

OFFICE OF INSPECTOR GENERAL

**Capping Report:
Observations of
Unannounced
Inspections of ICE
Facilities in 2019**



Homeland
Security

**July 1, 2020
OIG-20-45**

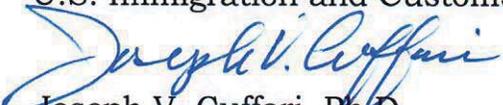


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Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

July 1, 2020

MEMORANDUM FOR: The Honorable Matthew T. Albence
Acting Director
U.S. Immigration and Customs Enforcement

FROM: 
Joseph V. Cuffari, Ph.D.
Inspector General

SUBJECT: *Capping Report: Observations of Unannounced
Inspections of ICE Facilities in 2019*

Attached for your information is our final report, *Capping Report: Observations of Unannounced Inspections of ICE Facilities in 2019*. We incorporated the formal comments from the U.S. Immigration and Customs Enforcement in the final report.

Consistent with our responsibility under the *Inspector General Act*, we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact Jackson Eaton, Acting Assistant Inspector General for Special Reviews and Evaluations at (202) 981-6000.

Attachment



DHS OIG HIGHLIGHTS

Capping Report: Observations of Unannounced Inspections of ICE Facilities in 2019

July 1, 2020

Why We Did These Inspections

As directed by Congress, we conduct annual unannounced inspections of U.S. Immigration and Customs Enforcement (ICE) detention facilities to ensure compliance with detention standards. In 2019, we inspected four detention facilities to evaluate their compliance with ICE detention standards.

What We Recommend

We made one recommendation to improve ICE's oversight of detention facility management and operations.

For Further Information:

Contact our Office of Public Affairs at (202) 981-6000, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

Our 2019 unannounced inspections of four detention facilities identified violations of ICE detention standards, which set requirements for facilities housing detainees. Although the conditions varied among the facilities and not every problem was present at each, our observations, interviews with detainees and staff, and review of documents revealed several common issues. At three facilities, we found segregation practices that infringed on detainee rights. Detainees at all four facilities had difficulties resolving issues through the grievance and communication systems, including allegations of verbal abuse by staff. Two facilities had issues with classifying detainees according to their risk levels, which could affect safety. Lastly, we identified living conditions at three facilities that violate ICE standards. Overall, these areas of noncompliance with detention standards inhibit the facilities' ability to establish environments that protect the rights, health, and safety of detainees.

ICE Response

ICE concurred with the report recommendation and described corrective actions to address the issues identified in this report. We consider the recommendation resolved and open.



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Abbreviations

| | |
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| CDF | Contract Detention Facility |
| ERO | Enforcement Removal Operations |
| ICE | Immigration and Customs Enforcement |
| IGSA | Intergovernmental Service Agreement |
| NDS | National Detention Standards |
| OIG | Office of Inspector General |
| PBNDS | Performance-Based National Detention Standards |
| RFID | Radio Frequency Identification |
| SPC | Service Processing Center |
| USMS IGA | U.S. Marshals Service Intergovernmental Agreement |



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Introduction

Currently, Immigration and Customs Enforcement (ICE) houses detainees at roughly 200 facilities nationwide, but the conditions and practices at those facilities can vary greatly. In recent years, the care and treatment of detainees have been the subject of increased congressional and public attention, and our program of unannounced inspections of ICE detention facilities has identified serious issues at several facilities. In fiscal year 2019, U.S. Immigration and Customs Enforcement (ICE) detained an average of 50,000 people per day. In 2019, we continued our program of Congressionally-directed unannounced inspections at four adult detention facilities. During these inspections, we found violations of ICE detention standards that undermine the protection of detainees' rights and the provision of a safe and healthy environment.

