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 El Paso Field Office

Torrance County Detention Facility
Estancia, New Mexico

November 16-18, 2021

COMPLIANCE INSPECTION
of the
TORRANCE COUNTY DETENTION FACILITY
Estancia, New Mexico

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COMPLIANCE INSPECTION TEAM MEMBERS

[redacted]	Acting Team Lead	ODO
	Inspections and Compliance Specialist	ODO
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	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 compliance inspection of the Torrance County Detention Facility (TCDF) in Estancia, New Mexico, from November 16 to 18, 2021.[1] The facility opened in 1990 and is owned and operated by CoreCivic. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at the facility in August 2019 under the oversight of ERO's Field Office Director (FOD) in El Paso (ERO El Paso). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2011 (2013 Errata).

ERO has assigned deportation officers and a detention services manager to the facility. A facility warden handles daily facility operations and manages [redacted] support personnel. Trinity Food Service provides food services, and CoreCivic provides medical care and commissary services at the facility. The facility does not hold any accreditations from any outside entities.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	[redacted]
Average ICE Detainee Population[3]	[redacted]
Male Detainee Population (as of November 16, 2021)	[redacted]
Female Detainee Population (as of November 16, 2021)	[redacted]

During its last inspection, in Fiscal Year (FY) 2021, ODO found nine deficiencies in the following areas: Admission and Release (2); Custody Classification System (1); Food Service (2); Funds and Personal Property (3); and Medical Care (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 October 12, 2021.
[3] *Ibid.*

COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population greater than 10, 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 its 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 PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 2011 (2013 ERRATA) MAJOR CATEGORIES

PBNDS 2011 (2013 Errata) Standards Inspected[5,6]	Deficiencies
Part 1 – Safety	
Emergency Plans	0
Environmental Health and Safety	0
Sub-Total	**0**
Part 2 – Security	
Admission and Release	1
Custody Classification System	0
Facility Security and Control	1
Funds and Personal Property	1
Post Orders	5
Searches of Detainees	0
Sexual Abuse and Assault Prevention and Intervention	2
Special Management Units	0
Use of Force and Restraints	0
Sub-Total	**10**
Part 4 – Care	
Food Service	0
Hunger Strikes	0
Medical Care	2
Medical Care (Women)	0
Personal Hygiene	0
Significant Self-harm and Suicide Prevention and Intervention	0
Sub-Total	**2**
Part 5 – Activities	
Correspondence and Other Mail	8
Marriage Requests	0
Trips for Non-Medical Emergencies	0
Voluntary Work Program	0
Sub-Total	**8**

[5] For greater detail on ODO's findings, see the *Compliance Inspection Findings* section of this report.
[6] Beginning in FY 2021, 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.

Part 6 – Justice	
Grievance Systems	0
Legal Rights Group Presentations	0
Sub-Total	**0**
Part 7 – Administration and Management	
Detainee Transfers	1
Detention Files	0
Interviews and Tours	0
Sub-Total	**1**
Total Deficiencies	**21**

DETAINEE RELATIONS

ODO interviewed 20 detainees, who each voluntarily agreed to participate. None of the detainees made allegations of discrimination, mistreatment, or abuse. One detainee exhibited signs of mental health issues during the interview, and ODO immediately referred him to both ERO El Paso and the facility's medical staff for follow-up. Most detainees reported satisfaction with facility services except for the concerns listed below.

Admission and Release: Eleven detainees stated they did not receive the ICE National Detainee Handbook nor the facility detainee handbook upon their admission to the facility.

- Action Taken: ODO reviewed the facility acknowledgement forms, signed by the detainees for receipt of the ICE National Detainee Handbook and the facility detainee handbook. On November 17, 2021, ODO confirmed the facility re-issued both handbooks to the detainees for which the detainees re-signed the facility acknowledgment forms. Additionally, the facility placed the forms in the detainees' detention files.

Food Service: One detainee stated the facility provided only one cup of water at every meal since approximately November 11, 2021. The detainee said that no facility staff was present when he asked for more water.

- Action Taken: On November 16, 2021, ODO observed lunch in the housing unit where the detainees consumed all meals and found the food service staff provided a water cooler with the meal and observed a second water cooler in the housing unit. The food service director informed ODO the facility turned off the water fountains due to COVID-19 and provided water coolers, 24 hours a day to the housing unit. The food service department routinely cleaned and refilled the water coolers before returning them to each housing unit.

