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U.S. Immigration and Customs Enforcement
Office of Professional Responsibility
Inspections and Detention Oversight Division
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**Office of Detention Oversight
Compliance Inspection**

**Enforcement and Removal Operations
ERO San Antonio Field Office**

**T. Don Hutto Residential Center
Taylor, Texas**


February 25-27, 2020

COMPLIANCE INSPECTION
of the
T. DON HUTTO RESIDENTIAL CENTER
Taylor, Texas

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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 T. Don Hutto Residential Center (TDHRC), in Taylor, Texas, from February 25 to 27, 2020.¹ The facility opened in January 1997 and is owned and operated by CoreCivic. The ICE Office of Enforcement and Removal Operations (ERO) began housing residents at TDHRC in 2006 under the oversight of ERO's Field Office Director (FOD) in San Antonio (ERO San Antonio). The facility operates under the Family Residential Detention Standards (FRDS).

An ERO Assistant Field Office Director (FOD) and Deportation Officers are assigned to the facility. A facility administrator is responsible for daily facility operations and is supported by ██████ personnel. Trinity Services Group manages TDHRC's food services and ICE Health Services Corps (IHSC) provides medical services. TDHRC was accredited by the National Commission on Correctional Health Care in February 2017.

Capacity and Population Statistics	Quantity
ICE Resident Bed Capacity ²	512
Average ICE Resident Population ³	488
Male Resident Population (as of 2/25/2020)	N/A
Female Resident Population (as of 2/25/2020)	428

During its last inspection, in FY 2018, ODO found 11 deficiencies in the following areas: Environmental Health and Safety (2), Staff-Resident Communications (2), Use of Physical Force and Restraints (2), Medical Care (2), Suicide Prevention and Intervention (1), and Visitation (2).

¹ This facility holds female residents with low security classification levels for periods greater than 72 hours.

² Data Source: ERO Facility List Report as of February 24, 2020.

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.

⁴ ODO reviews the facility’s compliance with selected standards in their entirety.

FINDINGS BY FAMILY RESIDENTIAL DETENTION STANDARDS MAJOR CATEGORIES

FRDS Standards Inspected ⁵	Deficiencies
Part 1 – Safety	
Environmental Health and Safety	2
Sub-Total	2
Part 2 – Security	
Admission and Release	1
Funds and Personal Property	1
Searches of Residents	0
Sexual Abuse and Assault Prevention and Intervention	0
Staff-Resident Communications	0
Use of Physical Control Measures and Restraints	1
Sub-Total	3
Part 3 – Order	
Discipline and Behavioral Management	1
Sub-Total	1
Part 4 – Care	
Food Service	1
Medical Care	4
Suicide Prevention and Intervention	2
Sub-Total	7
Part 5 – Activities	
Recreation	0
Religious Practices	0
Telephone Access	0
Visitation	1
Sub-Total	1
Part 6 – Justice	
Grievance System	0
Law Libraries and Legal Material	0
Sub-Total	0
Total Deficiencies	14

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

RESIDENT RELATIONS

ODO interviewed 23 residents, each of whom voluntarily agreed to participate. None of the residents made allegations of discrimination, mistreatment or abuse. Most residents reported satisfaction with facility services except for the concerns listed below.

Telephone Access: One resident stated she had not been able to access her telephone account because the voice recognition feature in her account had been deactivated.

- Action Taken: ODO spoke to the facility staff and confirmed the resident's account had not been recognizing the resident's voice. On February 25, 2020, the facility staff reactivated the resident's telephone account and she was able to access her account. The facility staff also explained to the resident she should let staff know immediately if the issue happens again.

Medical Care: One resident stated she had on-going abdominal pain and wanted to see a doctor. She stated the TDHRC medical staff tested her on previous occasions, and they gave her medication, but the abdominal pain had not subsided.

- Action Taken: ODO reviewed the resident's medical record with the facility medical staff and determined the resident was first seen by the TDHRC medical staff on November 29, 2019, with complaints of intermittent abdominal pain for one year. She was seen by a registered nurse (RN) and diagnosed with gastroesophageal reflux disease. The resident was prescribed Maalox as needed for 14 days and was told to follow up during sick call as needed. The resident returned to sick call on December 9, 2019, stating her abdominal pain decreased, but she was now experiencing diarrhea. On the same day, she was referred to a nurse practitioner (NP), who diagnosed the resident with gastritis, and the resident was prescribed Pepcid (used to treat the heartburn by decreasing acid). A laboratory test for H. Pylori (a bacteria that can be found in the digestive tract that can cause ulcers) was issued. On December 12, 2019, the test came back positive. The next day, the resident was seen again by the NP, started on an antibiotic, and a follow up visit was scheduled for January 8, 2020. While on the antibiotic, her symptoms continued and her Pepcid dose was increased. The resident was seen again on February 9, 2020, and notes reflected her symptoms were slightly better. The facility plan of care was to continue with the current treatment and to monitor the resident. Before ODO's departure from the facility, the resident was scheduled for another follow up appointment on April 1, 2020.