Background

ICE Enforcement and Removal Operations (ERO) oversees the detention of aliens in more than 200 facilities nationwide that it manages in conjunction with private contractors and government entities, including state and local governments. ICE uses the following types of detention facilities for adults:

- Service Processing Centers (SPC) owned by ICE, operated by ICE and contract employees, and dedicated to housing only ICE detainees;
- Contract Detention Facilities (CDF) owned and operated by private companies under contract with ICE, and dedicated to housing only ICE detainees;
- Dedicated Intergovernmental Service Agreement (IGSA) facilities — state and local facilities operating under an agreement with ICE, and dedicated to housing only ICE detainees;
- non-dedicated IGSA facilities — state and local facilities operating under an agreement with ICE, which house ICE detainees in addition to other confined populations (i.e., inmates), either together or separately; and
- U.S. Marshals Service Intergovernmental Agreement (USMS IGA) facilities — U.S.-Marshals-Service-contracted facilities also used by ICE, which house ICE detainees in addition to other confined populations (i.e., inmates), either together or separately.

ICE holds detainees in civil, not criminal, custody, which is not supposed to be punitive. Contracts and agreements with facilities holding ICE detainees require adherence to the *2000 National Detention Standards (2000 NDS)*, *2008*



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Performance-Based National Detention Standards (2008 PBNDS), or the 2011 PBNDS.¹ Detention standards establish consistent conditions of confinement, program operations, and management expectations within ICE's detention system. These standards set requirements for:

- environmental health and safety, e.g., cleanliness, sanitation, security, detainee searches, segregation,² and disciplinary systems;
- detainee care, e.g., food service, medical care, and personal hygiene;
- activities, e.g., visitation and recreation; and
- grievance systems.

As directed by Congress,³ we conduct annual unannounced inspections of ICE detention facilities to ensure compliance with detention standards. In addition to inspections conducted by OIG, ICE has various offices responsible for oversight and monitoring of detention standards. Specifically, ICE ERO contracts with a private company to inspect facilities, and ICE's Office of Detention Oversight conducts inspections as well. In 2019, we made unannounced visits to four detention facilities between March and July. We visited the Northwest Detention Center (Northwest) in Tacoma, Washington; El Paso Processing Center (El Paso) in El Paso, Texas; Cibola County Correctional Center (Cibola) in Milan, New Mexico; and Baker County Detention Center (Baker) in Macclenny, Florida.

According to ICE, these facilities collectively house a maximum of 3,207 detainees. Each facility varies by type, owner, operator, standards followed, and housing capacity, as shown in table 1.

¹ At the time of contracting, ICE and the contractor agree on which of the three sets of standards will apply to the facility. During the period OIG conducted the unannounced inspections discussed in this report, these were the operative standards applicable to facilities housing ICE detainees. ICE has since issued the new 2019 NDS.

² Segregation is the process of separating certain detainees from the general population for administrative, disciplinary, or protective reasons.

³ *Consolidated Appropriations Act, 2019*, Pub. L. No. 116-6, Division A, *Department of Homeland Security Appropriations Act, 2019*; Joint Explanatory Statement, 164 CONG. REC. H2045, H2547 (daily ed. Mar. 22, 2018); H.R. Rep. No. 115-948, at 15 (2018); S. Rep. No. 115-283, at 23 (2018).



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Table 1. Inspected Facility Information

| Facility | Type | Owned By | Operated By | Standards | Capacity |
|------------------|--------------------|--|-------------------------------|------------|----------|
| Northwest | CDF | GEO Group Inc. | GEO Group Inc. | 2011 PBNDS | 1,575 |
| El Paso | SPC | ICE | Global Precision Systems | 2011 PBNDS | 840 |
| Cibola | Non-dedicated IGSA | CoreCivic | CoreCivic | 2011 PBNDS | 500 |
| Baker | Non-dedicated IGSA | Baker Correctional Development Corporation | Baker County Sheriff's Office | 2000 NDS | 292 |

Source: OIG analysis of ICE-provided data

Results of Inspection

Our inspections of the four detention facilities revealed violations of ICE’s detention standards and raised concerns about the environment in which ICE holds detainees in these facilities. Although the conditions varied among the facilities and not every problem was present at each, our observations, interviews with detainees and staff, and review of documents revealed several prevalent issues. As reflected in table 2, we found segregation practices that infringe on detainee rights at three facilities. Detainees at all four facilities had difficulties resolving issues through the grievance and communication systems, including allegations of verbal abuse by staff. Two facilities had issues with properly classifying detainees according to risk level, which could affect safety. Further, we identified living conditions at three facilities that violate ICE standards.

