



**U.S. Immigration
and Customs
Enforcement**

Office of Acquisition Management
U.S. Department of Homeland Security
801 I Street, NW – Suite 910
Washington, DC 20536

January 28, 2016

Town of Farmville
116 N. Main Street
P.O. Box 368
Farmville, VA 23901

Attn: (b)(6), (b)(7)(C) Town Manager

Re: Contract Discrepancy Report (CDR) Number HQ-FY16-001, dated October 26, 2015,
Contract Number DROIGSA-08-0021

Dear (b)(6), (b)(7)(C)

This letter is in response to the letter, dated November 4, 2015, from ICA Farmville (vendor) requesting the Government retract the findings and proposed reductions contained in the Contract Deficiency Report (CDR) dated October 26, 2015.

On October 26, 2015, Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO), through the Office of Acquisition Management (OAQ) notified the vendor via CDR of four separate suspected violations that, based on language contained in the Quality Assurance Surveillance Plan (QASP) and if acted upon by ICE, would be grounds for a deduction to the vendor's monthly invoice. The violations are based on a June 2015 compliance inspection performed by ERO Custody Management as well as a facility review by the Department of Homeland Security, Office for Civil Rights and Civil Liberties; an independent civil rights and civil liberties oversight arm of the Department. On November 4, 2015, the vendor responded to the CDR with a request that ICE retract each specified violation. In its letter, the vendor provided additional narrative and supporting information as a rebuttal to each violation.

Below is a summary of the four suspected violations, the vendor's rebuttal, and the Government's decision:

Specification 1 – Use of Force (January 20-23, 2015).

This suspected violation is based on a use of force undertaken at the facility against a detainee from January 20-23, 2015. The use of force included the use of verbal commands, oleoresin capsicum (OC) spray, and placement on a four-point restraint bed for approximately two days.

The CDR concluded that the use of two bursts of OC spray on the detainee while he was in full restraints and confined to a medical isolation cell was a violation of several requirements of the ICE 2011 Performance Based National Detention Standard (2011 PBNDS), titled Use of Force and Restraints. Specifically, section V(B)(4) of the 2011 PBNDS states “[s]taff shall use only that amount of force necessary and reasonable to gain control of a detainee” and section V(E), which states “[t]he following acts and techniques are generally prohibited, unless both necessary and reasonable in the circumstances: 1. Striking a detainee when grasping or pushing him/her

would achieve the desired result; [and] 2. Using force against a detainee offering no resistance...”

The vendor’s rebuttal states that the PBNDS does not prohibit the actions that facility staff took, and that based on the totality of the evidence, they acted appropriately and in the best interest of the detainee in preventing harm to himself and getting the best treatment possible under the circumstances.

The 2011 PBNDS Use of Force and Restraints Standard provides facilities with the expected outcomes when force is applied to a detainee. Expected outcomes identified in the Standard is the facility endorsement of (1) “confrontation avoidance” as the preferred method for resolving situations; and (2) “calculated use of force” as a method by which to avoid confrontation and minimize the risk of injury to staff and the detainee. The vendor argues to treat this entire incident as an immediate use of force, meaning force needed as the behavior of the detainee constitutes a threat to self, staff, another detainee, property, or the security and orderly operation of the facility. Based on the information received by the government and provided by the vendor, the detainee in question appeared to be attempting to strangulate his own genitalia with the irons he was restrained with. If this were the perception of the officers during this incident, then based on language in the standards, this meets the actions where the facility should have responded with an immediate use of force.

Following the initial OC spray burst, the vendor argues that the detainee was still a threat to staff because the detainee was unresponsive to verbal commands despite the detainee being in full restraints, placed within a padded cell behind a locked door, and laying on the cell floor in a prone position for several seconds. While those facts may be correct, it is the assessment of the risk of this threat that is important. Based on information provided to the government, following the initial OC spray burst, the risk of a threat to staff appears to have been significantly minimized, especially when considering the above factors. Even with the minimal risk, the facility elected to spray the detainee with a second burst of OC spray to solicit compliance as opposed to authorizing a calculated use of force.

ICE generally defers to facility operators to determine which use of force technique is most appropriate given the circumstances on the ground. As with many instances of use of force, arguments can be made on both sides as to why, in retrospect, a particular action should or should not have been taken, hence the importance of the facility after-action-review.

It should also be noted, and to its credit, the vendor candidly admits that it failed to perform an after-action review of this use of force incident as stipulated in the 2011 PBNDS.

Decision

In response to Specification 1, the Government will retract the proposed deduction outlined in the CDR. Although the government will not impose a sanction, it will closely monitor the vendor’s compliance with the 2011 PBNDS Use of Force detention standard as well as the requirement to conduct after-action-reviews following both immediate and calculated use of force incidents. Future failures to perform after-action reviews or other aspects of the Use of Force detention standard may result in monetary sanctions.

Specification 2 – Use of Force (March 12-16, 2015)

This suspected violation is based on the use of restraint chair and restraint bed on a detainee from March 12-16, 2015 without sufficient justification. The CDR concluded that the use of the

restraint chair and restraint bed over a four day period was not in compliance with ICE 2011 Performance Based National Detention Standards (2011 PBNDS), titled Use of Force and Restraints and Medical Care. Specifically, section V(B)(1) of the 2.15 2011 PBNDS states “Restraints shall be applied for the least amount of time necessary to achieve the desired behavioral objectives,” and Standard 4.3, Medical Care, Section (V)(V) states, “Restraints for medical or mental health purposes may be authorized only by the facility’s CMA or designee, after determining that less restrictive measures are not appropriate. In the absence of the CMA, qualified medical personnel may apply restraints upon declaring a medical emergency. Within one-hour of initiation of emergency restraints or seclusion, qualified medical staff shall notify and obtain an order from the CMA or designee.”

Decision

For very similar reasons as outlined above in response to Specification 1, the Government will retract the proposed deduction for Specification 2.

Specification 3 – Food Service Incident/Disciplinary System

This suspected violation is based on an alleged contamination of food by detainee food service workers based on a report of white worms being found during the evening meal service on February 21, 2015. In response to the incident, on February 25, 2015, the vendor posted a memorandum to all detainees at the facility of the ramifications for individual detainees found to have been contaminating a meal. It was later learned that the contamination stemmed from either a distributor or manufacturer defect and not by way of food tampering by detainees.

The CDR concluded that the issuance of a memorandum to ICE detainees is a violation of section V(A)(3) of the 2011 PBNDS standard titled Disciplinary System, which states “[d]isciplinary action may not be capricious or retaliatory nor based on race, religion, national origin, gender, sexual orientation, disability, or political beliefs.” The vendor argues that the memorandum was not a disciplinary action and there were no actions taken against any detainee for the events that transpired.

The specifications set forth in the 2011 PBNDS standard titled Disciplinary Standard is clear in its requirements that a facility disciplinary system must provide progressive levels, appeals, etc. with policies and procedures that clearly define detainee rights. Additionally, disciplinary action may not be capricious or retaliatory. The vendor’s memorandum threatened detainees with discipline if they tampered with food, attempted to degrade the reputation of, attempted to tarnish the facility’s name, control or intimidate the operations or personnel of the facility, or who engaged in disruptive behavior. Specifically, the memorandum stated detainees will face consequences that are “severe, swift, and will most likely impact the outcome of [a detainee’s] immigration proceedings.” This memorandum can be construed as a threat to detainees who attempt to file legitimate grievances or complaints against the facility. The vendor’s actions should not create a chilling effect where detainees are fearful of lodging a complaint or grieving a matter within the facility. Additionally, to claim that actions “will most likely impact the outcome of [a detainee’s] immigration proceedings,” is beyond the pale. In no contract or agreement with the vendor is the vendor authorized to interpret what actions, or violations of rules, regulations, or crimes, would affect an individual’s immigration proceedings.

Decision

In response to Specification 3, the Government will continue with the proposed deduction as outlined in the CDR.

Specification 4 – Grievance Process

This suspected violation is based on a finding by ERO that the vendor did not provide the local ERO Field Office and the Office of Professional Responsibility with detainee grievances related to facility employee misconduct.

The CDR concluded that a failure to refer allegations of staff misconduct is in violation of section V(F) of the 2011 PBNDS standard titled Grievance System, which states “[u]pon 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.”

The vendor argues that while the grievances are categorized as “employee misconduct” the substance of the allegations against staff did not violate the “Facility Staff Conduct” policy. Additionally, the vendor argues that the Grievance System standard does not specify what is or is not to be considered staff misconduct and is therefore up to interpretation by the facility. The fact is that the standard does mandate that copies of any grievance alleging staff misconduct are to be referred to ERO and OPR Joint Intake Center; however, the allegations in this particular grievance are not the type that OPR would review.

Decision

By word-for-word articulation of PBNDS 2011, a detainee allegation of staff misconduct must be provided to both ERO and OPR; however, due to the nature of the misconduct allegations, the Government will retract the deduction related to Specification 4.

Global Recommendation

Based on a review of all the suspected violations that led to the issuance of CDR No. HQ-FY16-001 and the vendor’s response, the Government has decided to impose a deduction of \$25,000.

