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
Compliance Inspection

Enforcement and Removal Operations
ERO Phoenix Field Office

La Palma Correctional Center
Eloy, Arizona

January 25-29, 2021

COMPLIANCE INSPECTION
of the
La Palma Correctional Center
Eloy, Arizona

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COMPLIANCE INSPECTION TEAM MEMBERS

[redacted]	Team Lead	ODO
	Inspections and Compliance Specialist	ODO
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	Contractor	Creative Corrections
	Contractor	Creative Corrections
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	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 La Palma Correctional Center (LPCC) in Eloy, Arizona, from January 25-29, 2021.[1] The facility opened in June 2008 and is owned and operated by CoreCivic. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at LPCC in July 2018 under the oversight of ERO's Field Office Director in Phoenix (ERO Phoenix). 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 LPCC warden handles daily facility operations and is supported by [redacted] personnel. Trinity Service Group provides food services and CoreCivic provides medical care and commissary services at the facility. The facility was accredited by the American Correctional Association in January 2019. The facility started a Department of Homeland Security Prison Rape Elimination Act (PREA) audit in January 2021, but the facility had not completed the audit since an on-site visit had to be postponed due to the COVID-19 pandemic.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	1620
Average ICE Detainee Population[3]	[redacted]
Male Detainee Population (as of 1/25/2021)	[redacted]
Female Detainee Population (as of 1/25/2021)	N/A

During its last inspection, in Fiscal Year (FY) 2020, ODO found 20 deficiencies in the following areas: Admission and Release (4); Funds and Personal Property (2); Use of Force and Restraints (1); Food Service (3); Personal Hygiene (1); Grievance System (2); Sexual Abuse and Assault Prevention and Intervention (1); Special Management Units (2); Staff-Detainee Communication (3); and Telephone Access (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 25, 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	1
Sub-Total	**1**
Part 2 – Security	
Admission and Release	2
Custody Classification System	2
Facility Security and Control	0
Funds and Personal Property	1
Population Counts	0
Sexual Abuse and Assault Prevention and Intervention	0
Special Management Units	0
Staff-Detainee Communication	0
Use of Force and Restraints	1
Sub-Total	**6**
Part 4 – Care	
Food Service	2
Hunger Strikes	0
Medical Care	0
Significant Self-harm and Suicide Prevention and Intervention	0
Disability Identification, Assessment, and Accommodation	0
Sub-Total	**2**
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	**9**

[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 or mistreatment. One detainee described having suicidal ideations and another detainee reported a sexual assault during the interview process. ODO immediately referred both detainees to ERO Phoenix and the facility's medical staff for follow-up. Most detainees reported satisfaction with facility services except for the concerns listed below. ODO conducted detainee interviews via video teleconference.

Sexual Abuse and Assault Prevention and Intervention: One detainee stated another detainee raped him on or near December 10, 2020, and the incident occurred inside his cell. The detainee informed ODO he reported the incident to an unknown correctional officer (CO) at LPCC and he also called the facility's posted PREA hotline phone number to report the incident. Additionally, the detainee stated the facility took no action after he reported the incident and the detainee stated he felt depressed, suicidal, and had difficulty sleeping because of the assault.

- Action Taken: ODO immediately reported the rape allegation to a facility officer and to ERO Phoenix. The PREA protocol was initiated on January 25-26, 2021, and the detainee was taken to the facility's medical clinic for an examination and evaluation. On January 25, 2021, the detainee was also seen by an LPCC mental health provider who determined not to put the detainee on suicide watch. The detainee was last seen by the mental health provider on March 2, 2021, and he was receiving monthly follow-up counseling. ODO spoke to the chief of unit management/PREA compliance manager, who informed ODO a facility PREA investigator had initiated an investigation and interviewed the detainee about the allegation. ERO Phoenix also opened an investigation into the incident, reported the incident to the Joint Intake Center (JIC), and issued an ICE Significant Incident Report about the allegation. ERO Phoenix informed ODO, following the date of the alleged incident, they had removed the alleged perpetrator from the facility and deported him back to his home country. At the conclusion of the inspection, the facility's investigation of the incident was still in progress.