Table 2. Snapshot of Issues Found by Facility

| Facility | Segregation | Grievances/ Communication | Classification | Living Conditions |
|------------------|-------------|---------------------------|----------------|-------------------|
| Northwest | X | X | | |
| El Paso | | X | | X |
| Cibola | X | X | X | X |
| Baker | X | X | X | X |

Source: OIG observations and analysis



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Inappropriate Segregation Practices at Three Facilities Infringe on Detainee Rights

Facilities may place a detainee in segregation when the detainee's continued presence in the general population poses a threat to life, property, self, staff, or other detainees; for the secure and orderly operation of the facility; or for medical reasons.⁴ During our unannounced inspections, we identified serious issues with the administrative and disciplinary segregation of detainees at Cibola, Baker, and Northwest. Specifically, Cibola did not always include the relevant documents supporting segregation in the detainee's file. At Baker, staff did not personally observe segregated detainees every 30 minutes, nor were all segregated detainee activities logged. Northwest used restraints to control segregated detainees during any movement outside their cells. These practices violate detention policies and standards, and infringe on detainee rights.

Cibola Lacked Documentation Supporting the Use of Segregation

Facilities are required to complete a written segregation order and attach all memoranda, medical reports, and other relevant documents to the order before placing a detainee in administrative segregation.⁵ Cibola placed detainees in administrative segregation, but did not always include relevant documentation supporting the use of segregation. For example, two detainees were in administrative segregation for medical observation for 4 and 6 days, respectively. However, documentation was not included with the segregation orders supporting the need to observe the detainees in segregation rather than in the medical unit where they could be more closely monitored by medical staff. Another detainee had been in administrative segregation for 8 days at the time of our visit because the detainee was alleged to be a "security threat." However, supporting documentation was not included with the order to support the claim and justify use of segregation.

⁴ ICE, *Performance-Based National Detention Standards, 2011* (2011 PBNDS), Section 2.12.V.A, Special Management Units (Revised Dec. 2016). Administrative segregation is a form of separating a detainee from the general population when the continued presence of the detainee in the general population would pose a serious threat to life, property, self, staff, other detainees, or the security or orderly operation of the facility.

⁵ ICE, *Performance-Based National Detention Standards, 2011* (2011 PBNDS), Section 2.12.2, Special Management Units (Revised Dec. 2016).



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Baker Staff Did Not Personally Observe Segregated Detainees or Log Their Activities Consistently

The 2000 NDS require facilities to maintain a permanent segregation log recording detainee activities related to meals, recreation, visitors, and showers.⁶ In addition, Baker has implemented local guidelines for segregation, which include physically observing detainees at least every 30 minutes. We found Baker did not consistently log the activities of segregated detainees or conduct these 30-minute checks. Baker logged segregated detainee activities so poorly it was difficult to know whether detainees received meals, were allowed recreation or visitors, or were allowed showers. Additionally, Baker's segregation logs showed instances in which the time between checks was up to 3 hours, rather than 30 minutes as required. We also observed a 30-minute segregation check during which the guard passed by each cell with a Radio Frequency Identification (RFID)⁷ reader and scanned the RFID tag at each cell without physically observing the detainee. By not completing activity logs and timely physical checks, facility personnel violate applicable standards and guidelines, which are in place to promote detainee health and safety. Proper monitoring of detainees in segregation is particularly critical given that research has found segregation can have damaging psychological effects⁸ and is an established risk factor for suicide.⁹

Northwest Used Restraints on Segregated Detainees for Any Movement Outside of Cells

According to the 2011 PBNDS, placement in segregation alone does not constitute a valid basis for using restraints (i.e., handcuffs) on detainees. Further, restraints should only be used if necessary as a precaution against escape during transfer (e.g., to another facility, court, or hospital), when directed by the medical officer for medical reasons, or to prevent self-injury, injury to others, or serious property damage. During our visit at Northwest, we observed guards handcuffing detainees in segregation for every activity requiring detainees to be outside of their cells. For example, we observed guards handcuffing detainees to move them from the showers in segregation

⁶ ICE, *National Detention Standards, 2000* (2000 NDS), Special Management Unit – Administrative Segregation.

