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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 Denver Field Office

Denver Contract Detention Facility

Aurora, CO

April 12-14, 2016

**COMPLIANCE INSPECTION
for the
DENVER CONTRACT DETENTION FACILITY
Aurora, Colorado**

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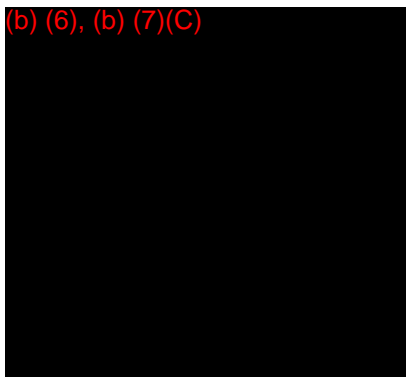
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INSPECTION TEAM MEMBERS



Lead Inspections and Compliance Specialist	ODO
Inspections and Compliance Specialist	ODO
Inspections and Compliance Specialist	ODO
Inspections and Compliance Specialist	ODO
Contractor	Creative Corrections
Contractor	Creative Corrections
Contractor	Creative Corrections
Contractor	Creative Corrections

EXECUTIVE SUMMARY

The Office of Detention Oversight (ODO) conducted a compliance inspection of the Denver Contract Detention Facility (DCDF) in Aurora, Colorado, from April 12 to 14, 2016.¹ DCDF opened in 1997 and is owned and operated by The GEO Group, Inc. (GEO). The Office of Enforcement and Removal Operations (ERO) began housing detainees at DCDF in July 2010 pursuant to a contract, under the oversight of ERO’s Field Office Director (FOD) in Denver.

ERO staff members are assigned to the facility. There is an ERO Detention Services Manager position assigned to the facility, but it is currently vacant. A GEO Warden is responsible for oversight of daily facility operations and is supported by (b) (7) personnel. GEO provides both medical care and food services. The facility is accredited by both the American Correctional Association and the National Commission on Correctional Health Care.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity ²	432
Average ICE Detainee Population ³	457
Male Detainee Population (as of 04/12/2016)	431
Female Detainee Population (as of 04/12/2016)	46

OVERALL FINDINGS

In May 2012, ODO conducted an inspection of the DCDF under the Performance-Based National Detention Standards (PBNDS) 2008, reviewing the facility’s compliance with 16 standards and finding the facility compliant with eight standards. There were a total of 11 deficiencies in the remaining eight standards.

Inspection Results Compared	FY 2012 (PBNDS 2008)	FY2016 (PBNDS 2011)
Standards Reviewed	16	16
Deficient Standards	8	9
Overall Number of Deficiencies	11	24
Deficient Priority Components	N/A ⁴	6
Corrective Actions Initiated	0	6

In FY2016, ODO conducted an inspection of the DCDF under the Performance Based National Detention Standards (PBNDS) 2011. ODO reviewed the facility’s compliance with 16 standards and found the facility compliant with seven standards. ODO found 24 deficiencies in the remaining nine standards, six of which were priority components and one of which was a repeat deficiency.⁵ Finally, ODO identified six instances in which the facility initiated corrective action during the course of the inspection.⁶

¹ Male and female detainees with low, medium low, medium high, and high security classification levels are detained at the facility for longer than 72 hours.

² Data Source: ERO Facility List Report as of April 11, 2016.

³ *Ibid.*

⁴ ICE identified and issued Priority Components for PBNDS 2008 in February 2013.

⁵ ODO identified a repeat deficiency from the May 2012 inspection in the Special Management Units standard.

⁶ Corrective actions, where immediately implemented, best practices, and ODO recommendations, as applicable, have been identified in the Inspection Findings section and annotated with a “C,” “BP,” or “R,” respectively.