COMPLIANCE INSPECTION FINDINGS

SAFETY

ENVIRONMENTAL HEALTH AND SAFETY (EH&S)

██████████ of all hazardous substances and safety data sheets in the facility, including locations and emergency numbers, were available in ██████████; however, ODO found there was no documentation a copy of the ██████████ was provided to the local fire department (**Deficiency EH&S-1**⁶).

Corrective Action: Prior to the completion of the inspection, the facility initiated corrective action on February 26, 2020, by forwarding a copy of the ██████████ to the local fire department (**C-1**).

ODO inspected the medical department and reviewed the ██████████ and found the ██████████ were not properly inventoried nor accounted for on a ██████████ basis (**Deficiency EH&S-2**⁷).

TDHRC is situated in proximity to railroad tracks and ODO observed the facility posted additional emergency plans for a hazardous chemical release and emergency plans for tornados throughout the facility and all housing units to provide direction for staff and residents in the event of a train derailment and/or chemical spill or natural disaster. ODO cites this as a **Best Practice**.

SECURITY

ADMISSION AND RELEASE (A&R)

The facility orientation procedures were not approved in advance by the Juvenile and Family Residential Management Unit (JFRMU) (**Deficiency A&R-1**⁸).

Corrective Action: Prior to the completion of the inspection, the facility initiated corrective action on February 26, 2020, by having as a representative of the JFRMU review and approve the local TDHRC orientation procedures (**C-2**).

FUNDS AND PERSONAL PROPERTY (F&PP)

Based on on-site observations in each housing unit and resident and staff interviews, ODO found

⁶ “The maintenance supervisor/fire safety authority shall maintain this information in the safety office (or equivalent), and a copy shall be provided to the local fire department.” See ICE Family Residential Detention Standards, Standard, Environmental Health and Safety, Section (V)(5).

⁷ “An inventory shall be kept of those items that pose a security risk, such as ██████████ and shall be checked ██████████ by an individual designated by the medical facility Health Service Administrator (HSA) or equivalent.” See ICE Family Residential Detention Standards, Standard, Environmental Health and Safety, Section (VIII)(4). **This is a Repeat Deficiency.**

⁸ “All facilities shall have a medium to provide ICE/DRO residents an orientation to the facility. Orientation procedures must be approved in advance by the JFRMU.” See ICE Family Residential Detention Standards, Standard, Admission and Release, Section (V)(5).

residents were not provided with securable space for storing their personal property in their housing unit area. Additionally, although residents were provided with plastic bins for their allowable property, they were not provided with the locks to secure their respective bin (**Deficiency F&PP-1⁹**).

USE OF PHYSICAL CONTROL MEASURES AND RESTRAINTS (UOPCM&R)

There was one instance of a UOPCM&R incident on a resident during the year preceding the inspection. ODO reviewed the TDHRC documentation and found the after-action review report documenting a finding of appropriate or inappropriate UOPCM&R was not provided to the JFRMU via a memorandum with the appropriate attachments (**Deficiency UOPM&R-1¹⁰**).

ORDER

DISCIPLINE AND BEHAVIORAL MANAGEMENT (D&BM)

Residents were provided with written rules during intake via a resident handbook, which specifies a graduated severity scale of prohibited acts identified as low, moderate, and major offenses. However, ODO reviewed the resident handbook and found sanctions for prohibited acts, as well as the procedure for appealing sanctions, were not included (**Deficiency D&BM-1¹¹**).

CARE

FOOD SERVICE (FS)

ODO found resident volunteer food service workers preparing sack meals for residents being transported (**Deficiency FS-1¹²**).

⁹ “Every housing area shall have lockers or other securable space for storing residents’ authorized personal property. The amount of storage space shall correspond to the number of residents assigned to that housing area.” *See* ICE Family Residential Detention Standards, Standard, Funds and Personal Property, Section (V)(5)(f).

¹⁰ “Within two working days of the After-Action Review Team’s determination, the facility administrator shall report the finding of appropriate or inappropriate use of force the outcome of the After-Action Review, and whether in the Facility Administrator’s opinion the use of force was appropriate or inappropriate. The report shall be made via memorandum, to ICE/DRO with appropriate attachments.” *See* ICE Family Residential Detention Standards, Standard, Use of Physical Force and Restraints, Section (V)(16)(d).