Medical Care: One detainee stated he believed he had an issue with his kidneys. On or about

November 8, 2021, the detainee reported he met with the facility medical staff to express his concern. The facility doctor examined the detainee, prescribed medication, and informed him to return if his condition worsened. On November 15, 2021, the detainee said he submitted a medical request; however, he has received no response from the medical staff.

- Action Taken: ODO interviewed the health services administrator (HSA) and found the detainee submitted a sick call request for testicular pain and painful urination on October 30, 2021. On October 31, 2021, a registered nurse (RN) evaluated the detainee and referred him to the facility's nurse practitioner (NP). On the same day, the NP met with the detainee and prescribed injectable and oral antibiotics and ibuprofen for pain. On November 16, 2021, the medical staff met with the detainee for his kidney complaint and referred him to the NP. On November 17, 2021, the NP completed the detainee's lab work, and scheduled him to review the lab work results on December 2, 2021. The detainee's results did not indicate any abnormalities, and the NP advised him to submit a sick call request if any medical issues persisted.

Medical Care: One detainee stated he met with facility medical staff about a toothache. The facility medical staff provided an antibiotic to prevent any infection and pain medication for his toothache; however, facility medical staff had not addressed his lower backpain. The detainee stated he would like to have his tooth extracted as per the dentist's recommendation.

- Action Taken: ODO interviewed the HSA and confirmed the detainee did not submit any sick call requests for lower back pain since his arrival to the facility. On November 3, 2021, the dentist examined the detainee's tooth and recommended a tooth extraction. On that same day, after the detainee signed a consent form for the procedure, the dentist extracted the tooth. The dentist prescribed an oral antibiotic and ibuprofen for the pain and educated the detainee on the possible symptoms/pain following the procedure. Furthermore, the dentist instructed the detainee to submit a sick call request if the pain continued.

  On November 18, 2021, the medical staff met with the detainee and prescribed pain medication for his back. On November 24, 2021, the NP met with the detainee for a follow-up appointment and adjusted the detainee's medication. The NP instructed the detainee to submit a sick call request if the pain continued.

Medical Care: One detainee stated he needed a tooth removed due to possible decay. The facility medical staff provided antibiotics, and the detainee expressed his desire for a follow-up appointment with the dentist.

- Action Taken: ODO interviewed the HSA and found on November 17, 2021, the detainee met with the facility's dentist about his tooth pain. The dentist examined the detainee, prescribed an oral antibiotic and ibuprofen for the pain, and recommended the detainee return after 10 days if the pain continued.

Medical Care: One detainee stated his frustration with the medical staff's slow response time after he submitted sick call requests for a dental issue and insomnia.

- Action Taken: ODO interviewed the HSA and confirmed the detainee submitted two sick call requests since his arrival on October 16, 2021. On October 18, 2021, the detainee submitted the first sick call request for his dental issue and met with the facility medical staff on the same day. The facility dentist received the detainee's request on October 19, 2021, but did not schedule an appointment due to the detainee's cohort status. On November 4, 2021, the detainee submitted the second sick call request for insomnia, and the facility nurse examined him on the same day. On November 9, 2021, the detainee had cleared cohort status, and the facility dentist filled the detainee's cavity and cleaned his teeth. The detainee did not submit any subsequent requests.

Medical Care: One detainee stated he received medication from the facility medical staff for his allergies, but he wanted to know what causes them.

- Action Taken: ODO interviewed the HSA and confirmed the facility's RN met with the detainee to discuss his allergies on October 31, 2021. The detainee had no difficulty breathing, but he complained of itchy eyes and a runny nose. The RN prescribed the detainee Zyrtec, educated him on its use, and explained his allergies as seasonal. The detainee will meet with the facility provider for a follow-up visit on December 3, 2021.

Significant Self-harm and Suicide Prevention and Intervention: One detainee stated he wanted to harm himself while residing at the facility. ODO offered him the opportunity for mental health counseling, but the detainee stated he felt he would not receive adequate treatment.

- Action Taken: ODO immediately notified the facility leadership and informed ERO El Paso about the detainee's self-harming ideations. The facility's medical staff then evaluated the detainee and cleared him to return to the general population. On November 30, 2021, ERO El Paso informed ODO the detainee had a *Fraihat v. ICE* review on November 19, 2021, and granted the detainee's release on the Order of Release on Recognizance. ERO El Paso scheduled the release of the detainee for November 30, 2021.

Sexual Abuse and Assault Prevention and Intervention: Nine male detainees stated female facility staff members do not announce their presence when entering the housing units.

