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 Saint Paul Field Office

Kandiyohi County Jail Willmar, Minnesota

March 8-11, 2021

COMPLIANCE INSPECTION
of the
KANDIYOHI COUNTY JAIL
Willmar, Minnesota

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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 contingency compliance inspection of the Kandiyohi County Jail (KCJ) in Willmar, Minnesota, from March 8 to 11, 2021.[1] The facility opened in 2001, is owned by Kandiyohi County, and operated by Kandiyohi County Sheriff's Office. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at KCJ in 2017 under the oversight of ERO's Field Office Director (FOD) in Saint Paul. The facility operates under the National Detention Standards (NDS) 2000.

ERO has not assigned deportation officers nor a detention service manager to the facility. A facility administrator handles daily facility operations and manages [redacted] support personnel. Summit provides food services, MEND Correctional Care provides medical care, and Turnkey Corrections provides commissary services at the facility. The facility holds no accreditations from any outside entities.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	87
Average ICE Detainee Population[3]	[redacted]
Male Detainee Population (as of March 8, 2021)	[redacted]
Female Detainee Population (as of March 8, 2021)	[redacted]

During its last inspection, in fiscal year (FY) 2020, ODO found 24 deficiencies in the following areas: Admission and Release (2); Detainee Classification System (1); Funds and Personal Property (1); Staff-Detainee Communication (1); Telephone Access (1); Visitation (3); Environmental Health and Safety (3); Use of Force (3); Medical Care (8); and Suicide Prevention and Intervention (1).

[1] This facility holds male and female detainees with low, medium-low, medium-high and high-security classification levels for periods greater than 72 hours.
[2] Data Source: ERO Facility List Report as of March 8, 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 NATIONAL DETENTION STANDARDS 2000 MAJOR CATEGORIES

NDS 2000 Standards Inspected[5]	Deficiencies
Part 1 – Detainee Services	
Access to Legal Material	0
Admission and Release	0
Detainee Classification System	0
Detainee Grievance Procedures	0
Food Service	0
Funds and Personal Property	0
Religious Practices	0
Staff-Detainee Communication	0
Telephone Access	0
Sub-Total	**0**
Part 2 – Security and Control	
Emergency Plans	0
Environmental Health and Safety	0
Population Counts	0
Special Management Unit (Administrative Segregation)	1
Special Management Unit (Disciplinary Segregation)	0
Use of Force	1
Sub-Total	**2**
Part 3 – Health Services	
Hunger Strikes	0
Medical Care	0
Suicide Prevention and Intervention	0
Sub-Total	**0**
Other Standards Inspected	
NDS 2019 Sexual Abuse and Assault Prevention and Intervention	0
Federal Performance-Based Detention Standards (FPBDS), Section A.7, Detainees with Disabilities	0
Sub-Total	**0**
Total Deficiencies	**2**

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

DETAINEE RELATIONS

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

Medical Care: One detainee stated he requested to have a magnetic resonance image (MRI) on his right knee because of pain, which resulted from playing soccer while in prison. The detainee stated he requested the MRI, but the facility restricted his recreation and did not grant his MRI request. Additionally, the detainee stated the facility prescribed him Naproxen for his knee pain.

> Action Taken: ODO spoke with the health services administrator (HSA) and found the detainee did not mention his knee issues during his initial health assessment with the nurse, nor with the provider during his physical examination on October 1, 2020. ODO found no documentation, which indicated the detainee requested an MRI. On November 5, 2020, the facility's medical staff evaluated the detainee and the detainee informed the provider he found the prescribed Naproxen acceptable. As a result, the facility's medical staff extended the Naproxen prescription to the detainee multiple times. The facility's medical staff restricted the detainee's recreation activities due to his knee pain. However, the facility's medical staff were unable to obtain any previous medical records regarding his knee issues, and so they lifted his recreational activity restriction on December 15, 2020. The HSA informed ODO the facility's medical staff have evaluated the detainee's gait during several medical encounters and found nothing to indicate a need for further evaluation by an MRI. The facility's medical staff has continued to recommend symptomatic treatment for his knee pain. On February 14, 2021, the facility's medical staff advised the detainee to report to medical if his knee pain symptoms continued and ODO found no record of the detainee returning to medical for knee pain. On March 11, 2021, at ODO's request, the facility instructed the detainee to submit a sick call request and follow-up with the facility's medical staff if necessary.

Medical Care: One detainee stated the facility's water supply was too hot, which resulted in her losing her hair. Additionally, she stated she went to medical in December 2020 due to her hair loss and again in February 2021 for blisters on her hands. On both occasions, the detainee stated the facility's medical staff informed her there was nothing they could do.

- Action Taken: ODO spoke with the HSA and reviewed the detainee's medical records. Regarding the detainee's concern about hair loss, ODO found the detainee raised this concern to a facility nurse on December 30, 2020. During this encounter, the detainee informed the nurse about her hair loss; however, ODO found nothing to indicate the detainee informed the nurse she felt the hair loss was due to the facility's hot water being too hot. The facility's medical staff educated the detainee on eating nutritious foods and on hair loss cycles. Additionally, ODO interviewed the facility's maintenance foreman, confirmed the facility controlled the water temperature by mixing valves, and the maximum water temperature recorded was 110 degrees Fahrenheit, which was within the industry standard.