In accordance with Section 2 of the Quality Assurance Surveillance Plan (QASP) for IGSA Number DROIGSA-08-0021, ICA/Farmville is subject to a deduction in an amount determined by ICE to be appropriate. Two and one half percent is the maximum percentage of total monthly withholding from an invoice attributable to functional category “Staff and Detainee Communication.” The maximum monthly withholding based on ICA’s average invoice would be approximately \$50,000. The Government has determined that, given the nature of the violation and in accordance with the terms and conditions of the contract and QASP, **a one-time deduction of \$25,000** will be applied to the next housing invoice received. The deduction is not retrievable by the Service Provider.

Should you have any questions, please feel free to contact (b)(6),(b)(7)(C) at (202) 732-(b)(6),(b)(7)(C) or (b)(6),(b)(7)(C)

Sincerely,

(b)(6),(b)(7)(C)

Contracting Officer

Cc:

(b)(6),(b)(7)(C)

Immigration Centers of America, ICA Farmville

(b)(6), (b)(7)(C)

Field Office COR



FARMVILLE DETENTION CENTER

OFFICE OF THE DIRECTOR
508 WATERWORKS ROAD
FARMVILLE, VIRGINIA 23901

February 16, 2016

(b)(6),(b)(7)(C)

Acting Deputy Assistant Director
Detention, Compliance & Removals
Office of Acquisition Management
U.S. Immigration and Customs Enforcement
U.S. Department of Homeland Security
500 12th St., SW
Washington, D.C. 20536

Dear (b)(6),(b)(7)(C)

ICA Farmville is in receipt of the deduction letter outlining the Government's final decision regarding Contract Discrepancy Report (CDR) HQ-FY16-001. Thank you for your positive response to the detailed answers and rebuttals to the CDR we submitted on November 4th, 2015.

We appreciate your letter and remain dedicated to providing U.S. Immigration and Customs Enforcement (ICE) with facilities and an operational environment that are wholly consistent with (and exceed) the U.S. Department of Homeland Security's (DHS) ongoing and long-term immigration detention reform efforts. We share the Department's goals to enhance the security and efficiency of ICE's nationwide detention system while also prioritizing detainee health, safety and well-being.

We are happy to learn of the Government's decision to retract three of the four findings and proposed reductions contained in the CDR dated October 26th, 2015. We continue to maintain that a more accurate, thorough analysis/investigation during the original inspection in June of 2015 would have led to fewer misleading conclusions and factual inaccuracies. Some discrepancies in the record and reports were also noted.

With regard to Specification #3, we still believe that the posted memorandum to ICE detainees was appropriate and should not be considered a disciplinary action under Section V(A)(3) of the 2011 Performance Based National Detention Standards. Indeed, there were no actions taken against any detainee for the events that transpired. It is our assertion that every rule and the spirit of every applicable rule was followed in this instance. The fact that the finding regarding Specification #3 was nonetheless promulgated by individuals outside of the announced decision making chain is also problematic.

Regardless, we remain prepared to comply with any and all ICE requirements going forward. It is our desire to take any and all steps to avoid a repeat of the occurrence which resulted in the release of this recent CDR. Due to the costs to both parties in time and related expenses, we accept this settlement in order to avoid a continuation of the matter.

We remain dedicated to the ICE mission of detention reform and to helping ICE achieve its' long and short-term goals. We are proud of our strong record of achievement and remain focused on providing exemplary services designed to meet the ICE mission.

If you have any questions, please do not hesitate to contact us at your convenience. We look forward to our continued partnership.

Sincerely,

(b)(6),(b)(7)(C)

Director of Detention
ICA-Farmville Detention Facility

(b)(6),(b)(7)(C)

Chairman of the Board
ICA-Farmville, LLC

(b)(6),(b)(7)(C)

cc (b)(6),(b)(7)(C) Assistant Director, Custody Management Division, Enforcement and Removal Operations, U.S. Immigration and Customs Enforcement

(b)(6),(b)(7)(C)

(b)(6),(b)(7)(C) Field Office Director, Washington Field Office, Enforcement and Removal Operations, U.S. Immigration and Customs Enforcement

(b)(6),(b)(7)(C)

(b)(6),(b)(7)(C) Contracting Officer Representative, Washington Field Office, Enforcement and Removal Operations, U.S. Immigration and Customs Enforcement



U.S. Immigration
and Customs
Enforcement

DATE: May 15, 2017

MEMORANDUM FOR: Acting Field Office Director
Washington Field Office

FROM: Supervisory Detention and Deportation Officer
Washington Field Office

SUBJECT: Management Referral - Findings
Class IV: OPR Case Number 201703093 and 201703539

Executive Summary:

On January 4, 2017, the Joint Intake Center (JIC) received a report from Immigration and Customs Enforcement (ICE) Supervisory Detention and Deportation Officer (SDDO) Enforcement and Removal Operations (ERO), Richmond, Virginia, who reported an immediate use of force incident on two non-compliant detainees who were in ICE custody at Immigration Centers of America (ICA) Farmville. On January 24, 2017, Assistant Field Office Director (AFOD) assigned the above management referral to SDDO (Exhibit 1) A second management referral was assigned relating to the same incident. (Exhibit 2)

Allegation: Immediate Use of Force incident involving ICA Officer on non-compliant detainees.

Finding: Referred. The allegation will be referred for further action.

Details of Inquiry:

, in her report to the JIC, reported that Oleoresin Capsicum (OC) Spray was deployed on two detainees identified as and who were not obeying verbal commands and refused to return to their bunks while in custody at ICA Farmville. relayed that OC Spray was deployed to gain compliance after verbal commands were given to reported that after OC deployment, complied and were moved to medical for de-contamination and evaluation. (Exhibit 1 and 2)

On January 24, 2017, [REDACTED] provided the ICA Farmville incident report, findings memo, ICA Guard Statements, medical evaluations, and video of the incident. A review of the incident report by [REDACTED] on that same date revealed that Officer(OFC) [REDACTED] was the officer who deployed the OC spray on [REDACTED] and [REDACTED]

On or about February 10, 2017, [REDACTED] reviewed [REDACTED] as to the current detention location of [REDACTED] to set up an interview. It was discovered that [REDACTED] was released on bond on January 11, 2017. It was discovered that [REDACTED] was still in custody at ICE Farmville. [REDACTED] coordinated with [REDACTED], Chief of Security, ICA Farmville to interview [REDACTED] and all involved parties on February 27, 2017.

On February 22, 2017, [REDACTED] reviewed the surveillance footage (video only, no sound). At 21:43:22, it can be seen that a large group of detainees are congregating near the front/officer station of the dorm. At 21:47:45, OFC [REDACTED] is walking from the front of the dorm to the rear and released a 1-2 second burst of OC spray at a large group of detainees. At 21:48:15, all detainees appear to be complying with verbal commands and returning to their bunks. At 21:53:12, exposed detainees appear to be escorted from the dorm to medical for decontamination and officers set up an exhaust fan. (Exhibit 3)

In OFC [REDACTED] written statement he relayed on January 3, 2017 at approximately 2145, he encountered a large crowd in Dorm 4 that were cursing and yelling at the ICA officers. OFC [REDACTED] and Officer [REDACTED] gave multiple verbal commands to "Get in your bunks or you will be sprayed." OFC [REDACTED] stated that the detainees continued to congregate and refused to comply. Assistant Shift Commander [REDACTED] and the overhead broadcast system continued to repeat the verbal command of "Get in your bunks or you will be sprayed." After several more commands OFC [REDACTED] stated that he deployed OC spray at [REDACTED]. Following the deployment of OC Spray, [REDACTED] complied with commands and were escorted to medical for decontamination. (Exhibit 4)

On February 27, 2017, [REDACTED] interviewed OFC [REDACTED] at ICA Farmville. OFC [REDACTED] remembered the incident and fully cooperated with the investigation. He stated that everything in his statement was true and accurate. OFC [REDACTED] stated that the detainees were upset about a previous decision to move other detainees from Dorm 4. OFC [REDACTED] stated that the detainees were given multiple verbal commands to return to their bunks and that no detainees were complying with the verbal commands. OFC [REDACTED] stated that he deployed OC spray in the direction of the faces of [REDACTED] for approximately 1 second. OFC [REDACTED] stated that they are instructed/trained to engage one individual at a time with OC spray. (Exhibit 5 and 6)

On February 27, 2017, [REDACTED] interviewed detainee [REDACTED] at ICA Farmville. ICA Officer [REDACTED] was used to translate between [REDACTED] and [REDACTED]. [REDACTED] stated that he was making food at the nearby microwave when he heard the verbal commands to return to his bunk. [REDACTED] stated that he understood the commands and stood near his bunk, not getting in it. [REDACTED] stated that he was directly exposed to the [REDACTED]

OC spray. stated that once the situation was under control he was promptly escorted to medical for decontamination. (Exhibit 5)

On March 14, 2017, Deportation Officer (DO) , an ICE/ERO certified Defensive Tactics Instructor (DTI), viewed the video at the Richmond ERO Office. DO opined that OFC deployed the OC in the correct 3 second burst manner. However, he had concerns relating to the non-compliance of the detainees. DO noted from the video that the detainees seemed to be compliant and that OFC did not address a specific threat but rather a large group. (Exhibit 7)

opines that OFC was not within the scope of the "ICA Use of Force and Restraint Policy," in that he did not use "a level of force that is necessary and reasonable to gain control of a detainee." (Exhibit 8). OFC did not identify a specific threat/detainee, he addressed an entire crowd with the use of the OC spray. OFC was not within the scope of the "ICE Use of Force Policy," in that he did not comply with the specific statement of a "chemical agent may be used as an intermediate force option to temporarily incapacitate an assailant." (Exhibit 9)

On May 10, 2017, received information from that on January 8, 2017, ICA Farmville conducted an after action review and re-training for officers involved in the January 3, 2017 use of force in dorm room 4. OFC was in attendance per his signature on the training form. (Exhibit 10)

On May 10, 2017, received information that the ICE ERO WAS Contracting Officer Technical Representative sent a contract discrepancy report (CDR) to ICA Farmville. The CDR recommended a \$10,000 fine. (Exhibit 11)

Findings:

Based on ICA Officer statements, ICA Officer interview, detainee interview, a review of surveillance video, and the opinion of a certified Defensive Tactics instructor, it appears that OFC was not within in the scope of the ICE or ICA Farmville use of force policy. The situation seemed to be tense, but the detainees were not being overly aggressive and appeared to be slowly complying with verbal commands. The After Action Report completed by ICA highlights that there was "poor threat management," and that OFC addressed 2 aliens and continued to move through the dorm to restore order. (Exhibit 12) The allegation will be referred for further action.