⁷ RFID technology enables RFID readers to capture data in RFID tags (e.g., meals, recreation, visitation, showers) and then store the data in a database.

⁸ National Institute of Justice, *Administrative Segregation in U.S. Prisons*, March 2016, <https://www.ncjrs.gov/pdffiles1/nij/249749.pdf>.

⁹ R. Reeves and A. Tamburello, "Single cells, segregated housing, and suicide in New Jersey Department of Corrections," *The Journal of the American Academy of Psychiatry and the Law* (December 2014), <http://jaapl.org/content/42/4/484.long>.



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back to their cells in segregation — a distance of about 10 yards. Further, guards placed segregated detainees in handcuffs during interviews with an OIG inspector within the segregation unit. Northwest’s segregation supervisor and guards said it is GEO’s¹⁰ policy to place all detainees held in segregation in restraints whenever outside their cells regardless of whether an individual detainee had a demonstrated need for restraints. Physically restraining all segregated detainees whenever they are outside their cells does not comport with ICE standards.

Detainees Experienced Difficulties Resolving Issues through the Grievance and Communication Systems

ICE standards establish procedures for detainees to file grievances regarding any aspect of their detention. Detainees also have the opportunity to submit written questions, requests, or concerns to the facility and ICE ERO staff. These processes aim to protect detainees’ rights and enhance security, safety, and orderly facility operations. Resolution depends on facility and ICE staff handling and addressing grievances and detainee communications properly and in a timely manner, but we found issues at each of the four facilities we inspected. Specifically, Northwest and El Paso grievance logs did not include required information. Northwest and Baker did not meet prescribed deadlines to provide responses to detainee grievances or communications. Further, Cibola and the local ICE field office did not properly address allegations of staff verbal abuse. Without effective, compliant grievance and communication processes, facilities and ICE risk ignoring or worsening serious deficiencies.

Northwest and El Paso Did Not Consistently Log Required Information

The 2011 PBDNS require facilities to maintain grievance logs including all grievances and relevant information. Our inspections of Northwest and El Paso revealed grievance logs that did not include all required information. At Northwest, we found when detainees submit grievances electronically, the system automatically populates the grievance log, but the facility did not consistently log grievances submitted via paper. At El Paso, the medical grievance log did not track the “date decision provided to detainee” as required, and two medical grievances were not included in the log. El Paso medical staff told us they did not know they were required to document this information and include every medical grievance in the log. Because of the missing information, these facilities do not have a full picture of detainee grievances and may not take appropriate action to protect detainees’ rights and ensure fair treatment.

¹⁰ GEO Group, Inc., the facility owner-operator.



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Northwest and Baker Did Not Respond to Grievances or Communications within Applicable Timeframes

According to ICE standards, facilities must respond to grievances within 5 calendar days¹¹ and to all other detainee communications within 72 hours.¹² However, Northwest and Baker did not meet these required deadlines. Of the 467 grievances¹³ filed from September 2018 to March 2019 at Northwest, 222 (47 percent) did not meet the 5-calendar-day response requirement, with 144 taking 10 days or longer to provide a response. Northwest staff told us they struggled to keep pace with the required response time due to the high volume of grievances they receive; with an average of 67 grievances per month during the period reviewed, Northwest had the highest grievance volume of the facilities we inspected.¹⁴ Additionally, we reviewed 180 communications¹⁵ submitted by detainees at Baker from February 2019 to July 2019, and found 45 (25 percent) did not meet the 72-hour response requirement, with 27 taking 10 days or longer to provide a response. Baker staff also said they struggled to keep pace with communications because of the number of requests received.

Cibola Did Not Properly Address Detainee Grievances of Staff Verbal Abuse

ICE detention facilities are required to forward detainee grievances alleging verbal abuse by staff to the local ICE field office for appropriate action.¹⁶ At Cibola, 15 of the 62 grievances (24 percent) filed from January 2019 to June 2019 contained allegations of staff verbal abuse toward detainees. In particular, these included complaints lodged by transgender detainees alleging staff used homophobic slurs and/or accused them of pretending to be transgender. Cibola forwarded the allegations to the local ICE field office, and both the local ICE field office and Cibola management told us they conducted an investigation, but neither could provide us documentation detailing what investigative steps were taken, whether the investigation substantiated the alleged misconduct, or the specific actions taken against staff members accused of verbal abuse. At the time of our visit in June 2019, detainees told us the verbal abuse was continuing.

