disciplinary Segregation, before his or her actual placement.” See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(D)(2)(a).

<sup>27</sup> “All relevant documentation must be attached to the order.” See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(D)(2)(a).

<sup>28</sup> “A copy of the completed Disciplinary Segregation Order shall be given to the detainee within 24 hours of placement in Disciplinary Segregation, unless delivery would jeopardize the safe, secure, or orderly operation of the facility.” See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(D)(2)(b).

<sup>29</sup> “The order shall be maintained on file in the SMU until the detainee is released from the SMU.” See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(D)(2)(b).

<sup>30</sup> “When the detainee is released from the SMU, the releasing officer shall indicate date and time of release on the Disciplinary Segregation Order, then forward the completed order to the chief of security for insertion into the detainee’s detention file.” See ICE PBNDS 2008, Standard, Special Management Units, Section (V)(D)(2)(b).

## USE OF FORCE AND RESTRAINTS (UOFR)

ODO interviewed the chief of security, reviewed two use-of-force (UOF) files that occurred during the inspection period, and found in one out of two files, the four-member after-action review team did not convene on the workday after the incident. Specifically, the after-action review team convened on the third workday after the incident (**Deficiency UOFR-143**<sup>31</sup>).

ODO interviewed the chief of security, reviewed two immediate UOF files along with the audiovisual recordings, which occurred during the inspection period, and found in two out of two files, the medical professional did not promptly examine the detainee and report the findings on the audiovisual record and the after-action review team did not note this discrepancy during its review of the incidents (**Deficiency UOFR-146**<sup>32</sup>).

## CARE

### FOOD SERVICE (FS)

ODO interviewed the food service director (FSD), toured the food service area, observed foods prepared from ingredients at room temperature, and found the staff did not cool the foods to 41 Fahrenheit (F) degrees within 2 hours of cooking. Specifically, on June 29, 2022, ODO observed the temperature of pasta salad at 63 F degrees, 3 hours after FS staff prepared the pasta salad (**Deficiency FS-143**<sup>33</sup>).

ODO reviewed the site-specific facility detainee handbook and found no details on the facility's no-pork menu (**Deficiency FS-199**<sup>34</sup>). **This is a repeat deficiency.**

ODO reviewed the three-compartment sink sanitizing concentration logs and found staff did not periodically check and adjust, as necessary, the chemical concentrations in the sanitizing solution using a test kit. Specifically, facility staff tested the sanitizing solution concentrations in 8 out of 178 days instead of daily (**Deficiency FS-352**<sup>35</sup>).

ODO reviewed dishwasher temperatures logs for 534 meals served during the inspection period and found in 16 out of 534 meals, staff did not check the temperature of the dishwasher (**Deficiency**

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<sup>31</sup> "This four-member After-Action Review team shall convene on the workday after the incident." See ICE PBNSD 2008, Standard, Use of Force and Restraints, Section (V)(P)(2).

<sup>32</sup> "The After-Action Review team shall also review the audiovisual recording of any use-of-force incidents for compliance with all provisions of this standard, with particular attention paid to: Whether a medical professional promptly examined the detainee, with the findings reported on the audiovisual record." See ICE PBNSD 2008, Standard, Use of Force and Restraints, Section (V)(P)(3).

<sup>33</sup> "Foods prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna, must be cooled to 41 F degrees within two hours of cooking." See ICE PBNSD 2008, Standard, Food Service, Section (V)(F)(3).

<sup>34</sup> "If a facility has a no-pork menu, in order to alleviate any confusion for those who observe no-pork diets for religious reasons, this information should be included in the facility's handbook and the facility orientation." See ICE PBNSD 2008, Standard, Food Service, Section (V)(G) (2nd 5).

<sup>35</sup> "Periodically check and adjust as necessary the chemical concentrations in a sanitizing solution, using a test kit." See ICE PBNSD 2008, Standard, Food Service, Section (V)(J)(7)(f)(4)(c)(5).



FS-411<sup>36</sup>).

ODO reviewed refrigeration/freezer temperature logs and found staff did not check temperatures on a site-specific schedule established by the food service administrator. Specifically, staff did not check refrigeration/freezer temperatures for 11 out of 356 scheduled checks (**Deficiency FS-413**<sup>37</sup>).

### HUNGER STRIKES (HS)

ODO reviewed █ custody staff training files and found in █ out of █ files, no documentation of annual training to recognize signs of a hunger strike and to implement procedures on referral for medical assessment and for management of a detainee on a hunger strike (**Deficiency HS-1**<sup>38</sup>). **This is a repeat deficiency.**

### MEDICAL CARE (MC)

ODO reviewed █ detainee medical records and found in █ out of █ records, the facility did not conduct a tuberculosis (TB) screening within 12 hours of intake. Specifically, facility staff completed the TB screening approximately 48 hours after the detainee arrived at the facility (**Deficiency MC-20**<sup>39</sup>).

ODO reviewed █ detainee medical records and found in █ out of █ records, a health care provider or a detention officer specially trained to perform this function, did not conduct an initial medical, dental, nor mental health screening within 12 hours of the detainee's arrival. Specifically, facility staff completed the initial medical, dental, and mental health screening approximately 48 hours after the detainee arrived at the facility (**Deficiency MC-74**<sup>40</sup>).