FINDINGS BY PBNDS 2011 MAJOR CATEGORIES

PBNDS 2011 STANDARDS INSPECTED ⁷	DEFICIENCIES
Part 1 – Safety	
1.2 - Environmental Health and Safety	0
Sub-Total	0
Part 2 – Security	
2.1 - Admission and Release	0
2.2 - Custody Classification System	0
2.5 - Funds and Personal Property	0
2.11 - Sexual Abuse and Assault Prevention and Intervention	1
2.12 - Special Management Units	5
2.13 - Staff-Detainee Communication	2
2.15 - Use of Force and Restraints	1
Sub-Total	9
Part 4 – Care	
4.1 - Food Services	0
4.3 - Medical Care	8
4.4 - Medical Care (Women)	0
4.6 – Significant Self-harm and Suicide Prevention and Intervention	0
Sub-Total	8
Part 5 – Activities	
5.6 - Telephone Access	1
Sub-Total	1
Part 6 – Justice	
6.1 - Detainee Handbook	3
6.2 - Grievance System	1
6.3 - Law Libraries and Legal Material	2
Sub-Total	6
Total Deficiencies	24

⁷ For greater detail on ODO's findings, see the *Inspection Findings* section of this report.

INSPECTION PROCESS

Every fiscal year, the Office of Detention Oversight (ODO), a unit within U.S. Immigration and Customs Enforcement's (ICE) Office of Professional Responsibility (OPR), conducts compliance inspections at detention facilities in which detainees are accommodated for periods in excess of 72 hours and with an average daily population greater than ten to determine compliance with the ICE National Detention Standards (NDS) 2000, or the Performance-Based National Detention Standards (PBNDS) 2008 or 2011, as applicable.

During the compliance inspection, ODO reviews each facility's compliance with those detention standards that directly affect detainee health, safety, and/or well-being.⁸ Any violation of written policy specifically linked to ICE detention standards, ICE policies, or operational procedures that ODO identifies is noted as a deficiency. ODO also highlights any deficiencies found involving those standards that ICE has designated under either the PBNDS 2008 or 2011, to be "priority components."⁹ Priority components have been selected from across a range of detention standards based on their critical importance to facility security and/or the health and safety, legal rights, and quality of life of detainees in ICE custody.

Immediately following an inspection, ODO hosts a closeout briefing in person with both facility and ERO field office management to discuss their preliminary findings, which are summarized and provided to ERO in a preliminary findings report. Thereafter, ODO provides ERO with a final compliance inspection report to: (i) assist ERO in working with the facility to develop a corrective action plan to resolve identified deficiencies; and (ii) provide senior ICE and ERO leadership with an independent assessment of the overall state of ICE detention facilities. The reports enable senior agency leadership to make decisions on the most appropriate actions for individual detention facilities nationwide.

⁸ ODO reviews the facility's compliance with selected standards in their entirety.

⁹ Priority components have not been identified for the NDS.

DETAINEE RELATIONS

ODO interviewed 36 detainees each of whom volunteered to participate. None of the detainees made allegations of mistreatment, abuse, or discrimination. The majority of detainees reported being satisfied with facility services, with the exception of the complaint below:

Detainee Handbook: Seven detainees alleged they did not receive either the ICE National Detainee Handbook or the local supplement.

- **Action Taken:** ODO interviewed a senior facility staff member in the admission area who stated that detainees receive the ICE National Detainee Handbook and local supplement during admission. ODO reviewed the detention files for the seven detainees and found all signed for the both the ICE National Detainee Handbook and local supplement during the admission process. ODO also inspected the intake area and noted a large quantity of English and Spanish handbooks readily available for distribution upon a detainee's arrival.

Medical Care: Two detainees complained of inadequate medical care.

- **Action Taken:** The first detainee complained she was not receiving adequate medical care for a painful lump that she believed was increasing in size. ODO reviewed the detainee's medical record with the facility medical staff and learned the detainee had recently completed an ultrasound evaluation of the lump at the local hospital. The detainee was scheduled for a follow-up appointment at the local hospital the week after ODO's inspection. Facility medical staff informed the detainee of her upcoming follow-up appointment during the inspection.
- **Action Taken:** The second detainee complained that he did not receive adequate medical care for a previous complaint of severe abdominal pain. The detainee stated he began experiencing abdominal pain during the late afternoon hours of February 14, 2016.¹⁰ He stated that security and nursing staff failed to give him proper attention despite complaints of worsening symptoms. ODO reviewed the detainee's medical record with the facility medical staff and found the detainee was moved to the medical unit for complaints of abdominal pain before midnight on February 14, 2016. The record documents the physician was called and provided orders to keep the detainee in medical for the night, and send the detainee to the emergency room if his condition worsened. The detainee was assessed again on February 15, 2016, at which time his condition was determined to have worsened. The physician was immediately contacted and ordered the detainee's transport to the hospital where the detainee had an emergency appendectomy.