- Action Taken: ODO reviewed the facility's Sexual Abuse and Assault Prevention and Intervention (SAAPI) policy, interviewed the SAAPI coordinator, and found the facility requires staff members of the opposite gender to announce their presence when entering a housing unit. On November 17, 2021, the SAAPI coordinator emailed and advised all facility staff to announce, "Female on-site!" or "Male on-site!" before entering housing units of the opposite gender. In addition, the SAAPI coordinator informed ODO she emailed all supervisors to remind all staff members of their required protocols. On November 18, 2021, the SAAPI coordinator told ODO the unit managers and the shift supervisors reviewed the facility's policy with staff. ODO noted this as an Area of Concern in the *Sexual Abuse and Assault Prevention and Intervention* section of the report.

COMPLIANCE INSPECTION FINDINGS

SECURITY

ADMISSION AND RELEASE (AR)

ODO reviewed the facility's AR policy and the site-specific detainee handbook, interviewed the AR supervisor, observed the intake process, and found the facility did not issue each newly admitted detainee a copy of the facility's detainee handbook, which fully describes all policies, procedures, and rules in effect at the facility Specifically, the AR staff did not issue the current facility detainee handbook, dated August 6, 2021, to detainees upon admission **(Deficiency AR-71[7])**.

FACILITY SECURITY AND CONTROL (FSC)

ODO reviewed the facility's FSC program, interviewed the chief of security, and found the facility officers admitted vehicles on-site without checking the validity of insurance **(Deficiency FSC-54[8])**.

> *Corrective Action:* Prior to completion of the inspection, the facility initiated corrective action by updating the sally port entry log to ensure the validity of automobile insurance. Also, the chief of security emailed a memorandum to all staff to ensure officers admit vehicles only with valid automobile insurance **(C-1)**.

FUNDS AND PERSONAL PROPERTY (FPP)

ODO reviewed the facility's FPP program and found the facility detainee handbook does not notify detainees that they may request and ERO Chicago will provide an ICE/ERO-certified copy of any identity document ERO Chicago has possession of to the detainees **(Deficiency FPP-16[9])**.

POST ORDERS (PO)

ODO reviewed the facility PO program and found the facility administrator did not approve, sign, nor date each post order on the last page. Additionally, not all other pages were initialed nor dated, specifically for the Suicide Precaution/Close Observation and Housing Control post orders **(Deficiency PO-9[10])**.

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[7] "In accordance with standard "6.1 Detainee Handbook," every facility shall issue to each newly admitted detainee a copy of the ICE National Detainee Handbook (handbook) and local supplement that fully describes all policies, procedures and rules in effect at the facility." *See* ICE PBNDS 2011 (2013 Errata), Standard, Admission & Release, Section (V)(G)(1).

[8] "The officer may admit the vehicle only if the license and insurance are valid." *See* ICE PBNDS 2011 (2013 Errata), Standard, Facility Security and Control, Section (V)(C)(2)(a).

[9] "The detainee handbook or equivalent shall notify the detainees of facility policies and procedures related to personal property, including: that, upon request, they shall be provided an ICE/ERO-certified copy of any identity document (e.g., passport, birth certificate), which shall then be placed in their A-files." *See* ICE PBNDS 2011 (2013 Errata), Standard, Funds and Personal Property, Section (V)(I).

[10] "*The facility administrator (or designee) shall:*

ODO reviewed the facility PO program and found the Housing Control Post Order did not include a six-part classification folder, which included Section 1: Specific post orders, listing activities chronologically, with responsibilities clearly defined; Section 2: Special instructions, if any, relating to the specific post; and Section 3: General post order applicable to all posts **(Deficiency PO-10[11])**.

ODO reviewed the facility PO program and found the Housing Control Post Order did not include a six-part classification folder, which included Section 4: Memorandum changing or updating the orders; Section 5: ICE/ERO detention standards and policies and facility practices relevant to the post; and Section 6: Review and signature form, dated, and with officer's name, printed and signed **(Deficiency PO-11[12])**.

ODO reviewed the facility PO program and found the shift supervisor did not consistently initial the post order log on each shift. Specifically, ODO visited two housing units and found in one out of two units a shift supervisor's initials were not entered in the log **(Deficiency PO-13[13])**.

ODO reviewed the facility PO program and found the facility does not always keep the POs and logbooks secure (under lock and key). Additionally, the facility left the Food Service PO and logbooks in an area accessible to detainees **(Deficiency PO-23[14])**.