Exhibits

(b)(7)(E)



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From: (b)(6),(b)(7)(C)
Sent: 21 Jul 2017 16:30:30 -0400
To: (b)(6),(b)(7)(C)
Cc:
Subject: RE: Deduction Request WAS \$10K for FARMVILLE
Attachments: OPR Case No. (b)(7)(E)

Hi (b)(7)(E)

Please see attached requested document.

Have a great weekend!

Sincerely,

(b)(6),(b)(7)(C)

Chief
Administrative Inquiry Unit
PCN
500 12th St., SW, Rm (b)(6),(b)(7)(C)
Washington, DC 20536
202.732.(b)(6),(b)(7)(C) - 202.42.(b)(6),(b)(7)(C)

From: (b)(6),(b)(7)(C)
Sent: Thursday, July 20, 2017 7:15 PM
To: (b)(6),(b)(7)(C)
Subject: RE: Deduction Request WAS \$10K for FARMVILLE

Thanks

From: (b)(6),(b)(7)(C)
Sent: Thursday, July 20, 2017 6:57 PM
To: (b)(6),(b)(7)(C)
Subject: RE: Deduction Request WAS \$10K for FARMVILLE

Hi (b)(6),(b)(7)(C)
Let me look into this and get back to you.

(b)(6),(b)(7)(C)
Sent with BlackBerry Work (www.blackberry.com)

From: (b)(6),(b)(7)(C)
Date: Thursday, Jul 20, 2017, 6:44 PM
To: (b)(6),(b)(7)(C)
Subject: FW: Deduction Request WAS \$10K for FARMVILLE

Can I get a copy of this report?

(b)(7)(E)

From: (b)(6),(b)(7)(C)
Sent: Thursday, July 20, 2017 5:19 PM
To: (b)(6),(b)(7)(C)
Cc: (b)(6),(b)(7)(C)
Subject: RE: Deduction Request WAS \$10K for FARMVILLE

(b)(6)

Good afternoon.

The findings behind the rational are contained within the AIU case denoted below.

I suggest OAQ or someone on your team reach out to AIU to obtain the final report which resulted in a substantiated finding.

Please let me know if there is anything ERO WAS can do to facilitate this action.

(b)(6),(b)(7)(C)

(b)(6),(b)(7)(C)
Acting Deputy Field Office Director
Washington Field Office

(b)(6),(b)(7)(C)
8209 Terminal Road
Lorton, VA 22079

D 571-64 (b)(6),(b)(7)(C)
C 202-49 (b)(6),(b)(7)(C)

Outlook (b)(6),(b)(7)(C)
HSDN (b)(6),(b)(7)(C)

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From: (b)(6),(b)(7)(C)
Date: Thursday, Jul 20, 2017, 5:07 PM
To: (b)(6),(b)(7)(C)
Cc: (b)(6),(b)(7)(C)

Subject: RE: Deduction Request WAS \$10K for FARMVILLE

(b)(5)



Sent with BlackBerry Work
(www.blackberry.com)

From: (b)(6),(b)(7)(C)

Date: Thursday, Jul 20, 2017, 3:53 PM

To: (b)(6),(b)(7)(C)

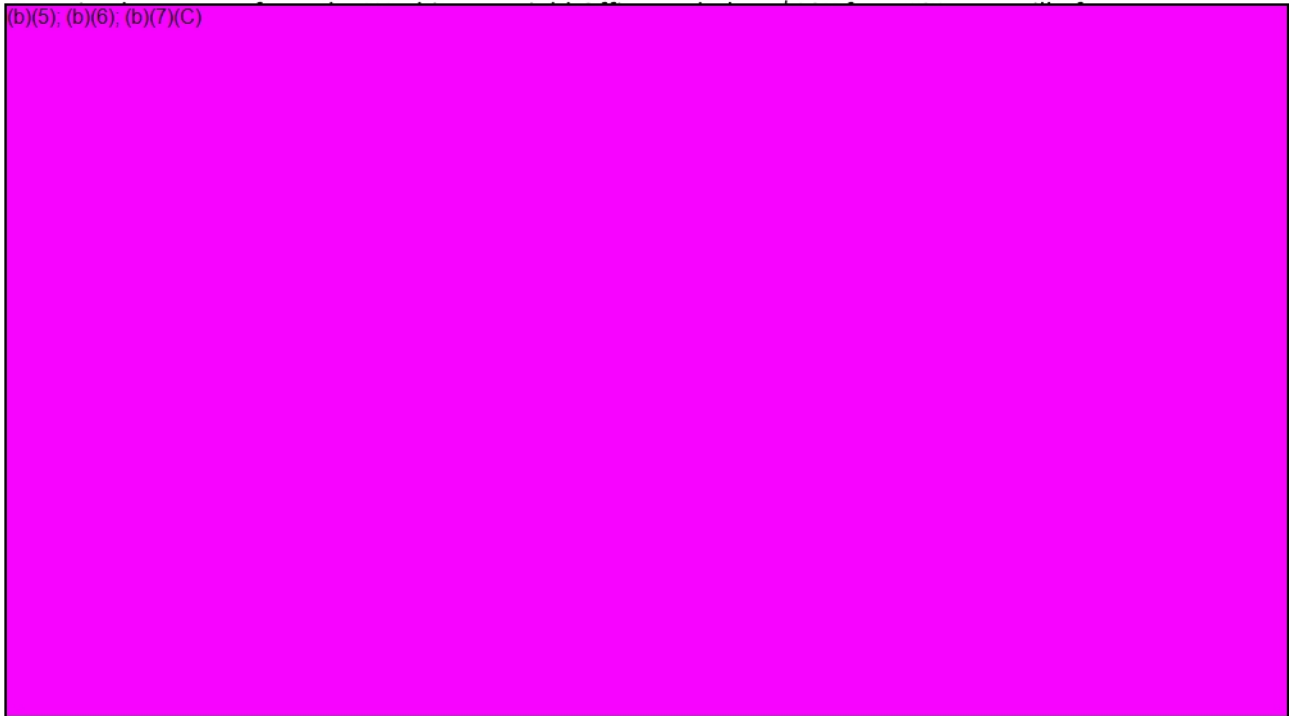
Cc: (b)(6),(b)(7)(C)

Subject: Deduction Request WAS \$10K for FARMVILLE

(b)(6),(b)(7)(C)



(b)(5), (b)(6), (b)(7)(C)



Per the QASP, requests for deductions or withholdings should be send to OAQ by ERO, so I am forwarding this information to you for review and recommendation on withholding.

(b)(5)

I'll await your recommendation.

Thanks

(b)(6),(b)(7)(C)

Detention, Compliance & Removals (DCR)

Section Chief

DHS | ICE | Office of Acquisition Management (OAQ)

801 "I" Street, N.W., Room (b)(6),(b)(7)(C)

Mail Stop (b)(6),(b)(7)(C)

Washington, D.C. 20536-5750

Phone: (202) 732- (b)(6),(b)(7)(C)

Cell: (202) 380- (b)(6),(b)(7)(C)

Email: (b)(6),(b)(7)(C)

CONTRACT DISCREPANCY REPORT	1. CONTRACT NUMBER DROIGSA-08-0021
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Report Number:	Date: 05/08/2017
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2. TO: (Contractor and Manager Name) (b)(6), (b)(7)(C) Director Farmville Detention Center	3. FROM: (Name of COTR) (b)(6), (b)(7)(C) Management/Program Analyst (COTR) ICE/ERO WAS Field Office 703-285- (b)(6), (b)(7)(C)
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DATES

CONTRACTOR NOTIFICATION 05/08/2017	CONTRACTOR RESPONSE DUE BY 05/17/17	RETURNED BY CONTRACTOR	ACTION COMPLETE
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4. DISCREPANCY OR PROBLEM (Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)

ICE ERO WAS conducted a review of the events that occurred on January 3, 2017 at ICA Farmville, Farmville, VA.

Based on ICA Officer statements, ICA Officer interviews, detainee interviews, a review of surveillance video, and the opinion of a certified Defensive Tactics instructor, it was determined that ICA OFC (b)(6) was not within the scope of the ICE or ICA Farmville use of force policy for his use of OC spray on an ICE detainee.