ODO reviewed █ custody staff training files and found in █ out of █ files, no documentation of annual training for cardiopulmonary resuscitation nor automated external defibrillators, nor

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<sup>36</sup> "Checks of equipment temperatures shall follow this schedule: ...

• Dishwashers: every meal;"

See ICE PBNDS 2008, Standard, Food Service, Section (V)(J)(13).

<sup>37</sup> "Checks of equipment temperatures shall follow this schedule: ...

• Refrigeration/freezer equipment (walk-in units): site-specific schedule, established by the FSA." See ICE PBNDS 2008, Standard, Food Service, Section (V)(J)(13).

<sup>38</sup> "All staff shall be initially and annually trained to recognize the signs of a hunger strike and on the procedures for referral for medical assessment, and on the correct procedures for managing a detainee on a hunger strike." See ICE PBNDS 2008, Standard, Hunger Strikes, Section (V)(A).

<sup>39</sup> "All new arrivals shall receive TB screening within 12 hours of intake and using methods in accordance with CDC guidelines for non-minimal risk detention facilities [symptom screening plus at least one of the following: tuberculin skin test (TST), chest radiography, or QuantiFERON-TB Gold or In-tube test (QFT)]; for CDC guidelines on prevention and control of TB in correctional and detention settings, see [http://www.cdc.gov/tb/pubs/mmwr/Maj\\_guide/Correctional.htm/](http://www.cdc.gov/tb/pubs/mmwr/Maj_guide/Correctional.htm/)." See ICE PBNDS 2008, Standard, Medical Care, Section (V)(C)(2).

<sup>40</sup> "Initial medical, dental, and mental health screening shall be done within 12 hours of arrival by a health care provider or a detention officer specially trained to perform this function." See ICE PBNDS 2008, Standard, Medical Care, Section (V)(I)(1).

emergency first aid training (**Deficiency MC-131**<sup>41</sup>).

## **PERSONAL HYGIENE (PH)**

ODO observed a detainee barber in the barber shop clipping hair of other detainees and not sanitizing the equipment after servicing each detainee (**Deficiency PH-33**<sup>42</sup>).

## **SUICIDE PREVENTION AND INTERVENTION (SPI)**

ODO reviewed █ custody staff training files and found in █ out of █ files, no documentation of annual SPI training for facility staff who interact with and bear responsibility for detainees (**Deficiency SPI-4**<sup>43</sup>).

ODO reviewed █ detainee medical records and found in █ out of █ records, a qualified health care professional or health-trained correctional officer did not conduct an initial mental health screening by within 24 hours of the detainee's admission. Specifically, facility staff completed the initial mental health screening approximately 48 hours after the detainee arrived at the facility (**Deficiency SPI-7**<sup>44</sup>).

## **ACTIVITIES**

### **TELEPHONE ACCESS (TA)**

ODO reviewed the facility telephone access policy, interviewed the housing unit manager, reviewed the documentation provided by the facility, and found no documentation for inspecting and logging telephones daily. Specifically, ODO inspected three housing unit logs covering the period from January to June 2022 and found several dates lacked entries for daily phone checks (**Deficiency TA-8**<sup>45</sup>).

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<sup>41</sup> "The plan will include the following: ...

- All detention staff shall receive cardiopulmonary resuscitation (CPR, AED) , and emergency first aid training annually;
- Detention and health care personnel will be trained annually to respond to health-related situations within four (4) minutes;"

*See ICE PBNDS 2008, Standard, Medical Care, Section (V)(O).*

<sup>42</sup> "Detainees shall be provided hair care services in a manner and environment that promotes sanitation and safety, in accordance with the requirements for Barber Operations in the Detention Standard on Environmental Health and Safety." *See ICE PBNDS 2008, Standard, Personal Hygiene, Section (V)(F).*

<sup>43</sup> "All facility staff who interact with and/or are responsible for detainees shall be trained, during orientation and at least annually." *See ICE PBNDS 2008, Standard, Suicide Prevention and Intervention, Section (V)(A).*

<sup>44</sup> "All detainees shall receive an initial mental health screening, by a qualified health care professional or health-trained Correctional Officer, who has been specially trained, within 24 hours of admission." *See ICE PBNDS 2008, Standard, Suicide Prevention and Intervention, Section (V)(B).*

<sup>45</sup> "Designated facility staff shall inspect the telephones daily, promptly report out-of-order telephones to the repair service and ensure that required repairs are completed quickly. This information will be logged." *See ICE PBNDS 2008, Standard, Telephone Access, Section (V)(A)(3).*

## CONCLUSION

During this inspection, ODO assessed the facility's compliance with 17 standards under PBNDS 2008 and found the facility in compliance with 5 of those standards. ODO found 40 deficiencies in the remaining 12 standards. ODO noted a significant increase in the number of deficiencies cited in this follow-up inspection as compared to the full inspection ODO conducted in December 2021, and recommends ERO Phoenix work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. ODO has not received the UCAP for ODO's last inspection of CCA FCC in December 2021.

<b>Compliance Inspection Results Compared</b>	<b>First FY 2022 (PBNDS 2008)</b>	<b>Second FY 2022 (PBNDS 2008)</b>
Standards Reviewed	22	17
Deficient Standards	4	12
Overall Number of Deficiencies	5	40
Repeat Deficiencies	0	3
Areas Of Concern	0	0
Corrective Actions	0	0
Facility Rating	Superior	N/A