SEXUAL ABUSE AND ASSAULT PREVENTION AND INTERVENTION (SAAPI)

ODO reviewed the facility's SAAPI program and found the facility's written policy does not include the requirement for coordinating with the ICE OPR for investigation nor referral of incidents of sexual assault to another investigative agency, discipline, and prosecution of assailants **(Deficiency SAAPI-6[15])**.

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1. approve, sign and date each Post Order on the last page of each section;
2. initial and date all other pages."

See ICE PBNDS 2011 (2013 Errata), Standard, Special Management Units, Section (V)(C)(1-2).

[11] "*The post orders for each post shall be issued in a six-part classification folder and shall be organized as follows:*
Section 1: Specific post orders, listing activities chronologically, with responsibilities clearly defined;
Section 2: Special instructions, if any, relating to the specific post;
Section 3: General post orders applicable to all posts."

See ICE PBNDS 2011 (2013 Errata), Standard, Special Management Units, Section (V)(D)(1-3).

[12] "*The post orders for each post shall be issued in a six-part classification folder and shall be organized as follows:*
Section 4: Memoranda changing or updating the post orders;
Section 5: ICE/ERO detention standards and policies and facility practices relevant to the post; and
Section 6: Review and signature form, dated and with the officer's name printed and signed."

See ICE PBNDS 2011 (2013 Errata), Standard, Special Management Units, Section (V)(D)(4-6).

[13] *"The shift supervisor shall visit each housing area and initial the log on each shift." See* ICE PBNDS 2011 (2013 Errata), Standard, Special Management Units, Section (V)(E).

[14] "Post Orders and logbooks are confidential and must be kept secure (under lock and key) at all times, and shall never be left in an area accessible to detainees." *See* ICE PBNDS 2011 (2013 Errata), Standard, Special Management Units, Section (V)(G)(1).

[15] "Each facility administrator shall have written policy and procedures for a Sexual Abuse or Assault Prevention and Intervention Program that includes, at a minimum: the requirements for coordination with the ICE Office of Professional Responsibility (OPR) for investigation or referral of incidents of sexual assault to another investigative agency, and discipline and prosecution of assailants." *See* ICE PBNDS 2011 (2013 Errata), Standard, Sexual Abuse and Assault Prevention and Intervention, Section (V)(A)(6).

ODO reviewed the facility's SAAPI program and found the facility's written policy does not include required reporting through the facility's chain-of-command, from the reporting official to the highest facility official and the FOD **(Deficiency SAAPI-7[16])**.

During the detainee interviews, nine male detainees informed ODO that female officers do not announce their presence when entering the housing unit. The SAAPI coordinator reminded all facility staff members to announce their presence when entering a housing unit of the opposite gender. Furthermore, the unit managers and the shift supervisors reviewed the facility's policy with staff. ODO noted this as an **Area of Concern**.

CARE

MEDICAL CARE (MC)

ODO reviewed [redacted] detainee medical records and found in [redacted] out of [redacted] records, the facility did not screen the detainees for tuberculosis (TB) within 12 hours of their admission to the facility. The facility screened the detainees for TB between 3 and 9 days after the detainees' arrival to the facility **(Deficiency MC-29[17])**.

ODO reviewed [redacted] detainee medical records and found in [redacted] out of [redacted] records, the clinical medical authority did not review the comprehensive health assessments to determine the priority for treatment **(Deficiency MC-133[18])**.

ACTIVITIES

CORRESPONDENCE AND OTHER MAIL (COM)

ODO reviewed the facility COM program and found the facility detainee handbook does not specify the facility shall open and inspect general correspondence addressed to the detainee in the detainee's presence unless the facility administrator authorizes inspection without the detainee's presence for security reasons **(Deficiency COM-15[19])**.

ODO reviewed the facility COM program and found the facility detainee handbook does not include instructions on labeling special correspondence as "special correspondence" or "legal mail" **(Deficiency COM-16[20])**.

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[16] "Each facility must have a policy and procedure for required reporting through the facility's chain-of-command procedure, from the reporting official to the highest facility official as well as the Field Office Director." *See* ICE PBNDS 2011 (2013 Errata), Standard, Sexual Abuse and Assault Prevention and Intervention, Section (V)(A).

[17] "All new arrivals shall receive TB screening within 12 hours of intake and in accordance with CDC guidelines (www.cdc.gov/tb)." *See* ICE PBNDS 2011 (2013 Errata), Standard, Medical Care, Section (V)(C)(2).

[18] "The CMA shall be responsible for review of all comprehensive health assessments to assess the priority for treatment." *See* ICE PBNDS 2011 (2013 Errata), Standard, Medical Care, Section (V)(L).