Staff-Detainee Communication: Five detainees alleged they had minimal or no contact with ERO Deportation Officers (DO).

- **Action Taken:** ODO toured detainee housing units and observed staff-detainee communication schedules are posted in the housing units showing which days of the week Deportation Officers (DO) visit the detainee housing units. According to the schedules, each housing unit is visited at least once per week by a DO. During the

¹⁰ The detainee also provided ODO with a copy of an unsigned and undated statement documenting his complaint.

inspection, ODO observed ERO staff meeting with detainees in their housing units, including the detainees who complained of having little or no contact with DOs.

INSPECTION FINDINGS

SECURITY

SEXUAL ABUSE AND ASSAULT PREVENTION AND INTERVENTION (SAAPI)

ODO reviewed 20 randomly selected detention officer and contractor training files, and confirmed all completed the required initial and annual refresher training on the facility's SAAPI program. ODO also reviewed the facility's SAAPI lesson plans and training aids and found they address all required topics except the instruction that sexual abuse and/or assault is never an acceptable consequence of detention (**Deficiency SAAPI-1¹¹**).

SPECIAL MANAGEMENT UNITS (SMU)

ODO toured DCDF's SMU and observed that at the time of the inspection, the facility had five detainees on administrative segregation and one detainee on disciplinary segregation. ODO reviewed the detention files for all six detainees in the SMU and found that although segregation orders were completed in each case, the orders were not provided to the detainees immediately, as required by the standard (**Deficiency SMU-1¹², and Deficiency SMU-2¹³**). ODO interviewed SMU staff and reviewed the facility's SMU policy and found that in policy and in practice, both administrative and disciplinary segregation orders may instead be delivered to detainees up to 24 hours following their issuance.

Corrective Action: Prior to the completion of the inspection, the facility initiated corrective action by revising the facility segregation policy to require that detainees be provided with copies of both administrative segregation and disciplinary segregation orders immediately (**C-1**).

Of the five detainees on administrative segregation, ODO found that with one exception, each received required supervisory status reviews within 72 hours of placement. In the outstanding case, the first supervisory review was conducted five days after the detainees' placement in administrative segregation (**Deficiency SMU-3¹⁴**).

During review of detention file for the one detainee in the disciplinary SMU, ODO found that the detainee was denied recreation privileges without proper documentation for the denial.

¹¹ Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for employees, volunteers and contract personnel and shall also be included in annual refresher training thereafter. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy. The facility must maintain written documentation verifying employee, volunteer and contractor training. Training shall include: instruction that sexual abuse and/or assault is never an acceptable consequence of detention." See ICE PBNDS 2011, Standard, Sexual Abuse or Assault Prevention and Intervention Program, Section (V)(E)(3).

¹² "The administrative segregation order shall be immediately provided to the detainee in a language or manner the detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operation of the facility." See ICE PBNDS 2011, Standard, Special Management Unit, Section (V)(A)(2)(f). **This is a priority component.**

¹³ "The completed disciplinary segregation order shall be immediately provided to the detainee in a language or manner the detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operations of the facility." See ICE PBNDS 2011, Special Management Units, Section (V)(A)(2)(f).

¹⁴ "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). **This is a priority component. This is a repeat deficiency.**

Specifically, although the detainee’s file contained a memorandum prepared by an SMU supervisor outlining reasons for denying recreation, ODO found no written authorization for the denial from the facility administrator documenting why the detainee posed an unreasonable risk even when recreating alone (**Deficiency SMU-4¹⁵**). In addition, ODO found no documentation the detainee was provided written notification of the reasons for denial of recreation privileges, the duration, or conditions for reinstatement (**Deficiency SMU-5¹⁶**).