¹¹ 2011 PBNDS, Section 6.2.V.C, Grievance System.

¹² 2000 NDS, Staff-Detainee Communication.

¹³ Common grievances concerned food, medical issues, and property.

¹⁴ The average numbers of grievances per month for similar periods reviewed at the other facilities were El Paso 2, Cibola 10, and Baker 8.

¹⁵ Common communications concerned visitation, case status, and requests for religious items.

¹⁶ Memorandum from Alonzo Pena, ICE Deputy Director, *Directing Complaints Appropriately to the Joint Intake Center (JIC), the Office of Professional Responsibility (OPR), the Office of the Inspector General (OIG), or Local Management*, November 10, 2010.



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Detainee Classification Issues at Two Facilities Could Affect Safety

ICE detention facilities house detainees of various backgrounds, including some who served prison sentences following criminal convictions, and others with nonviolent, civil immigration violations awaiting resolution of their cases. Facilities must classify detainees according to risk level in order to assign housing with others of similar background and criminal or civil history, and ensure separation of high- and low-risk detainees. During our unannounced inspections, we found Baker and Cibola relied on initial classification levels noted on ICE detainee transfer forms rather than on full assessments of detainee information. In addition, Baker did not consistently conduct supervisory reviews, and its reassessment guidelines and practices did not comply with the required timeframes in the NDS. These deficiencies prevent facilities from ensuring detainees with comparable criminal histories are grouped together, which may expose noncriminal and nonviolent detainees to physical and psychological danger.

Baker and Cibola Did Not Base Classification Levels on Full Assessments of Detainee Information

Prior to detention, ICE ERO reviews each detainee's criminal histories and classifies each in its system according to risk level.¹⁷ ICE ERO includes the classification level from its system on Form I-216, which documents the transfer of a detainee from one location to another.¹⁸ Once a detainee arrives at a facility, ICE standards require the classification specialist assigned to intake processing to review criminal, institutional, medical, and victimization information and complete a custody classification worksheet or equivalent in order to classify the detainee.¹⁹ Despite this requirement, our inspections of Baker and Cibola found the facilities relied solely on the level noted on the I-216 to classify detainees. Accordingly, detainee classification levels did not reflect a full assessment of the detainee's history.

Baker's classification specialist told us, for those detainees for whom ICE ERO provided a classification using the I-216 (approximately 85 to 90 percent of

¹⁷ ICE *Performance-Based National Detention Standards, 2011*, Section V.C, Custody Classification System, Section 2.2. B, Custody Classification Score and C. Classification Information, (Rev. 2016).

¹⁸ ICE ERO uses Form I-216, Record of Persons and Property Transferred, as a manifest when transporting people and property from one location to the next. The form includes information such as detainee alien number, name, gender, and ICE's classification level for the detainee.

¹⁹ ICE, *National Detention Standards, 2000*, Detainee Classification System, Section III.D. See also ICE *Performance-Based National Detention Standards, 2011*, Section V.C, Custody Classification System, (Rev. 2016).



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detainees), she conducts the required criminal history checks and completes the classification worksheet as part of the initial assessment process. However, if her initial assessment differs from the I-216, she will change her own assessment to match the classification level provided by ICE ERO. The classification specialist did not use any other detainee history information to validate ICE ERO's classification levels, such as the detention and immigration history. For instance, of the 28 detainee files we reviewed, we identified two female detainees who would have been assessed at a low classification level had an assessment been based on the detainee's criminal history. Instead, the classification specialist assigned the two detainees a medium level because it was the level listed on ICE ERO's I-216. Notably, the medium level classification was pending ICE ERO supervisor approval and was not final on the I-216 when it was reviewed. Baker's classification specialist may be more likely to classify female detainees at the medium level and above because Baker had only one housing dorm for females, which was for medium- and high-level detainees, and NDS restricts the commingling of detainees classified at different levels.