On 01/04/2017, at approximately 0150, WAS CC received a call from ICA Farmville Assistant Shift Commander (b)(6), (b)(7)(C) regarding a Use of Force incident involving detainees (b)(6), (b)(7)(C) and (b)(6), (b)(7)(C). Assistant Shift Commander (b)(6), (b)(7)(C) stated that last night at approximately 2145 hours, ICA Farmville Office (b)(6), (b)(7)(C) deployed OC spray to ensure compliance with orders.

The two detainees were attempting to start a group demonstration out in the common area. ICA Farmville Officers ordered the two detainees to return to their bunks. The detainees did not listen to verbal commands. Office (b)(6), (b)(7)(C) deployed OC spray in order to ensure compliance. The detainees were decontaminated and placed into restricted housing units. When asked whether the Use of Force incident was immediate or calculated in nature, Assistant Shift Commander (b)(6), (b)(7)(C) stated that he considers the incident to be immediate in nature.

5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR)
(b)(6)

6. TO: (COTR) (b)(6), (b)(7)(C) 703-285- (b)(6), (b)(7)(C)	7. FROM: (Contractor) (b)(6), (b)(7)(C) 434-39- (b)(6), (b)(7)(C)
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8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (Cite applicable Q.A. program procedures or new A.W. procedures.)

9. SIGNATURE OF CONTRACTOR REPRESENTATIVE	10. DATE
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11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: (Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary)

12. GOVERNMENT ACTIONS (Payment withholding, cure notice, show cause, other.)
A fine of \$10,000.00 is recommended by ICE.

CLOSE OUT			
	NAME AND TITLE	SIGNATURE	DATE
CONTRACTOR NOTIFIED	(b)(6), (b)(7)(C)	(b)(6), (b)(7)(C)	05/08/2017
COTR	(b)(6), (b)(7)(C)	(b)(6), (b)(7)(C)	07/24/17
CONTRACTING	2019-ICLI-0020-000		

CONTRACT DISCREPANCY REPORT			1. CONTRACT NUMBER DROIGSA-08-0021
Report Number:			Date:11/28/2017
2. TO: (Contractor and Manager Name) (b)(6),(b)(7)(C) Director Farmville Detention Center		3. FROM: (Name of COTR) (b)(6),(b)(7)(C) Management/Program Analyst (COTR) ICE/ERO WAS Field Office 703-2-(b)(6),(b)(7)	
DATES			
CONTRACTOR NOTIFICATION 11/28/2017	CONTRACTOR RESPONSE DUE BY: 12/5/2017 by 2:00PM EST	RETURNED BY CONTRACTOR:	ACTION COMPLETE:
4. DISCREPANCY OR PROBLEM (Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)			
<p>On 7/3/2017, Detainee (b)(6),(b)(7)(C) escaped custody from ICE Transportation Services as described below:</p> <p>Two transportation officers from the Immigration Centers of America (ICA) reported that shortly after departing the Loudoun County Adult Detention Center for the ERO Washington Field Office in Fairfax, Virginia with (b)(6),(b)(7)(C) began complaining that his handcuffs were cutting off his circulation. One of the ICA Officers decided to stop on VA-267 (Dulles Toll Road) near Exit 9A and toll booth 6 to loosen the detainee's handcuffs. ICA Policy states that officers are only able to stop at secure locations. No other location is acceptable. Additionally, per ICA policy, detainees are to be transported in full restraints. During this transport, (b)(6),(b)(7)(C) was transported in handcuffs with a belly chain.</p> <p>After stopping, one of the ICA officers secured his assigned weapon and proceeded to loosen the detainee's handcuffs. When the officer opened the door and loosened one of the detainee's handcuffs, the detainee struck the officer and forced his way out of the vehicle. The other ICA Officer, who was seated in the front passenger seat, exited the vehicle to assist the officer who was being assaulted. The detainee (b)(6),(b)(7)(C) foot towards a wooded area and the officers gave chase; however, they were unable to regain custody of (b)(6),(b)(7)(C).</p> <p>ICA Officer (b)(6),(b)(7)(C) and (b)(6),(b)(7)(C) were not within the scope of the "ICA Transportation by Land Policy," in that they did not transport the detainee in full restraints (ICE defines this as handcuffs, belly chain, and leg irons).</p> <p>ICA Officer (b)(6),(b)(7)(C) and (b)(6),(b)(7)(C) were not within the scope of the "ICA Transportation by Land Policy as an armed officer was not present whenever a detainee enters or exits a vehicle outside a secure area.</p> <p>Although the officers followed the ICA Policy of "officers will check the fit of restraining devices immediately after application, at every relay point, and any time the detainee complains." The Officers failed to place proper restraints on (b)(6),(b)(7)(C) prior to the departure from LCADC. The ICA Officers could have prevented the escape (b)(6),(b)(7)(C) was placed in full restraints and practiced proper contact and cover techniques.</p>			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6),(b)(7)(C)			
6. TO: (COTR) (b)(6),(b)(7)(C) 703-285-(b)(6),(b)(7)(C)		7. FROM: (Contractor) (b)(6),(b)(7)(C) 434-395-(b)(6),(b)(7)(C)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (Cite applicable Q.A. program procedures or new A.W. procedures.)			
Please see the attached.			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE (b)(6),(b)(7)(C)			10. DATE 12/4/2017

11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: *(Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary)*

12. GOVERNMENT ACTIONS *(Payment withholding, cure notice, show cause, other.)*

CLOSE OUT			
	NAME AND TITLE	SIGNATURE	DATE
CONTRACTOR NOTIFIED			
COTR			
CONTRACTING OFFICER			



IMMIGRATION CENTERS OF AMERICA

7113 THREE CHOPT ROAD
RICHMOND, VIRGINIA 23226

December 4, 2017

(b)(6),(b)(7)(C)

Management/Program Analyst (COTR)
Washington Field Office
2675 Prosperity Avenue
Fairfax, Virginia 20598

Dear (b)(6),(b)(7)(C)

After the escape, there was a full investigation of the incident and the officer's actions. A review of their training records reveals that they had been thoroughly trained to standard in accordance with company policy and the Performance-Based National Detention Standards (PBNDS). During the investigation, both officers were able to verbally articulate from memory what the PBNDS, Use of Restraints Policy, and the Transportation by Land Policy require. They acknowledged not following policy intentionally. The investigation further revealed that certain ICE Supervisory personnel of the Fairfax Field Office had given directives to ICA Transportation officers about not using restraints in contrast to the requirements of the PBNDS. At the end of the investigation, ICA concluded that regardless of the conflicting directives by ICE supervisors, ICA policy and procedure bind ICA employees, and those employees have a duty to report conflicts in policy to an ICA supervisor. These two officers made no such attempt. Thus, taking responsibility into their own hands by making their own decisions to violate policy caused them to be primarily responsible for the escape. Based on the outcome of the investigation, both officers involved were terminated from employment.

In an effort to prevent another incident, the Transportation Manager made a trip to the ICE Fairfax Office and personally reinforced the policies on the Use of Restraints and Transportation by Land with all ICA staff. The areas of training that were covered included how to apply restraints, when and where to check restraints, and who could authorize the removal of restraints during a transport. It was further reinforced that ICE Supervisory personnel do not have the authority to override the PBNDS requirements or company policy requirements. ICA officers are to follow the PBNDS and company policy at all costs and must notify a supervisor immediately if

they receive contradictory instructions. Additionally, training on proper uniform and equipment use, to include wearing of the protective vest, was reinforced.

Finally, the officers signed a memo stating they had received additional training on the policies and procedures mentioned above and that they understood that failure to follow these policies could result in disciplinary action up to and including termination. A copy of the memorandums was placed in each officer's personnel file.

We apologize that the actions of our officers resulted in this event. As unfortunate as it was, it provides us with a real-world example for our current and future staff about why complacency and intentional violation of policy is never acceptable. We will continue to train all ICA staff to operate at a high level and to set the expectation that anything less is unacceptable and will be met with severe consequences.

Respectfully,

(b)(6),(b)(7)(C)

A large black rectangular redaction box covers the signature area. The text "(b)(6),(b)(7)(C)" is printed in red at the top left corner of the box.

CEO

From: (b)(6),(b)(7)(C)
Sent: 5 Dec 2017 15:19:18 -0500
To: (b)(6),(b)(7)(C)
Cc: (b)(6),(b)(7)(C)
Subject: RE: CDR Response
Attachments: CDR Response.pdf

I have reviewed that attached response by ICA to the escape of Detainee (b)(6),(b)(7)(C) (b)(6),(b)(7)(C) At no time did I, nor do I have knowledge of another supervisor who directed any ICA with officer to transport a detainee contrary to that which is required by PBNDS, ERO Policy, or any other authority that ICA officers would be responsible for. To the contrary, I have on multiple occasions directed ICE trained Defensive Tactics Instructors to train ICA officers in the proper ICE techniques.

(b)(6),(b)(7)(C)

Supervisory Detention and Deportation Officer
U.S. Immigration and Customs Enforcement
Enforcement and Removal Operations
TDY – Folkston ICE Processing Center

~~Confidentiality Notice: This fax/e-mail transmission, with accompanying records, is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or privileged information belonging to the sender, including individually identifiable health information subject to the privacy and security provisions of HIPAA. This information may be protected by pertinent privilege(s), e.g., attorney-client, doctor-patient, HIPAA etc., which will be enforced to the fullest extent of the law. If you are not the intended recipient, you are hereby notified that any examination, analysis, disclosure, copying, dissemination, distribution, sharing, or use of the information in this transmission is strictly prohibited. If you have received this message and associated documents in error, please notify the sender immediately for instructions. If this message was received by e-mail, please delete the original message.~~

From: (b)(6),(b)(7)(C)
Sent: Tuesday, December 05, 2017 12:21 PM
To: (b)(6),(b)(7)(C)
Cc: (b)(6),(b)(7)(C)
Subject: FW: CDR Response

(b)(6),(b)(7)(C)

Can you take a look at this ICA/Farmville response and let me know what if it represents the facts of the situation.