Corrective Action: Prior to the completion of the inspection, the facility initiated corrective action by restoring the detainee’s recreation privileges (**C-2**).

STAFF DETAINEE COMMUNICATION (SDC)

The facility handbook does not contain contact information for the ERO Field Office or the scheduled hours and days that ERO deportation officers are available to be contacted by detainees (**Deficiency SDC-1¹⁷**).

ODO reviewed ERO’s electronic files of completed detainee requests from January to April 2016, and interviewed senior ERO staff regarding the handling of detainee requests, and found that although completed detainee request forms are scanned and saved electronically by year, month, and the detainee’s last name and A-number, they are not recorded in a physical or electronic logbook specifically designed for that purpose (**Deficiency SDC-2¹⁸**).

USE OF FORCE AND RESTRAINTS (UOF&R)

ODO reviewed DCDF’s Use of Force policy and the post orders for “Master Control,” and found the facility administrator has not designated and incorporated into the post orders for master control the responsibility for maintaining video cameras used to record use-of-force incidents (**Deficiency UOF & R-1¹⁹**).

Corrective Action: Prior to the completion of the inspection, the facility initiated corrective action by revising the post orders for master control to include a requirement that a designated staff member be responsible for maintaining the video cameras used to record use-of-force incidents (**C-3**).

¹⁵ “A detainee may be denied recreation privileges only with the facility administrator’s written authorization, documenting why the detainee poses an unreasonable risk even when recreating alone.” See ICE PBNDS 2011, Standard, Special Management Units, Section (V)(X)(3)(a). **This is a priority component.**

¹⁶ “When recreation privileges are suspended, the disciplinary panel or facility administrator shall provide the detainee written notification, including the reason(s) for the suspension, any conditions that must be met before restoration of privileges, and the duration of the suspension provided the requisite conditions are met for restoration.” See ICE PBNDS 2011, Standard, Special Management Units, Section (V)(X)(3)(c).

¹⁷ “The local supplement to the detainee handbook shall include contact information for the ICE/ERO Field Office and the scheduled hours and days that ICE/ERO staff is available to be contacted by detainees at the facility.” See ICE PBNDS 2011, Standard, Staff Detainee Communication, Section (V)(A).

¹⁸ “All requests shall be recorded in a logbook (or electronic logbook) specifically designed for that purpose.” See ICE PBNDS 2011, Standard, Staff Detainee Communication, Section (V)(B)(2).

¹⁹ “Since audiovisual recording equipment must often be readily available, each facility administrator shall designate and incorporate in one or more post orders responsibility for:

1. maintaining cameras and other audiovisual equipment;
2. regularly scheduled and documented testing to ensure all parts, including batteries, are in working order; and
3. keeping back-up supplies on hand (e.g., batteries, tapes or other recording media, lens cleaners).” See ICE PBNDS 2011, Standard, Use of Force and Restraints, Section (V)(K)(1)(2)(3).

CARE

MEDICAL CARE (MC)

ODO reviewed 32 medical records and confirmed that although intake screenings are consistently completed within 12 hours of intake, and the GEO intake screening forms cover all required components of the standard, there was no documentation in the medical records that the Health Services Administrator (HSA) was notified of detainees determined to be in need of mental health services during the intake screening (**Deficiency MC-1²⁰**).

Detainees referred for mental health treatment are not consistently evaluated within 72 hours of referral (**Deficiency MC-2²¹**). ODO's review of 11 mental health referrals resulting from intake screenings found that five were not assessed within 72 hours. The delayed assessments were completed between four and eight days following the referral.

Of the 32 detainee medical records reviewed by ODO, 23 detainees had clinically significant medical findings that were identified during intake screening, and required evaluation by a provider to facilitate treatment; however, only one of those 23 detainees received a health assessment within two working days (**Deficiency MC-3²²**). The remaining 22 detainees with clinically significant findings received health assessments between three and 13 days following arrival.

ODO found the facility's physicians or a physician assistant completed 23 of the 32 health assessments; Registered Nurses (RN) conducted the remaining nine, including six with clinically significant health issues identified at intake. Of the nine health assessments conducted by an RN, two were not reviewed by a physician (**Deficiency MC-4²³**).