From our review of detention files, Cibola also appeared to base detainee classification levels on the I-216 instead of fully assessing the detainee's history. The classification specialist at Cibola told us she conducts a review to ensure the ICE ERO classification is correct, but she does not document her review in the classification worksheets. Therefore, we were unable to validate the classification of any detainees at Cibola to evaluate whether detainee classifications and housing assignments were correct.

Baker Did Not Always Conduct Supervisory Classification Reviews

To ensure accurate classifications, facilities must conduct supervisory reviews of the initial classification assessment, reassessments, and overrides of ICE ERO classification levels.²⁰ At Baker, supervisory reviews of classification assessments were not always completed. According to Baker's local guidelines, intake and booking staff must complete the initial assessment before assigning housing. Then, the classification specialist must validate the initial assessment within 72 hours. We found the supervisor did not review the initial assessment in 6 of 28 (21 percent) classification files we reviewed. Additionally, of the 28 classification files we reviewed, 10 included reassessments, 9 of which (90 percent) did not undergo supervisory review to certify the accurate classification and housing of the detainees. Without proper supervisory review, Baker risks violating ICE classification standards and incorrectly classifying detainees, which affects housing assignments and, potentially, safety.

²⁰ 2000 NDS, Detainee Classification System.



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Baker's Local Guidelines and Practices Did Not Meet Required Reassessment Timelines

The NDS Detainee Classification System requires facilities to complete the first classification reassessment 45 to 60 days after the date of the initial assessment, with subsequent reassessments completed at 60-to-90-day intervals. Although NDS allows IGSA facilities to adopt alternatives provided they meet or exceed the objectives, Baker's local guidelines do not meet or exceed the timeframes for reassessments. Rather, Baker's guidelines direct the classification specialist to complete the first reassessment at least 120 days after the initial assessment, with subsequent reassessments every 120 days thereafter.²¹ Of the 28 classification files we reviewed at Baker, 23 detainees were still at the facility at the time of our visit. Of those 23 detainees, 5 were overdue for their first reassessment (ranging from 30 to 164 days overdue), and 1 of the 5 had been at the facility long enough that a second reassessment should have been done, based on the NDS requirements.

Living Conditions at Three Facilities Violate ICE Standards

We identified issues with living conditions at El Paso, Cibola, and Baker, such as torn mattresses, worn fitness equipment, leaking toilets and sinks, and inoperable hot water in detainee cells. These living conditions not only violate ICE detention standards, but, in some instances, may also pose a health and safety risk to detainees.

El Paso

According to the 2011 PBNDS, detainees shall have suitable, clean bedding.²² However, during our site visit at El Paso, we found several housing unit mattresses with sizable tears along the seams (see figure 1). El Paso staff replaced all bedding we identified as unacceptable during our visit.

²¹ Baker County Sheriff's Office Corrections Bureau Guidelines, *Classification System*, April 2017.

²² 2011 PBNDS, Section 4.5, Personal Hygiene (Revised Dec. 2016).



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Figure 1. Torn mattresses observed by OIG at El Paso on April 30, 2019.
Source: OIG

Although the 2011 PBNDS require “maintaining high facility standards of cleanliness and sanitation,”²³ we observed toilets and sinks leaking water onto the floor in the housing units, which could lead to mold, mildew, or slips and falls (see figure 2). The standards also require facilities to complete preventive maintenance on issues such as water leaks.²⁴



Figure 2. Detainee sinks and toilets leaking water observed by OIG at El Paso on April 30, 2019. Source: OIG

The 2011 PBNDS also require the facility to provide operable exercise equipment for detainees,²⁵ but we observed damaged fitness equipment in the recreation areas at El Paso (see figure 3). Damage made the exercise equipment difficult and unsafe for detainees to use. During our visit, El Paso

²³ 2011 PBNDS, Section 1.2, Environmental Health and Safety (Revised Dec. 2016).

²⁴ 2011 PBNDS, Section 1.2, Environmental Health and Safety, V.A.1 (Revised Dec. 2016).

²⁵ 2011 PBNDS, Section 5.4, Recreation.