¹¹ “The resident handbook shall notify residents of the following:

b. The prohibited acts and potential sanctions for prohibited acts.

c. The procedure for appealing sanctions or adverse administrative findings.” *See* ICE Family Residential Detention Standards, Standard, Discipline and Behavior Management, Section (VI)(11)(b and c).

¹² “Members of the food service staff shall prepare sack meals for bus or air service. While resident volunteers assigned to the food service shall not be involved in preparing meals for transportation, they may prepare sack meals for on-site consumption.

A designated member of the bus or plan crew shall pick up from the food service all sack meals prepared to be used during transportation. Before departing, this crewmember shall inspect the sacks for:

- Quality of contents
- Proper wrapping
- Correct individual counts” *See* ICE Family Residential Detention Standards, Standard, Food Service, Section (V)(8)(c)(2).

MEDICAL CARE (MC)

ODO reviewed the professional credential files maintained by the TDHRC medical department and found each professional had current position descriptions in their files. However, ODO found the following discrepancies in [REDACTED] instances: [REDACTED] missing telehealth psychiatrist (THP) license was not available on-site, [REDACTED] RNs and [REDACTED] licensed practical nurse licenses were expired, and [REDACTED] RNs, [REDACTED] vocational nurse, and [REDACTED] clinical social worker licenses were not primary source verified in a timely manner. on-site Hence, the professional credential files were not accurate at the time of renewal for the TDHRC medical staff (**Deficiency MC-1**¹³).

Corrective Action: Prior to the completion of the inspection, on February 27, 2020, the assistant health services administrator corrected these deficiencies by looking up each license from the professional's respective state board of licensure online and printing the authentication page. The license for the THP was acquired from the off-site location where he is stationed (**C-3**).

Although TDHRC does have current annual training for all medical staff and the proper equipment in place to respond to a medical emergency, the facility did not have a written medical emergency plan approved by the clinical medical authority (**Deficiency MC-2**¹⁴).

Dental health appraisals were performed during the physical examination. Of the 25 medical files reviewed, ODO found an RN performed six of the dental examinations, which should have been performed by a physician, physician's assistant, or NP, if they were trained by a licensed dentist (**Deficiency MC-3**¹⁵).

ODO reviewed medical administrative meeting minutes and verified they were conducted quarterly; however, the facility administrator was not in attendance or included in the meeting minutes distribution and communicable disease and infectious control activities were not discussed either. Additionally, the facility medical staff collects data on hypertensive and diabetic detainees during internal reviews and for quality assurance purposes; however, the data was not analyzed to determine if the medical treatment was effective (**Deficiency MC-4**¹⁶).

¹³ "All health care staff shall have valid professional licenses and/or certifications. DIHS shall be consulted to determine the appropriate credentials requirements for health care providers.

Medical personnel credentialing and verification shall comply with the standards established by JCAHO." See Family Residential Detention Standards, Standard, Medical Care, Section (V)(7).

¹⁴ "Each facility shall have a plan for delivery of 24-hour emergency health care when immediate outside medical attention is required.

A plan shall be prepared in consultation with the facility's routine medical provider, to include:

- An on-call provider;

A list, available to all staff, of telephone numbers for local ambulances and hospital services." See Family Residential Detention Standards, Standard, Medical Care, Section (V)(13).

¹⁵ "An initial dental screening exam should be performed within 14 days of the resident's arrival. The initial dental screening may be performed by a physician, physicians' assistant, or nurse practitioner – if trained by a licensed dentist." See Family Residential Detention Standards, Standard, Medical Care, Section (V)(11). **This is a Repeat Deficiency.**

¹⁶ "The facility administrator and health services administrator shall meet at least quarterly and include other facility and medical staff as appropriate.

The meeting agenda shall include, at a minimum:

In December 2019, TDHRC was selected as a pilot site to offer sexually transmitted disease testing for all residents, and if the test results were positive, treatment was provided to the residents at the TDHRC medical clinic. The facility medical staff discovered one case of a newly identified human immunodeficiency virus infection and several residents, who tested positive for chlamydia or gonorrhea. ODO reviewed the facility documentation and found all residents with positive test results were treated at the TDHRC medical clinic. Additionally, the facility reported all cases to the local health department. ODO cited this as a **Best Practice**.

SUICIDE PREVENTION AND INTERVENTION (SP&I)

ODO reviewed the TDHRC's Suicide Prevention and Intervention local operating procedure and found the procedure stated neither the clinical director (CD), a physician, nor a behavioral health provider (BHP) have the authority to remove a resident from suicide watch. Section 6.3.6 of IHSC Directive 07-04 stated a BHP, CD or designee are the only staff authorized to terminate a suicide watch. TDHRC was in compliance with the IHSC directive; however, TDHRC was not in compliance with ICE FRDS, which stated only the CD may terminate a suicide watch (**Deficiency SP&I-1¹⁷**).