Thanks,

(b)(6),(b)(7)(C)

Management/Program Analyst (COR)
WAS Field Office
2675 Prosperity Ave., Fairfax VA 22031

703-285-7000 (V)
703-798-3333 (3B)
703-285-6236 (Fax)

From: (b)(6),(b)(7)(C)
Sent: Tuesday, December 5, 2017 12:15 PM
To: (b)(6),(b)(7)(C)
Cc: (b)(6),(b)(7)(C)
Subject: RE: CDR Response

(b)(6),(b)(7)(C)

Please review their response and determine if it is acceptable and adequate.

Thank you, (b)(6),(b)(7)(C)

From: (b)(6),(b)(7)(C)
Sent: Monday, December 04, 2017 11:32 AM
To: (b)(6),(b)(7)(C)
Cc: (b)(6),(b)(7)(C)
Subject: CDR Response

CONTRACT DISCREPANCY REPORT		1. CONTRACT NUMBER DROIGSA-08-0021	
Report Number:		Date: 11/28/2017	
2. TO: (Contractor and Manager Name) (b)(6);(b)(7)(C) Director Farmville Detention Center		3. FROM: (Name of COTR) (b)(6);(b)(7) Management/Program Analyst (COTR) ICE/ERO WAS Field Office 703-285-6 (b)(6)	
DATES			
CONTRACTOR NOTIFICATION 11/28/2017	CONTRACTOR RESPONSE DUE BY: 12/5/2017 by 2:00PM EST	RETURNED BY CONTRACTOR:	ACTION COMPLETE:
4. DISCREPANCY OR PROBLEM <i>(Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)</i>			
<p>On 7/3/2017, Detainee (b)(6);(b)(7)(C) escaped custody from ICE Transportation Services as described below.</p> <p>Two transportation officers from the Immigration Centers of America (ICA) reported that shortly after departing the Loudoun County Adult Detention Center for the ERO Washington Field Office in Fairfax, Virginia with (b)(6);(b)(7)(C) began complaining that his handcuffs were cutting off his circulation. One of the ICA Officers decided to stop on VA-267 (Dulles Toll Road) near Exit 9A and toll booth 6 to loosen the detainee's handcuffs. ICA Policy states that officers are only able to stop at secure locations. No other location is acceptable. Additionally, per ICA policy, detainees are to be transported in full restraints. During this transport (b)(6);(b)(7)(C) was transported in handcuffs with a belly chain.</p> <p>After stopping, one of the ICA officers secured his assigned weapon and proceeded to loosen the detainee's handcuffs. When the officer opened the door and loosened one of the detainee's handcuffs, the detainee struck the officer and forced his way out of the vehicle. The other ICA Officer, who was seated in the front passenger seat, exited the vehicle to assist the officer who was being assaulted. The detainee fled on foot towards a wooded area and the officers gave chase; however, they were unable to regain custody of (b)(6);(b)(7)(C).</p> <p>ICA Officer (b)(6);(b)(7)(C) were not within the scope of the "ICA Transportation by Land Policy," in that they did not transport the detainee in full restraints (ICE defines this as handcuffs, belly chain, and leg irons).</p> <p>ICA Officer (b)(6);(b)(7)(C) were not within the scope of the "ICA Transportation by Land Policy as an armed officer was not present whenever a detainee enters or exits a vehicle outside a secure area.</p> <p>Although the officers followed the ICA Policy of "officers will check the fit of restraining devices immediately after application, at every relay point, and any time the detainee complains." The Officers failed to place proper restraints on (b)(6);(b)(7)(C) prior to the departure from LCADC. The ICA Officers could have prevented the escape (b)(6);(b)(7)(C) as placed in full restraints and practiced proper contact and cover techniques.</p>			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6);			
6. TO: (COTR) (b)(6);(b)(7)(C) 703-285- (b)(6)		7. FROM: (Contractor) (b)(6);(b)(7)(C) 434-395- (b)(6)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. <i>(Cite applicable Q.A. program procedures or new A.W. procedures.)</i>			
Please see the attached.			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE (b)(6);(b)(7)(C)		10. DATE 12/4/2017	

CONTRACT DISCREPANCY REPORT			1. CONTRACT NUMBER DROIGSA-08-0021
Report Number:		Date: 10/27/2015	
2. TO: (Contractor and Manager Name) (b)(6),(b)(7)(C) Director Farmville Detention Center		3. FROM: (Name of COTR) (b)(6),(b)(7)(C) Management Program Analyst (COTR) ICE/ERO WAS Field Office 703-2-(b)(6),(b)(7)(C)	
DATES			
CONTRACTOR NOTIFICATION 03/06/2015	CONTRACTOR RESPONSE DUE BY 03/10/15	RETURNED BY CONTRACTOR	ACTION COMPLETE
4. DISCREPANCY OR PROBLEM (Describe in Detail: Include reference in PWS / D (b)(6),(b)(7)(C) if necessary.) On October 23rd, 2015, ICA/Farmville Acting Director (b)(6),(b)(7)(C) informed the Washington Field Office (WAS FO) AFOD (b)(6),(b)(7)(C) that they were removing 18 detainees from the Common Fare Meal program for violations within the ordering of Non Approved food from the Commissary. This is against the April 3 rd , 2014 bulletin ICA Farmville received stating that PBNDS 2011 standards revising the process that is required for the removal of a detainee from the Common Fare Meals. Concurrence from the Washington Field Office (WAS FO) is required for the removal of any detainee from the Common Fare meals. ICA did not provide letter or get approval from the WAS FO to remove any of the detainees from the meals.			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6),(b)(7)(C)			
		7. FROM: (Contractor) (b)(6),(b)(7)(C) 434-395-8-(b)(6),(7)(C)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (Cite applicable Q.A. program procedures or new A.W. procedures.) No Contractor response is required.			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE			10. DATE
11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: (Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary) Issues with Larva were corrected and new procedures are in place to prevent another outbreak.			
12. GOVERNMENT ACTIONS (Payment withholding, cure notice, show cause, other.) No Financial Penalties are recommended at this time.			
CLOSE OUT			
CONTRACTOR NOTIFIED	NAME AND TITLE	SIGNATURE	DATE
COTR			
CONTRACTING OFFICER	2019-ICLI-00028 638		

CONTRACT DISCREPANCY REPORT		1. CONTRACT NUMBER DROOIGSA-08-0021	
Report Number: HQ -FY16-001		Date: 10/26/2015	
2. TO: ICA/Farmville Detention Center 508 Waterworks Road Farmville, VA 23901 Town Manager: (b)(6),(b)(7)(C)		3. FROM: Headquarters Custody Management U.S. Immigration & Customs Enforcement 500 12 th ST SW Washington, DC 20054	
DATES			
CONTRACTOR NOTIFICATION 10/26/2015	CONTRACTOR RESPONSE DUE 11/13/2015	RETURNED BY CONTRACTOR	ACTION COMPLETE
4. DISCREPANCY OR PROBLEM <i>(Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)</i>			
Specification 1 – Use of Force (January 20-23, 2015)			
<p>Factual Background: On January 21, 2015, at approximately 15:02, Immigration and Customs Enforcement (ICE) detainee (b)(6),(b)(7)(C) was placed in handcuffs and leg-irons and moved to padded cell #PAD-1, located in the health services area at Immigration Centers of America Farmville (ICA Farmville). At 15:10, medical staff noted that (b)(6),(b)(7)(C) had been removed from the restraint chair and placed in a padded cell in his underwear.</p> <p>Video recording provided to ICE begins at approximately 15:50 on January 21, 2015. The detainee is seen standing in the middle of a cell by himself, in handcuffs and leg-irons. He is naked; his underwear is caught in his leg-irons and a suicide smock is folded on the floor at his feet. While standing in shackles in the middle of the cell, he was moving his hands in the area of his genitals, but his exact actions and intent are not clear on the video. At approximately 15:52:17, he dropped to his knees.</p> <p>While the detainee was in the padded cell, ICA Farmville staff deployed a burst of oleoresin capsicum (OC) spray through the slot of the cell door. According to the video ICE reviewed, the first burst of OC spray occurred at 15:52:48. After the initial burst, at approximately 15:53:02, the ICE detainee stood up and faced the wall. At 15:53:12, he lay on the floor with his head to the door, and laid prone in what appeared from the video to be a passive posture. At approximately 15:53:45, the detainee, after being given verbal commands through the slot in the door (so it appears), moved away from the cell door on his hands and knees to the center of the cell facing the door.</p> <p>While the detainee was on his hands and knees in what appeared to be a passive posture at approximately 15:54:20, ICA Farmville staff deployed a second burst of OC spray which appeared to hit the detainee in his face and upper torso area. The detainee remained in the cell until 15:57:40 when ICA Farmville staff entered the cell and dragged the detainee out, across the hall, and into a different cell.</p> <p>Following a medical assessment, the detainee was placed onto a 4-point restraint bed in cell #M-20. The detainee remained in 4-point restraint bed until 10:52 a.m., January 23, 2015.</p> <p>Analysis: The use of two bursts of OC spray on (b)(6),(b)(7)(C) while he was in full restraints and confined to a medical isolation cell was a violation of several requirements of the ICE 2011 Performance Based National Detention Standards (PBNDS 2011) Standard 2.15, <i>Use of Force</i></p>			

and Restraints. These include Section V(A)(4), which states that staff shall use only that amount of force "necessary and reasonable to gain control of a detainee"; and Section V(E), which states "The following acts and techniques are generally prohibited, unless both necessary and reasonable in the circumstances: 1. Striking a detainee when grasping or pushing him/her would achieve the desired result; 2. Using force against a detainee offering no resistance..."