Significant Self-harm and Suicide Prevention and Intervention: A transgender female detainee stated another detainee verbally attacked her and a CO from her housing unit harassed her. She informed ODO she submitted a request to see a psychiatrist in early January 2021, and the facility had not provided counseling for the incident nor for past trauma. Additionally, she informed ODO she had suicidal ideations and would like to be moved to another housing unit or transferred to another facility.

- Action Taken: ODO informed the facility's health services administrator (HSA) of the detainee's suicidal ideations and requested the HSA conduct a medical record review of the detainee's medical records. A facility nurse evaluated the detainee on January 8, 2021, for a medical request the facility's medical staff received that day. During the nurse's evaluation, the detainee reported having previous thoughts of harming herself; however, she denied having current thoughts of committing self-harm. The nurse consulted with the facility's psychiatrist and the psychiatrist prescribed a one-time dose of clonidine (0.1 mg) for anxiety. The psychiatrist determined additional suicidal precautions were not necessary for the detainee. The facility's medical staff scheduled

an appointment for January 12, 2021, for her to follow-up with the facility's psychiatry staff, for her anxiety and depression. The facility's psychiatry staff implemented and adjusted a treatment plan, which included medication of varying doses for her anxiety and depression, and monthly follow-ups by the facility's psychiatry staff. The facility's psychiatry staff instructed the detainee to request follow-ups sooner than one-month, if needed. During the inspection, ERO Phoenix offered to move the detainee into their protective custody (PC) unit because her classification level prevented a move to another housing unit; however, she refused the move to the PC unit. On January 21, 2021, the LPCC Facility Investigator, examined the allegation of staff misconduct and it was determined that there was no indication/evidence the CO in the detainee's housing unit had mistreated any detainee. Therefore, the staff misconduct allegation was not reported to the JIC.

Food Service: Seven out of the 12 detainees interviewed stated their meals were repetitive and the food was not of good quality. One detainee stated the facility punished his housing unit for three-months, from September 2020 thru November 2020, by serving sandwiches for all three of their daily meals. Additionally, the facility did not tell the detainees why their housing unit was being punished.

- Action Taken: ODO interviewed the facility's food service director, quality assurance manager, and chief of security, and found the COVID-19 pandemic significantly affected the facility's food service operation between August 2020 and December 2020. Specifically, the facility had to remove all detainees from their work assignments in the food service department, which left only Trinity Service Group contract staff to handle all food service department operations. Trinity Service Group had between two and three contract staff assigned to the morning shift and between three and four contract staff assigned to the evening shift. The reduced workforce prevented the food service department from executing their main 35-day cycle menu, which resulted in the food service department implementing a temporary, one-week box lunch menu.

  Beginning in early December 2020, the food service department added four to five contract staff and six to ten medically cleared detainees to both the morning and evening shifts. This additional staffing allowed the facility's food service department to transition from the one-week box lunch menu to a full-service one-week cycle menu. The facility's food service department further expanded to a full-service two-week cycle menu on January 22, 2021.

  ODO reviewed the three alternate menus the facility implemented and found although the menus were limited as compared to the facility's 35-day cycle menu, a registered dietician certified each menu as nutritionally adequate. A facility housing unit manager spoke with the detainee who stated his housing unit was being punished. The housing unit manager explained to the detainee the facility had to implement the temporary menus due to the COVID-19 pandemic and it was not for disciplinary reasons. Because this was a contingency inspection, ODO was unable to assess the quality of the food the facility served the detainees.

COMPLIANCE INSPECTION FINDINGS

SAFETY

ENVIRONMENTAL HEALTH AND SAFETY (EH&S)

ODO interviewed the facility's safety manager, reviewed six [redacted], and found the [redacted] **eficiency EH&S-42**[6]).

SECURITY

ADMISSION AND RELEASE (A&R)

ODO reviewed 12 detainee files and found all 12 files contained an Order to Detain or Release Form (Form I-203); however, 2 out of 12 Forms I-203s did not bear the authorizing official signature, which was a repeat deficiency **(Deficiency A&R-54**[7]**)**.

ODO interviewed the facility's release staff and found the facility did not conduct a check for wants and warrants during the release process **(Deficiency A&R-77**[8]**)**.