[19] "At a minimum, the notification shall specify: That general correspondence and other mail addressed to detainees shall be opened and inspected in the detainee's presence, unless the facility administrator authorizes inspection without the detainee's presence for security reasons." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(C)(3).

[20] "At a minimum, the notification shall specify: The definition of special correspondence or legal mail, including

ODO reviewed the facility COM program and found the facility detainee handbook does not clearly state the detainee's responsibility to inform senders of the labeling requirement **(Deficiency COM-17[21])**.

ODO reviewed the facility COM program and found the facility detainee handbook does not specify the facility may only open incoming special correspondence or legal mail in the detainee's presence **(Deficiency COM-18[22])**.

ODO reviewed the facility COM program and found the facility detainee handbook does not specify facility staff shall not open nor inspect outgoing special correspondence and/or legal mail **(Deficiency COM-19[23])**.

ODO reviewed the facility COM program and found the facility detainee handbook does not specify how to obtain approval to send or receive packages **(Deficiency COM-20[24])**.

ODO reviewed the facility COM program and found the facility does not have detainees present when they inspect correspondence or other mail, including packages, unless otherwise authorized by the facility administrator **(Deficiency COM-51[25])**.

ODO reviewed the facility COM program, the facility Prohibited Items form, and found the facility administrator does not always provide non-detainees with a written notice explaining when the facility rejects incoming or outgoing mail. The facility will only provide non-detainees a written notice, signed by the facility administrator, if a detainee requests their prohibited items be picked up by a visitor **(Deficiency COM-61[26])**.

instructions on the proper labeling as "special correspondence" or "legal mail" to ensure that it is treated as privileged mail; the notification shall clearly state that it is the detainee's responsibility to inform senders of the labeling requirement." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(C)(4).

[21] "At a minimum, the notification shall specify: the notification shall clearly state that it is the detainee's responsibility to inform senders of the labeling requirement." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(C)(4).

[22] "At a minimum, the notification shall specify: That incoming special correspondence or legal mail may only be opened in the detainee's presence, and may be inspected for contraband, but not read, and that outgoing special correspondence or legal mail shall not be opened, inspected or read." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(C)(5).

[23] "That incoming special correspondence or legal mail may only be opened in the detainee's presence, and may be inspected for contraband, but not read, and that outgoing special correspondence or legal mail shall not be opened, inspected or read." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(C)(5).

[24] "At a minimum, the notification shall specify: That packages may neither be sent nor received without advance arrangements approved by the facility administrator, as well as information regarding how to obtain such approval." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(C)(6).

[25] "The detainee must be present when the correspondence or other mail, including packages, is inspected, unless otherwise authorized by the facility administrator." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(G)(1).

[26] "Both sender and addressee shall be provided written notice, signed by the facility administrator, with explanation, when the facility rejects incoming or outgoing mail." *See* ICE PBNDS 2011 (2013 Errata), Standard, Correspondence and Other Mail, Section (V)(H).

ADMINISTRATION AND MANAGEMENT

DETAINEE TRANSFERS (DT)

ODO reviewed the facility ICE Detainee Transfer Notification form, interviewed staff, and found the facility does not ensure a detainee acknowledges, in writing, he or she may place a domestic phone call, at no expense, upon admission into the receiving facility **(Deficiency DT-1 [27])**.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 26 standards under PBNDS 2011 (2013 Errata) and found the facility in compliance with 18 of those standards. ODO found 21 deficiencies in the remaining 8 standards. ODO commends facility staff members for their responsiveness during this inspection and notes there was one instance where the facility's staff initiated immediate corrective action during the inspection. ODO recommends ERO El Paso work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. ODO has not received the uniform corrective action plan for ODO's last inspection of TCDF in May 2021.

Compliance Inspection Results Compared	FY 2021 (PBNDS 2011) (2013 Errata)	FY 2022 (PBNDS 2011) (2013 Errata)
Standards Reviewed	11	26
Deficient Standards	5	8
Overall Number of Deficiencies	9	21
Repeat Deficiencies	0	0
Areas of Concern	0	1
Corrective Actions	2	1
Facility Rating	N/A	Superior

[27] "The sending facility shall ensure that the detainee acknowledges, in writing, that: he or she may place a domestic phone call, at no expense to the detainee, upon admission into the receiving facility." *See* ICE PBNDS 2011 (2013 Errata), Standard, Detainee Transfers, Section, (V)(B)(2)(c)(3)