When ICA Farmville staff first deployed OC spray on (b)(6),(b)(7)(C) on January 21, he was kneeling naked on the floor in an empty cell in handcuffs and leg-irons, and appeared calm. The facility administrator later explained to ICE that (b)(6),(b)(7)(C) "was harming himself by wrapping the chain of his hand irons around his genitalia," and in response, the administrator "made the determination that a delay in controlling the situation could seriously endanger the detainee and cause irreparable harm." However, medical staff subsequently noted no injury to the detainee's genitalia when they examined him soon after the incident. There is no indication in the records ICA Farmville provided to ICE that (b)(6),(b)(7)(C) was ever violent or assaultive toward staff before the initial OC spray, and in fact (b)(6),(b)(7)(C) had cooperated with several moves (from GP cell to RHU cell, from RHU cell to a restraint chair, and from the restraint chair to the padded cell) in the previous two days.

Even if the first spray had been a legitimate use of force, the second spray was not. By the time of the second spray (b)(6),(b)(7)(C) was entirely subdued and had in fact been lying prone on the floor for several seconds before rising to his hands and knees and backing away from the cell door. He was not engaging in any conduct that might have been interpreted as "self-harm." He was still in full restraints and in a passive posture. Yet the facility pursued a second immediate use of force, and the facility administrator has offered no plausible justification for the determination that staff could not safely enter the cell and extract the detainee without the second use of OC spray.

Specification 2 – Use of Force (March 12-16, 2015)

Factual Background: On Thursday, March 12, 2015, video footage shows ICE detainee (b)(6),(b)(7)(C) squirting soap on the floor of the cell. He then filled the soap container with water from the sink and sprayed the floor, and for approximately the next fifteen minutes, he slid on the soapy floor. Facility staff members are visible through the window in the cell door a number of times during this behavior. At around 07:34, the detainee began to use his socks to wipe down the floor, toilet, and sink. At times, it appeared that the detainee was speaking to facility staff through the cell door. Finally, at approximately 07:44:30, after again wiping the floor, he approached the cell door, turned around, willingly put his hands through the slot, and was handcuffed by facility staff. About a minute later, he was escorted from his cell without incident.

A video recording from the hall camera that begins at 07:52 the same day captures several Farmville staff placing (b)(6),(b)(7)(C) in a restraint chair. A nurse checked him, and he is wheeled back into the cell in the restraint chair at around 07:59. A moment later, a few facility staff members also enter the cell, exit, and then close the door at approximately 08:01.

A third video recording, this time from a handheld camera, provides a closer view of facility staff strapping (b)(6),(b)(7)(C) into the restraint chair. He was calm and compliant, and his eyes were closed, throughout the restraint process. When the officers wheeled him back into the cell, (b)(6),(b)(7)(C) shifted the chair around slightly with his feet. (b)(7)(E) entered the cell and moved the chair so it faced the back wall and was blocked by the bed from moving in the direction he had been shifting it. Then the video ended.

The facility's mental health staff was notified of the decision to place the detainee in a restraint chair between 08:00 and 09:00 on the morning of March 12. Medical records during this period noted no injury at the time of (b)(6),(b)(7)(C) placement in the restraint chair, and revealed that he

was cooperative. Medical checks were then documented every two hours until around 18:30 on the evening of March 12. At that point facility staff moved (b)(6),(b)(7)(C) from the restraint chair in the residential housing unit to a restraint bed in the medical unit. From 23:00 on Thursday, March 12, to 08:50 on Friday, March 13, no checks are documented, but documentation resumes from that point and continues every two to four hours until the detainee was removed from the restraint bed at 11:07 on Monday, March 16, 2015.

Analysis: ICA Farmville's use of the restraint chair and restraint bed (four- and five-point restraints) on detainee (b)(6),(b)(7)(C) for over four days was not sufficiently justified and was not in compliance with the PBNDS 2011 Standard 2.15, *Use of Force and Restraints*, Section V.B.1, titled- "Principles Governing the Use of Force and Application of Restraints," which states, "Restraints shall be applied for the least amount of time necessary to achieve the desired behavioral objectives," or in compliance with Standard 4.3, *Medical Care*, Section V.V, which states, "Restraints for medical or mental health purposes may be authorized only by the facility's CMA or designee, after determining that less restrictive measures are not appropriate. In the absence of the CMA, qualified medical personnel may apply restraints upon declaring a medical emergency. Within one-hour of initiation of emergency restraints or seclusion, qualified medical staff shall notify and obtain an order from the CMA or designee."

As noted in a report that resulted from an ERO site visit, "[t]here is no documentation or video recordings depicting the detainee's negative or noncompliant behavior, to justify the continuation of restraints beyond March 12th." In a subsequent written justification for the use of restraints submitted to ICE on September 18, 2015, the facility administrator asserts that

(b)(6),(b)(7)(C) "stopped taking his medicine and over the course of four days slowly decompensated." In fact, medical records indicate that he was weaned off psychotropic medication in mid-February. The facility administrator also wrote that, following (b)(6),(b)(7)(C) placement in the SMU cell, "it was not long before [the detainee] became violent, punching and kicking the walls and doors of his cell." However, during the ensuing four days, the detainee was apparently not viewed by facility staff as being "a highly assaultive and aggressive detainee," (citing PBNDS 2.15 V.M.) considering that his restraints were removed by staff every two hours, apparently without serious incident. For extensive periods during the four days, staff documented that the detainee was "compliant during exercise," including, for example, between 08:43 on Friday, March 13 until 06:34 on Saturday 14 March. Although the detainee's behavior is not clearly described in the instances when the logs record that he was "non-compliant with exercise", there is no indication that he was assaultive on those occasions.

Finally, in his subsequent written justification for the ongoing use of restraints, the facility administrator wrote: "Managing a detainee in this condition is a significant drain on staff resources and the quality of care. Considering the detainee was not taking medication, and his behavior was a repeat of the episode in January, there was substantial reason to believe the detainee would be combative." Four-point restraints should not have been used for this extensive length of time in anticipation of how the detainee might have behaved in the future, or because the detainee's behavior, precipitated by mental illness, resulted in a drain on facility resources.

Specification 3 – Food Service Incident / Disciplinary System

Factual Background: On Saturday, February 21, 2015, detainees reported white worms on their evening meal trays. The next day, the general district manager for the food service provider visited ICA Farmville to investigate these complaints. He could not find evidence of a problematic food product and incorrectly "surmised" (citing an ICE Field Office COR) that a kitchen worker had sabotaged the meal, without any specific evidence of sabotage.

On February 25, 2015, ICA Farmville issued a memorandum to ICE detainees in response to the food service incident. The memorandum advised ICE detainees that the investigation of the food service incident had revealed evidence of tampering by detainees who worked in the kitchen and that all kitchen workers who were on duty at the time of incident had been released from working in the kitchen. In this memo, ICA Farmville accused "a few detainees within the

population” of “trying to degrade the reputation” of the facility and “making attempts to tarnish our ... good name in the community.” The author then wrote “I will not be manipulated or intimidated by liars and those within the population looking to stir up trouble.” ICA Farmville also offered incentives and rewards for any information regarding the incident or information regarding “other attempts to manipulate the operations.” In the memo, ICA Farmville informed detainees that upon completion of their investigation, those ICE detainees responsible will be criminally charged and immediately transferred to a local regional jail to await prosecution. The memo goes on to state that ICA Farmville will not tolerate tampering with food, attempts to control or intimidate the operations or personnel of the facility, or disruptive behavior; and that consequences for those detainees who engage in these activities “will be severe, swift, and will most likely impact the outcome of their immigration proceedings.”

At dinner on Monday, March 2, 2015, detainees again reported white worms on their meal trays. Following a more thorough inspection of the kitchen and various meal preparation products, ICE and facility staff found weevil larva in a container of beef base. Accordingly, the facility found that the food incident was not the result of tampering by the detainee food service workers but that of a defect that derived from either the distributor or manufacturer of the food product.

Analysis: Issuance of this memorandum to ICE detainees in response to a food service incident is in violation of PBNDS 2011 Standard 3.1, *Disciplinary System*, Section V(A)(3), which states “[d]isciplinary action may not be capricious or retaliatory nor based on race, religion, national origin, gender, sexual orientation, disability or political beliefs”.

Detainees were removed from the kitchen work detail without due process. Detainees were also threatened with swift and severe consequences, including criminal prosecution, that would likely impact a detainee’s immigration proceedings.