Mandatory suicide prevention training is provided to all new TDHRC employees and repeated annually. ODO reviewed the objectives, lesson plan, and power point presentation and found the training included all the required elements of the standard. However, a review of the TDHRC training records for ■ non-medical staff members and ■ medical staff members found ■ of the ■ medical staff members had not received the required annual suicide prevention training (**Deficiency SP&I-2¹⁸**).

c. Review and discussion of communicable disease and infectious control activities
AND

The health authority shall implement a system of internal review and quality assurance. Elements of the system shall include:

- Collecting and analyzing data combined with planning, intervening, and reassessing, and evaluating defined data.
 - On-site monitoring of health service outcomes on a regular basis through:
- b. Review of prescribing practices and administration of medication practices.
d. Monitoring of corrective action plans.
f. Developing and implement corrective action plans to address and resolve identified problems and concerns.
g. Reevaluation problems or concerns to determine whether the corrective measures have achieved and sustained the desired results.
h. Incorporating findings of internal review activities into the organization's educational and training activities.
j. Issuing a quarterly report to the health services administrator and facility administrator of the findings of internal review activities." See Family Residential Detention Standards, Standard, Medical Care, Section (V)(25) (c) and (V)(25)(b)(d)(f)(g)(h)(j).

¹⁷ "4. A resident formerly under a suicide watch may be returned to general population only if it can be reasonably presented that the resident does not pose a danger to himself or herself, or others, and upon written authorization from the CD." See Family Residential Detention Standards, Standard, Suicide Prevention and Intervention, Section (V)(4).
This is a Repeat Deficiency.

- ¹⁸ "All staff with responsibility for resident supervision shall be trained, during orientation and at least annually, on:
- a. Identification of the warning signs and symptoms of impending suicidal behavior
 - b. Demographic, cultural, and precipitating factors of suicidal behavior
 - c. Interaction with suicidal and depressed residents
 - d. Communication between residential staff and health care personnel

ACTIVITIES

VISITATION (V)

During the inspection, ODO noticed the facility did not keep blank G-28, Notice of Entry of Appearance as Attorney or Accredited Representative forms available in the visitation reception area (**Deficiency V-1¹⁹**).

Corrective Action: During the course of the inspection, on February 26, 2020, the facility initiated corrective action by supplying blank Form G-28's to the visiting reception area (**C-4**).

CONCLUSION

ODO reviewed the facility's compliance with 17 standards under FRDS. ODO found the facility compliant with eight standards and identified 14 deficiencies in the remaining nine standards. ODO commends facility staff for their responsiveness during this inspection and notes there were four instances where staff initiated immediate corrective action during the inspection.

In the areas of Medical Care and Suicide Prevention and Intervention, ODO noted some findings were a result of a lack of proper documentation. The facility is encouraged to keep all medical staff credentials up-to-date; develop a medical emergency plan; re-visit its dental examination procedures; include the facility administrator and communicable disease and infectious control activities in quarterly meetings; consult with IHSC on the proper process for terminating a suicide watch; and for all medical staff to receive required suicide watch annual training. Lastly, in Food Service, the facility should not involve resident volunteer food service workers in the preparation of sack meals for resident transport.

ODO commends the facility for two **Best Practices** in its use of posted emergency plans for a hazardous chemical release throughout the facility in the event of a train derailment; and for its pilot program that offers sexually transmitted disease testing for all residents and treatment for residents with positive test results. ODO recommends ERO work with the facility to remedy any deficiencies which remain outstanding as applicable and in accordance with contractual obligations.

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- e. Referral procedures
 - f. Housing observation and suicide-watch level procedures
 - g. Follow-up monitoring of residents who have attempted suicide." See Family Residential Detention Standards, Standard, Suicide Prevention and Intervention, Section (V)(2).

¹⁹ "Once an attorney-client relationship has been established, the legal representative shall complete and submit a Form G-28, which shall be available in the legal visitation reception area. Staff shall collect completed forms and forward them to ICE/ERO." See ICE Family Residential Detention Standards, Standard, Visitation, Section, (V)(10)(h).

Compliance Inspection Results Compared	FY 2018 (FRDS)	FY 2020 (FRDS)
Standards Reviewed	14	17
Deficient Standards	6	9
Overall Number of Deficiencies	11	14
Deficient Priority Components	N/A	N/A
Repeat Deficiencies	N/A	3
Corrective Actions	2	4