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staff installed replacement parts for exercise equipment ordered prior to our inspection, and ordered additional parts for other exercise equipment that we identified as deficient.



Figure 3. Detainee exercise equipment with missing or worn arm pads observed by OIG at El Paso on April 30, 2019. *Source:* OIG

Cibola

Similar to El Paso, during our visit to Cibola we found several housing unit mattresses with tears (see figure 4). Cibola staff replaced torn mattresses during our visit.



Figure 4. Torn mattresses observed by OIG at Cibola on June 20, 2019. *Source:* OIG

Despite the requirement to provide detainees a standard issue of clothing, including at least two pairs of socks and one pair of footwear,²⁶ Cibola issued most detainees flip-flops. We observed boxes of flip-flops and closed-toed

²⁶ 2011 PBNDS, Section 4.5, Personal Hygiene.



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sandals in the storage room; however, detainees complained Cibola issues the closed-toed sandals to some detainees, but not others. After we pointed out the inconsistency, Cibola staff made an on-the-spot correction and issued detainees closed-toed sandals.

Baker County

Baker has adapted 2000 NDS and implemented guidelines for the maintenance of the facility. According to Baker’s guidelines,²⁷ each cell must contain the following, among other requirements:

- lavatory with cold and tempered [hot] running water;
- faucets that are maintained and operational; and
- showers that are maintained so each detainee may bathe daily.

Despite these guidelines, we observed showers with inoperable hot water buttons. We also found faucets and showers that did not work properly, resulting in water leaking on the floor or spraying all over the immediate area. As shown in figure 5, detainees rigged the faucets with plastic straws in order to have an operable sink.



Figure 5. Leaking faucet without plastic straw (left) and faucet with plastic straw (right) observed by OIG at Baker on July 30, 2019.

Source: OIG

²⁷ Baker County Sheriff’s Office Corrections Division Guidelines, *Maintenance of Detention Facility*, March 2019, Section IV. B.



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Figure 6 shows an operable shower and a shower with a small shampoo bottle affixed to it in an effort to direct the spray of water.



Figure 6. Operable shower (left) and shower with a small shampoo bottle affixed to it (right) observed by OIG at Baker on July 30, 2019.

Source: OIG

Recommendation

We recommend the Acting Director of U.S. Immigration and Customs Enforcement ensure Enforcement and Removal Operations field offices overseeing the detention facilities covered in this report address identified issues and ensure facility compliance with relevant detention standards.

Management Comments and OIG Analysis

ICE concurred with our recommendation and described corrective actions to address the issues identified in this report. Appendix B contains ICE management comments in their entirety. We also received technical comments to the draft report and revised the report as appropriate. We consider the recommendation resolved and open. A summary of ICE's response and our analysis follows.

ICE Comments to Recommendation 1: Concur. ICE ERO has reviewed each of the issues outlined in this report and directed field offices to take ongoing actions to address the deficiencies OIG identified. Specifically, according to ICE, ERO Field Operations will ensure that local field office personnel review this report and resolve identified issues. ERO Custody Management will arrange for Special Assessment Reviews (SARs) to be conducted at each of the



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detention facilities covered in this report. As with prior SARs conducted to respond to OIG findings, these SARs will review each of the issues identified by the OIG unannounced inspections to document that each has been addressed, as appropriate. ICE will provide copies of the SAR reports to OIG to document facility compliance with ICE's detention standards as part of its request for recommendation closure. Estimated Completion Date: December 31, 2020

OIG Analysis: We consider these actions responsive to the recommendation, which is resolved and open. We will close this recommendation when we receive documentation confirming that the SARs and other corrective actions have been completed.



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Appendix A

Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General was established by the *Homeland Security Act of 2002* (Public Law 107–296) by amendment to the *Inspector General Act of 1978*.

DHS OIG initiated this inspection at Congress' direction. As part of our unannounced inspections, we also review and analyze concerns raised by immigrant rights groups and complaints to the DHS OIG Hotline about conditions for aliens in U.S. ICE custody. We generally limited our scope to the 2011 PBNDS and 2000 NDS for health, safety, medical care, mental health care, grievances, classification and searches, use of segregation, use of force, language access, and staff training. We focused on elements of the 2011 PBNDS and 2000 NDS that could be observed and evaluated without specialized training in medical, mental health, education, or corrections. Our visits to these four facilities were unannounced so we could observe normal conditions and operations.