Specification 4 – Grievance Process

Factual Background: In June 2015, the ICE Detention Management Unit (DMU) reviewed 68 grievances filed at ICA Farmville between January and April 2015. Twenty-one of these alleged staff misconduct. According to the facility’s grievance officer, and as corroborated by DMU through a review of facility grievance records, none of these resulted in notifications to the ICE Enforcement and Removal Operations (ERO) Field Office or to ICE’s Office of Professional Responsibility (OPR).

Analysis: The failure to refer allegations of staff misconduct to ICE ERO and ICE OPR is a violation of PBNDS 2011 Standard 6.2, *Grievance System*, Section V.F, titled “Allegations of Staff Misconduct.” This section states, “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.” ICA Farmville did not comply with this section of Standard 6.2 in at least 21 cases between January and April 2015.

Summary:

The Performance Requirements Summary as a part of the Quality Assurance Surveillance Plan (QASP) indicates the possible deductions and withholdings that may be taken for violations of specific performance standards (PBNDS 2011). The specific maximum deductions that may be taken based on the facts above are as follows:

Specification 1 – January 2015

Violations
Security (Use of Force and Restraints): 20%

TOTAL: 20% (January invoice)

Specification 2 – March 2015

Violations
Security (Use of Force and Restraints): 20%

TOTAL: 20% (March invoice)

Specification 3 – February 2015

Violations
Order (Disciplinary System): 10%

TOTAL: 10% (February invoice)

Specification 4 – April 2015

Violations
Justice (Grievance System): 10%

TOTAL: 10% (April invoice (Note: Although the grievances span a number of months, only one month will be used for the QASP deduction))

Per the Quality Assurance Surveillance Plan, ICA Farmville is subject to a deduction of up to 60% of the monthly invoice for these violations.

ICA Farmville is required to submit a full response to the contract discrepancies outlined herein. ICA Farmville must also provide a full incident investigation and a corrective action plan to ensure these types of contract violations do not reoccur in the future.

5. SIGNATURE OF CONTRACTING OFFICER

(b)(6),(b)(7)(C)

6. TO: (OAO)

8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (Cite applicable Q.A. program procedures or new A.W. procedures.)

9. SIGNATURE OF CONTRACTOR REPRESENTATIVE

10. DATE

11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: (Acceptable response plan, partial acceptance of response plan, rejection: attach continuation sheet if necessary)

12. GOVERNMENT ACTIONS (Payment withholding, cure notice, show cause, other.)

CLOSE OUT

J		1. CONTRACT NUMBER DROIGSA-08-0021	
Report Number:		Date:03/01/2018	
2. TO: (Contractor and Manager Name) (b)(6),(b)(7)(C) Director Immigration Centers of America (ICA) Farmville Detention Center		3. FROM: (Name of COTR) (b)(6),(b)(7)(C) Management/Program Analyst (COTR) ICE/ERO WAS Field Office 703-285-(b)(6),(b)(7)(C)	
DATES			
CONTRACTOR NOTIFICATION :TBD 03/01/18	CONTRACTOR RESPONSE DUE BY :TBD03/08/18	RETURNED BY CONTRACTOR:TBD03/05/18	ACTION COMPLETE :TBD03/08/18
4. DISCREPANCY OR PROBLEM (Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.) On Friday, 02/09/18, an ICE Deportation Officer issued an I-203 for the release of detainee (b)(6),(b)(7)(C) (b)(6),(b)(7)(C) ICA contract (b)(6),(b)(7)(C) informed the Deportation Officer that since the detainee was in medical for a possible ailment, he was not medically cleared to be released. As ICE was ordering a release and not a transfer to another facility, the I-203 should have been honored immediately. The situation was not resolved until Wednesday, February 14 th , 2018 when the issue was elevated to ICA Farmville management. The detainee was released on 02/14/18; five days after his release should have been effected.			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6),(b)(7)(C)			
703-285-(b)(6),(b)(7)(C)		7. FROM: (Contractor) (b)(6),(b)(7)(C) 434-395-(b)(6),(b)(7)(C)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (Cite applicable Q.A. program procedures or new A.W. procedures.):TBD			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE		10. DATE	
11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: (Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary)			
12. GOVERNMENT ACTIONS (Payment withholding, cure notice, show cause, other.) A fine of (b)(4) is recommended by the WAS FO.			
CLOSE OUT			
CONTRACTOR NOTIFIED	NAME AND TITLE (b)(6) Director	SIGNATURE (b)(6),(b)(7)(C)	DATE 03/08/18
	COTR (b)(6) COR		03/08/18
CONTRACTING OFFICER			

CONTRACT DISCREPANCY REPORT		1. CONTRACT NUMBER DROIGSA-08-0021	
Report Number: CDR-001 FY19		Date: 04/18/2019	
2. TO: (Contractor and Manager Name) (b)(6),(b)(7)(C) Director Immigration Centers of America (ICA) Farmville Detention Center		3. FROM: (Name of COTR) (b)(6),(b)(7)(C) Management/Program Analyst (COTR) ICE/ERO WAS Field Office 703-285- (b)(6) (b)(7)(C)	
DATES			
CONTRACTOR NOTIFICATION 04/18/2019	CONTRACTOR RESPONSE DUE BY : 04/28/2019	RETURNED BY CONTRACTOR:	ACTION COMPLETE
4. DISCREPANCY OR PROBLEM (<i>Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.</i>)			
<p>On Monday, March 18, 2019, ICA Detention (b)(6),(b)(7)(C) assisted detainee (b)(6),(b)(7)(C) with a shower in the Restricted Housing Unit (RHU) when (b)(6),(b)(7)(C) asked for a razor to shave. The RHU Guard supplied the razor to (b)(6),(b)(7)(C) but the RHU Guard failed to record the correct name (b)(6),(b)(7)(C) on the razor log.</p> <p>After the shower, the Guards escorted detainee (b)(6),(b)(7)(C) back to his cell in medical; however, the RHU Guard failed to retrieve the razor from (b)(6),(b)(7)(C) before (b)(6),(b)(7)(C) left the RHU. Upon realizing the razor was missing, the Guards conducted a shakedown of the RHU as well as the medical cell housing (b)(6),(b)(7)(C). ICA staff interviewed detainee (b)(6),(b)(7)(C) who stated that (b)(6),(b)(7)(C) did not have the razor.</p> <p>On Tuesday, March 19, 2019 at around 0221 hours, (b)(6),(b)(7)(C) injured himself in a suicide attempt with the razor.</p> <p>There are 3 failures in the QASP for this event: Permanent Logs, Control of Contraband, and Security Inspections. The RHU Guard failed to follow ICA procedures by 1) improperly recording the name of the detainee provide the razor in the RHU and 2) not retrieving the razor from the detainee. Furthermore, ICA staff failed to locate the razor following a security inspection of the detainee, the RHU, and the medical cell housing the detainee. As a result of ICA's failures, a detainee injured himself in a suicide attempt.</p>			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6),(b)(7)(C)			
6. TO: (COTR) (b)(6),(b)(7)(C) 703-285- (b)(6),(b)(7)(C)		7. FROM: (Contractor) (b)(6),(b)(7)(C) 434-39- (b)(6),(b)(7)(C)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (<i>Cite applicable Q.A. program procedures or new A.W. procedures.</i>): TBD			
<p>On March 19, 2019 Detainee (b)(6),(b)(7)(C) was found to be in possession of a razor in his cell and had made cuts to his wrist area. An assessment by Mental Health staff later that day concluded that this act would be considered a suicide attempt.</p> <p>The cause of this event has been determined to be due to in-experience of the assigned RHU Officer as well as the RHU Officer failing to read his assigned Post Orders, a failure of the RHU Officer correctly accounting for razors assigned from the RHU to detainees by not annotating the correct detainee in the razor log, and failing to retrieve the razor upon completion of the shower. It was also found that the detainee was issued a razor in the shower, which is contrary to the Post Orders which states that detainees will be issued razors in their cell. Detainee (b)(6),(b)(7)(C) was housed in medical, however, he was brought to the RHU for a shower due to his erratic behavior necessitating the use of full restraints during movement. The Medical Officer Post Order was changed in 2018 to reflect that detainees housed in medical would only be issues a razor in their cell for a period of 20 minutes.</p> <p>This has resulted in the Officer being suspended from duty without pay for 5 working days (60 hours), a negative counseling filed in his personnel file, re-training of the Officer prior to being allowed to return to duty, and a restriction of the Officer from working RHU duties for a period of 1 year. All security staff have been provided re-training of the Post Order online, as well as comm (b)(6),(b)(7)(C) of the incident and contributing factors discussed during guard-mount training (b)(7)(E) who were escorting detainee (b)(6),(b)(7)(C) to and from his cell in Medical were verbally coun (b)(6),(b)(7)(C) due to their roles as senior officers who were assigned to assist Officer (b)(6),(b)(7)(C) and answer questions he might have due to Officer (b)(6),(b)(7)(C) inexperience working duties as the RHU Officer.</p> <p>The Deputy Director of Operations and the Chief of Security have reviewed both the Restricted Housing Unit Officer Post Order and Special Instructions and the Medical Officer Post Order and Special Instructions and though both provide adequate instruction to Officers for daily operations, have identified areas that will be revised to provide better understanding of special circumstances surrounding detainees who are not on Segregation status, but have security procedures in place due to behavior issues. There is also consideration of change to procedures for better control of razors in controlled housing units by implementing a time limit for detainee housed in the RHU (currently in place for detainee housed in Medical), a designated time for shaving/issuance of razors, or a change to location for issuance. These suggestions will be presented to the Director for consideration prior to implementation. All updates and potential changes, in addition to placement of tray slots in the Medical Housing Unit shower, will provide additional coverage and security for the future.</p>			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE 2019-ICLI-00028 645		10. DATE	