ODO reviewed the credential and training files of all (b) RNs on staff at DCDF and found the files do not contain documentation showing the RNs were trained by a physician to conduct physical assessments (**Deficiency MC-5²⁴**).

ODO reviewed 25 sick call requests and found that although each request was immediately triaged, none were time stamped, and four were not date stamped, in contravention of the standard (**Deficiency MC-6²⁵**).

²⁰ "If at any time during the screening process, there is an indication of need of, or a request for mental health services, the HSA must be notified within 24 hours. 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).

²¹ "Any detainee referred for mental health treatment shall receive a comprehensive evaluation by a licensed mental health provider as medically indicated no later than 72 hours after the referral, or sooner if necessary." See ICE PBNDS 2011, Standard, Medical Care, Section (V)(N)(3).

²² "Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated, and the detainee shall receive a health assessment no later than two working days from the initial screening." See ICE PBNDS 2011, Standard, Medical Care, Section (V)(J).

²³ "The CMA shall be responsible for review of all comprehensive health assessments to assess the priority for treatment." See ICE PBNDS 2011, Standard Medical Care, Section (V)(L).

²⁴ "Physical examinations shall be performed by a physician, physician assistant, nurse practitioner, RN (with documented training provided by physician) or other healthcare provider permitted by law." See ICE PBNDS 2011, Standard, Medical Care, Section (V)(L). **This is a priority component.**

²⁵ "All written sick call requests shall be date and time stamped and filed in the detainee's medical record." See ICE PBNDS 2011, Standard, Care, Section (V)(Q).

ODO reviewed 32 medication administration records (MAR) and found documentation was incomplete in nine of the MARs (**Deficiency MC-7²⁶**). Specifically, one MAR had more than 15 incomplete signature boxes over a three month period, and the remaining eight MARs had between one and three missing entries per month.

ODO reviewed the medical records of 26 detainees enrolled in the chronic care clinic and found 11 of the records did not contain the required medical/psychiatric alerts forms (**Deficiency MC-8²⁷**). ODO interviewed a senior medical staff member who stated medical/psychiatric alert forms are completed only for detainees identified with chronic conditions during intake. Medical/psychiatric alerts are not created for detainees identified with chronic conditions during initial medical or mental health assessments or by way of sick call or other subsequent encounter with medical staff.

ACTIVITIES

TELEPHONE ACCESS (TA)

ODO toured the detainee housing units and observed that telephone access hours were not posted in each housing unit (**Deficiency TA-1²⁸**).

Corrective Action: Prior to the completion of the inspection, telephone access hours were posted in each housing unit (**C-4**).

JUSTICE

DETAINEE HANDBOOK (DH)

ODO reviewed the facility handbook and found the handbook does not notify detainees of the facility's policies on the monitoring of telephone calls (**Deficiency DH-1²⁹**).

Corrective Action: Prior to the completion of the inspection, the facility updated the detainee handbook to notify detainees that telephone calls are monitored (**C-5**).

²⁶ "Written records of all prescribed medication given to or refused by detainees shall be maintained." See ICE PBNDS 2011, Standard, Medical Care, Section (V)(S).

²⁷ "Where a detainee has a serious medical or mental health condition or otherwise requires special or close medical care, medical staff complete a Medical/Psychiatric Alert form (IHSC-834) or equivalent, and file the form in the detainee's medical record. Where medical staff furthermore determine the condition to be serious enough to require medical clearance of the detainee prior to transfer or removal, medical staff also place a medical hold on the detainee using the Medical/Psychiatric Alert form (IHSC-834) or equivalent, which serves to prevent ICE from transferring or removing the detainee without the prior clearance of medical staff at the facility. The facility administrator receives notice of all medical/psychiatric alerts or holds, and notifies ICE/ERO of any medical alerts or holds placed on a detainee that is to be transferred." See ICE PBNDS 2011, Standard, Medical Care, Section (V)(M).

²⁸ "Telephone access hours shall also be posted." See ICE PBNDS 2011, Standard, Telephone Access, Section (V)(C).