Regarding the blisters on the detainee's hands, ODO found a facility nurse documented the detainee having small calluses on her hands, not blisters. On February 10, 2021, the facility's medical staff instructed her to report to medical if her calluses grew or if she developed fluid accumulation in the calluses. ODO found no additional sick call requests for the calluses. At ODO's request, the facility's medical staff followed-up with the detainee and reminded her to submit sick call requests as needed for her conditions.

Religious Practices: Two detainees stated they were part of a small prayer group that met for approximately 30 minutes, prior to reporting to their rooms for the night; however, a correctional officer broke up their prayer group one night in December 2020, and they had not met since, because they feared they would get in trouble.

- Action Taken: ODO spoke with the facility's religious services coordinator (RSC) and found that the facility's policy prohibited religious services from occurring in the housing unit day rooms; however, the detainees were permitted to use the programs room if they requested access. On March 11, 2021, at ODO's request, the facility's RSC spoke with the detainees regarding the requirement to request access to the programs room.

Religious Practices: One detainee stated he asked for approval from the facility staff to pray with the other Muslims in a Jumu'ah, but the facility staff denied his request.

- Action Taken: ODO spoke with the facility's RSC and found the detainee submitted two requests to the facility, one for an additional prayer rug and another for a Quran. The facility provided both items to him and he had not made any additional requests. ODO noted the facility scheduled a Jumu'ah prayer each Friday and only required detainees to sign up in advance each week to participate. On March 11, 2021, at ODO's request, the facility's RSC spoke with the detainee to inform him of this practice so he could participate in any upcoming Jumu'ah prayers.

Sexual Abuse and Assault Prevention and Intervention: One detainee claimed in late July/early August 2020, a fellow detainee, who was her assigned bunk mate, sexually assaulted and abused her. The detainee stated she requested to move to another room to be away from her abuser but did not detail any of the sexual harassment/assault to the facility. The detainee stated she was concerned if she reported the incident in its entirety, the result would negatively impact her abuser's immigration case. The facility denied her request to move her to another room, but advised her if there were any additional issues, she should let them know. The detainee stated she was preparing to submit another grievance detailing the abuse when the abuser was removed from the facility. The detainee stated she felt the issue was resolved and did not inform the facility or ICE/ERO.

- Action Taken: On March 8, 2021, ODO immediately reported the incident to both ERO Saint Paul and the facility leadership. ERO Saint Paul responded the same evening, stating they assigned the case to the supervisory detention and deportation officer, and the assistant field office director who oversaw the facility. The facility administrator responded early the next morning, stating the facility scheduled the detainee to see a mental health provider later that day. Additionally, the facility

administrator informed ODO the Prison Rape Elimination Act (PREA) investigation had been assigned to one of the Kandiyohi County Sheriff's Office detectives who specialized in PREA, and the matter was being treated as a criminal event due to the touching and exposure. On March 11, 2021, the facility administrator informed ODO the facility scheduled the detainee for an interview with the PREA investigator later that morning.

COMPLIANCE INSPECTION FINDINGS

SECURITY AND CONTROL

SPECIAL MANAGEMENT UNIT (ADMINISTRATIVE SEGREGATION) (SMUAS)

ODO reviewed 12 detainee files, which included 5 detainee files for detainees the facility housed in their administrative segregation (AS) for COVID-19 quarantine. ODO found the facility's medical staff had not signed four out of five AS orders **(Deficiency SMUAS-6[6])**.

USE OF FORCE (UOF)

ODO reviewed KCJ's restraint equipment and found KCJ did not receive ERO Saint Paul's approval to use its restraint chair **(Deficiency UOF-43[7])**.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 18 standards under NDS 2000, 1 standard under NDS 2019, 1 standard under FPBDS, and found the facility in compliance with 18 of those standards. ODO found two deficiencies in the remaining two standards. ODO commends facility staff for its responsiveness and professionalism during this inspection. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations.

Compliance Inspection Results Compared	FY 2020 (NDS 2000)	FY 2021 (NDS 2000)/(NDS 2019)/(FPBDS)
Standards Reviewed	18	18/1/1
Deficient Standards	10	2
Overall Number of Deficiencies	24	2
Repeat Deficiencies	4	0
Areas of Concern	3	0
Corrective Actions	0	0

[6] "A medical professional ordering a detainee removed from the general population shall complete and sign the Administrative Segregation Order, unless the detainee will stay in the medical department's isolation/segregation ward." *See* ICE NDS 2000, Standard, Special Management Unit (Administrative Segregation), Section (III)(A)(3)(e).

[7] "Deviations from the following list of restraint equipment are prohibited: …

9. Any other INS-approved restraint device." *See* ICE NDS 2000, Standard, Use of Force, Section (III)(C)(9).