CONTRACT DISCREPANCY REPORT		1. CONTRACT NUMBER DROOIGSA-08-0021	
Report Number: WAS-FY13-001		Date: 4/24/2013	
2. TO: ICA/Farmville Detention Center 508 Waterworks Road Farmville, VA 22909 Town Manager: (b)(6),(b)(7)(C)		3. FROM: (b)(6),(b)(7)(C) U.S. Immigration & Customs Enforcement 2675 Prosperity Avenue. Fairfax, VA 22031 COR: (b)(6),(b)(7)(C)	
DATES			
CONTRACTOR NOTIFICATION 4/24/2013	CONTRACTOR RESPONSE DUE 5/01/2013	RETURNED BY CONTRACTOR	ACTION COMPLETE
4. DISCREPANCY OR PROBLEM (Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)			
(b)(6),(b)(7)(C) Mexico, Admitted to Farmville: 3/20/13 Larceny, Resisting Public Officer, DUI			
(b)(6),(b)(7)(C) Belize, Admitted to Farmville: 4/10/13 Public Intoxication, ID Theft			
At 1445 hours, Office (b)(6),(b)(7)(C) was supervising 53 detainees participating in outdoor recreation on the soccer field. A detainee requested to be let back into the building and as Office (b)(6),(b)(7)(C) was calling for the door to be opened to let the detainee inside, at the opposite end of the recreation yard, the two subjects ran towards the containment fence and scaled it. Officer (b)(6),(b)(7)(C) observed them and immediately sounded his body alarm, called an emergency situation on the radio, and ran towards the escaping subjects. Utilizing their jackets the detainees spread apart the coils of razor wire at the bottom of a perimeter fence gate. The detainees were able to lie on their bellies and get under the gate which was off the ground by approximately 12 inches. Both detainees then ran west into the woods out of sight. The escape took 26 seconds. Responding staff responded to the soccer field. The facility was locked down, a perimeter patrol dispatched and emergency plans implemented. The following is a brief synopsis of the timeline of events:			
1445 Escape (26 seconds) 1448 Facility lockdown, perimeter security posted, Farmville PD notified 1450 ICE notified, Director notified, Investigator notified, Entrance gate closed 1453 Farmville PD arrives 1455 Emergency Count started; cleared 1552, Television, Telephone and Radio services turned off, Visitation terminated, Outdoor recreation terminated 1510 Screening officer posted with PR orders and descriptions 1535 ID of escapees (b)(6),(b)(7)(C) ascertained; screening officer and perimeter patrol provided updated subject information 1600 Visitors and off going staff cleared to leave the facility; vehicles searched before departure 1625 ICE Fugitive Apprehension Team arrives 1945 Director arrives, facility returned to normal operations with the exception of outdoor recreation 2015 Perimeter patrol and screening officer stands down			
Corrective action required.			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6),(b)(7)(C)			
6. TO: (COR) See Attached		7. FROM: (Contractor) See Attached	

<p>8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (Cite applicable Q.A. program procedures or new A.W. procedures.)</p> <p>See Attached</p>			
<p>9. SIGNATURE OF CONTRACTOR REPRESENTATIVE</p> <p>See Attached</p>			<p>10. DATE</p>
<p>11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: (Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary)</p> <p>The WAS FO accepts the corrections that are provided by ICA/Farmville as a condition of correction for the escape. ICA/Farmville has completed the improvements for the fence, gateways and placed detention officers in the outdoor perimeter fence area.</p>			
<p>12. GOVERNMENT ACTIONS (Payment withholding, cure notice, show cause, other.)</p> <p>Improvements provided by ICA/Farmville are sufficient.</p>			
CLOSE OUT			
	NAME AND TITLE	SIGNATURE	DATE
CONTRACTOR NOTIFIED	(b)(6),(b)(7)(C)	//S//	
COTR		//S//	5/02/2013
CONTRACTING OFFICER			

CONTRACT DISCREPANCY REPORT			1. CONTRACT NUMBER DROOIGSA-08-0021
Report Number:			Date:01/04/2012
2. TO: (Contractor and Manager Name) (b)(6),(b)(7)(C) ICE/ICA Farmville Detention Center		(b)(6),(b)(7)(C) of COTR) Management Program Analyst (COTR) ICE/ERO - WAS Field Office 703-285 (b)(6),(b)(7)(C)	
DATES			
CONTRACTOR NOTIFICATION 01/04/2012	CONTRACTOR RESPONSE DUE BY 01/06/12	RETURNED BY CONTRACTOR	ACTION COMPLETE
4. DISCREPANCY OR PROBLEM <i>(Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)</i> On January 03, 2012 a 203, 216 was issued by the WAS FO to move 3 detainees to Hampton Roads Regional Jail. ICA/Farmville transportation picked up the 3 detainees from the WAS FO in Fairfax, VA and proceeded to drop 2 detainees off at Hampton Roads, then took 1 detainee (b)(6),(b)(7)(C) with a CLS Code of Level 3, to the Farmville Detention Center which can not house Level 3 Detainees. The facility DSM discovered there were no 203 and 216 for the detainee and notified ICE leadership. The facility administration chose to place the detainee in medical. an questioned ICE about the lack of documents and could not classify the detainee. A quick call would have corrected the situation and we could have informed them that they delivered the detainee to the wrong facility. Instead, they were not up front about the mistake and the detainee had to stay at Farmville overnight before they were transported back to Hampton Roads. In the same day they delivered a detainee, (b)(6),(b)(7)(C) (b)(6),(b)(7)(C) to Hampton Roads instead of his intended destination, Farmville. This is two mistakes within hours on the same day and is unacceptable. To date, ICA has not acknowledged these mistakes. All forms (203's and 216's) were prepared to standard.			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6),(b)(7)(C)			
6. TO: (COTR) (b)(6),(b)(7)(C)		7. FROM: (Contractor) (b)(6),(b)(7)(C) 434-395 (b)(6)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. <i>(Cite applicable Q.A. program procedures or new A.W. procedures.)</i> On January 3, 2012 at approximately 2354 hours, ICA officers (b)(6),(b)(7)(C) and (b)(6),(b)(7)(C) arrived at the facility and had four detainees on board to include detainee (b)(6),(b)(7)(C) (b)(6),(b)(7)(C). The detainees entered the facility and began in-processing. At some point and time during the processing, the detainee who was transported to ICA-Farmville spoke up and informed the officers that the Fairfax ICE agents had been calling him the wrong name all day. The 216's were checked against the wrist bands and it was determined that the detainee was wearing the wrong wrist band. The Shift Commander contacted Hampton Roads and found out that the detainee who was scheduled to come to Farmville was actually at Hampton Roads and was also wearing the wrong wrist band. At approximately 1:45 AM, the Transportation Manager contacted the Director and advised him of the situation. Due to the fact that the drivers had already been on duty for several hours and no other drivers were available, the decision was made to finish processing the detainee into Farmville and house him in the medical department until morning. Coordination to transfer the detainee was made with ICE on the morning of January 4, 2012 and the detainee was transported to Hampton Roads at 1113 hrs on January 4, 2012.			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE			10. DATE
2019-ICLI-00028 648			
11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: <i>(Acceptable response/plan, partial</i>			

CONTRACT DISCREPANCY REPORT		1. CONTRACT NUMBER HSCEDM-14-F-IG039	
Report Number:		Date:03/10/2015	
2. TO: (Contractor and Manager Name) (b)(6);(b)(7)(C) Director Farmville Detention Center		3. FROM: (Name of COTR) (b)(6);(b)(7)(C) Management/Program Analyst (COTR) ICE/ERO WAS Field Office 703-285-(b)(6);	
DATES			
CONTRACTOR NOTIFICATION 03/06/2015	CONTRACTOR RESPONSE DUE BY 03/10/15	RETURNED BY CONTRACTOR	ACTION COMPLETE
4. DISCREPANCY OR PROBLEM <i>(Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)</i> On February 21st, 2015, Bug Larva was found in the first served meal of the day approximately 0715 hours in 3 Dorms at the facility. All meals were confiscated and new replacement meals were served. On March 2 nd , Bug Larva was found in meals served in Dorm 2 and meals were confiscated and new replacement meals were served. Please see Letter Attachments for more details on the situation and the results of the investigation that followed.			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR) (b)(6);(b)(7)(C)			
6. TO: (COTR) (b)(6);(b)(7)(C)		7. FROM: (Contractor) (b)(6);(b)(7)(C) 434-395-(b)(6);(b)(7)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. <i>(Cite applicable Q.A. program procedures or new A.W. procedures.)</i> No Contractor response is required.			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE			10. DATE
11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: <i>(Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary)</i> Issues wth Larva were corrected and new procedures are in place to prevent another outbreak.			
12. GOVERNMENT ACTIONS <i>(Payment withholding, cure notice, show cause, other.)</i> No Financial Penalties are recommended at this time.			
CLOSE OUT			
CONTRACTOR NOTIFIED	NAME AND TITLE	SIGNATURE	DATE
COTR			
CONTRACTING OFFICER			