CUSTODY CLASSIFICATION SYSTEM (CCS)

ODO reviewed the facility's classification policy, procedures, and documentation, spoke with the facility's classification staff, and found ERO Phoenix had not reviewed nor approved the facility's locally developed custody classification instrument **(Deficiency CCS-2**[9]**)**.

ODO reviewed the classification records for 12 detainees and found one detainee, who the facility initially classified as low-custody, was found guilty of institutional misconduct for assault, and the facility subsequently reclassified him as low-custody and housed him in a low-custody housing unit **(Deficiency CCS-38**[10]**)**.

FUNDS AND PERSONAL PROPERTY (F&PP)

ODO reviewed the facility's personal property inventory form and found the form did not contain the disposition of the article with the capital letter "S" for "safekeeping" (by the facility's name),

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[6] "Every area shall maintain a [redacted] used and store there. … The entries shall contain relevant data, including purchase dates and quantities, use dates and quantities and quantities on hand." *See* ICE PBNDS 2011, Standard, Environmental Health and Safety, Section (V)(B)(3).

[7] "An Order to Detain or an Order to Release the detainee (Form I-203 or I-203a), bearing the appropriate ICE/ERO Authorizing Official signature, must accompany each newly arriving detainee." *See* ICE PBNDS 2011, Standard, Admission & Release, Section (V)(E). **This is a Repeat Deficiency**.

[8] "Necessary steps include but are not limited to: checking wants and warrants." *See* ICE PBNDS 2011, Standard, Admission and Release, Section (V)(H).

[9] "Facilities may rely on the ICE Custody Classification Worksheet, or a similar locally established system, subject to ICE/ERO evaluation and approval." *See* ICE PBNDS 2011, Standard, Custody Classification System, Section (V)(A).

[10] [redacted]

nor the capital letter "R" for "retained" (by the detainee' name). Additionally, ODO reviewed 12 detainee files and found the facility did not designate property as "S" nor "R" on any of the personal property inventory forms from the 12 detainee files **(Deficiency F&PP-87[11])**.

USE OF FORCE AND RESTRAINTS (UOF&R)

ODO reviewed the audio-visual recordings for three out of six calculated UOF incidents, which took place since ODO's last inspection, and found the UOF team members did not remove their [redacted] to reveal their faces when they introduced themselves in two out of three audio-visual recordings **(Deficiency UOF&R-73[12])**.

CARE

FOOD SERVICE (FS)

ODO interviewed the facility's chaplain and quality assurance manager and found the facility did not file Authorization for Common Fare Participation Forms used for religious diet participation in the detainee's detention file **(Deficiency FS-175[13])**.

ODO interviewed the facility's chaplain and quality assurance manager and found the facility did not file the second copy of the consultation sheet for religious diet participation in the detainee's detention file **(Deficiency FS-186[14])**.

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 14 of those standards. ODO found nine deficiencies in the remaining six standards. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations.

[11] "The personal property inventory form must contain the following information at a minimum: a. "S" for "safekeeping" (by the facility); or b. R" for "retained" (by the detainee)." *See* ICE PBNDS 2011, Standard, Funds and Personal Property, Section (V)(I)(3)(a-b).

[12] "Calculated use-of-force incidents shall be audio visually-recorded in the following order: … b. Faces of all team members shall briefly appear (with helmets removed and heads uncovered), one at a time, identified by name and title." *See* ICE PBNDS 2011, Standard, Use of Force and Restraints, Section (V)(I)(2)(b).

[13] "If participation is approved, the chaplain or FSA shall forward a copy of the form for inclusion in the detainee's detention file." *See* ICE PBNDS 2011, Standard, Food Service, Section (V)(G)(1).

[14] "The second copy of the consultation sheet shall be filed in the detainee's detention file." *See* ICE PBNDS 2011, Standard, Food Service, Section (V)(G)(1).

Compliance Inspection Results Compared	FY 2020 (PBNDS 2011) (Revised 2016)	FY 2021 (PBNDS 2011) (Revised 2016)
Standards Reviewed	19	20
Deficient Standards	10	6
Overall Number of Deficiencies	20	9
Repeat Deficiencies	2	1
Areas of Concern	0	0
Corrective Actions	2	0