²⁹ "While all applicable topics from the handbook must be addressed, it is especially important that each local supplement notify each detainee of: the facility's policies on telephone access and on the monitoring of telephone calls, if telephone calls are monitored." See ICE PBNDS 2011, Standard, Detainee Handbook, Section (V)(B)(7).

This is a priority component.

ODO reviewed the facility handbook and found the handbook does not provide the contact information for the local ERO field office or the scheduled hours and days that ERO staff is available to be contacted by detainees (**Deficiency DH-2³⁰**).

ODO interviewed the facility training officer who stated that each new employee receives a copy of both the ICE National Detainee Handbook as well as the facility detainee handbook; however, the contents of the ICE National Detainee Handbook and the facility handbook are not addressed during annual staff refresher training (**Deficiency DH-3³¹**).

GRIEVANCE SYSTEM (GS)

ODO reviewed the facility's grievance log from September 2015 to April 2016 and found 20 detainee grievances alleging staff misconduct which were all sent to the ERO field office by the facility during that period. ODO interviewed a Supervisory Deportation and Detention Officer (SDDO) who stated that not all the grievances alleging staff misconduct received by the ERO field office are sent to the ICE Office of Professional Responsibility (OPR), the Joint Intake Center, and/or the local OPR office for appropriate action (**Deficiency GS-1³²**). The SDDO stated that only those grievances with significant allegations are forwarded; grievances considered by ERO to be minor, are handled by ERO or facility staff.

LAW LIBRARIES AND LEGAL MATERIAL (LL&LM)

ODO interviewed the facility law library coordinator and learned that the law library coordinator does not inspect the law library on a weekly basis (**Deficiency LL&LM-1³³**).

ODO tested the law library computers and identified that four of the eight law library computers were inoperable due to an outdated version of the installed LexisNexis software (**Deficiency LL&LM-2³⁴**).

³⁰ "While all applicable topics from the handbook must be addressed, it is especially important that each local supplement notify each detainee of contact information for the ICE/ERO Field Office and the scheduled hours and days that ICE/ERO staff is available to be contacted by detainees at the facility." *See*, ICE PBNDS 2011, Standard, Detainee Handbook, Section (V)(B)(14).

³¹ "The facility administrator shall provide a copy of the ICE Handbook and the local supplement to every staff member who has contact with detainees and shall address their contents in initial and annual staff training." *See* ICE PBNDS 2011, Standard, Detainee Handbook, Section (V)(D).

³² Upon receipt, facility staff must forward all detainee grievances containing allegations of staff misconduct to a supervisor or higher-level official in the chain of command. While such grievances are to be processed through the facility's established grievance system, CDFs and IGSA facilities must also forward a copy of any grievances alleging staff misconduct to ICE/ERO in a timely manner with a copy going to ICE's Office of Professional Responsibility (OPR) Joint Intake Center and/or local OPR office for appropriate action." *See* ICE PBNDS 2011, Standard, Section Grievance System, Section (V)(F). **This is a priority component.**

³³ "Each facility administrator shall designate a facility law library coordinator to be responsible for inspecting legal materials weekly, updating them, maintaining them in good condition and replacing them promptly as needed." *See* ICE PBNDS 2011, Standard, Law Libraries and Legal Material, Section (V)(2).

³⁴ "LexisNexis CD Rom (or ICE/ERO approved equivalent) As an alternative to obtaining and maintaining the paper-based publications in 'Appendix 6.3.A: List of Legal Reference Materials for Detention Facilities,' facilities may make available in the law library the LexisNexis CD Rom provided by ICE/ERO containing the required publications. The facility administrator must certify to the respective Field Office Director, with verification from the Field Office Director that the facility provides detainees sufficient access to: a) operable computers capable of running the LexisNexis CD ROM...." *See* ICE PBNDS 2011, Standard, Law Libraries and Legal Material, Section (V)(E)(1)(a)(2).

Corrective Action: Prior to the completion of the inspection all eight law library computers were updated the current version of the LexisNexis software and were operational for detainee use **(C-6)**.