Prior to our inspections, we reviewed relevant background information, including:

- OIG Hotline complaints
- ICE *2011 Performance-Based National Detention Standards*
- ICE *2000 National Detention Standards*
- DHS Office for Civil Rights and Civil Liberties reports
- ICE Office of Detention Oversight reports
- Information from nongovernmental organizations
- Information provided in congressional requests
- Information provided from state and local governments requests

We visited four facilities:

- Northwest Detention Center, Washington (March 19–21, 2019)
- El Paso Service Processing Center, Texas (April 30–May 2, 2019)
- Cibola County Correctional Center, New Mexico (June 18–20, 2019)
- Baker County Detention Center, Florida (July 30–August 1, 2019)



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During the inspections we:

- inspected areas used by detainees, including intake processing areas; medical facilities; kitchens and dining facilities; residential areas, including sleeping, showering, and toilet facilities; legal services areas, including law libraries, immigration proceedings, and rights presentations; recreational facilities; and barber shops;
- reviewed facilities' compliance with key health, safety, and welfare requirements of the PBNDS and NDS for classification and searches, segregation, use of force and restraints, medical care, mental health care, medical and nonmedical grievances, and access to translation and interpretation;
- interviewed ICE and detention facility staff members, including key ICE operational and detention facility oversight staff, detention facility wardens or someone in an equivalent position, and detention facility medical, classification, grievance, and compliance officers;
- interviewed detainees held at the detention facilities to evaluate compliance with 2011 PBNDS and 2000 NDS grievance procedures and grievance resolution; and
- reviewed documentary evidence, including medical files, and grievance and communication logs and files.

We conducted this review under the authority of the *Inspector General Act of 1978, as amended*, and according to the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.



OFFICE OF INSPECTOR GENERAL
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Appendix B
ICE Comments to the Draft Report

Office of the Chief Financial Officer

U.S. Department of Homeland Security
500 12th Street, SW
Washington, DC 20536



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

April 27, 2020

MEMORANDUM FOR: Joseph V. Cuffari, Ph.D.
Inspector General

FROM: Stephen A. Roncone STEPHEN A
Chief Financial Officer and RONCONE
Senior Component Accountable Official

SUBJECT: Management Response to Draft Report: “Capping Report:
Observations of Unannounced Inspections of ICE Facilities in
2019” (Project No. 19-031-ISP-ICE)

Digitally signed by
STEPHEN A RONCONE
Date: 2020.04.27
07:59:10 -04'00'

Thank you for the opportunity to comment on this draft report. U.S. Immigration and Customs Enforcement (ICE) appreciates the work of the Office of Inspector General (OIG) in planning and conducting its review and issuing this report.

ICE is pleased to note OIG’s recognition of corrective actions taken during OIG detention facility inspections. Specifically, the OIG reports that facility personnel replaced bedding, installed parts to repair exercise equipment, and issued footwear to detainees. In addition to these completed actions which OIG observed while on site, ICE has initiated actions to address the findings described in this draft report.

It is also important to note that the OIG recognized ICE’s more than a decade long collaboration with stakeholders to improve the safety, security, and conditions of confinement for detainees in a June 2018 report.¹ ICE utilizes a layered approach to monitor conditions at facilities, with processes in place to implement corrective actions in instances of non-compliance with ICE detention standards. For example, ICE’s detention operations are overseen by field office personnel, through inspections by ICE’s Office of Professional Responsibility (OPR), and via other programmatic oversight and inspections by Enforcement and Removal Operations (ERO).

¹ OIG-18-67, “ICE’s Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,” dated June 26, 2018.

www.ice.gov



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Management Response to Draft Report: “Capping Report: Observations of Unannounced Inspections of ICE Facilities in 2019”

Page 2

ICE works daily to ensure that facilities comply with ICE detention standards or personnel take the necessary corrective action to address any concerns. As part of this, ERO has a Detention Monitoring Program through which onsite Detention Service Monitors continuously monitor compliance with ICE detention standards, as the OIG acknowledged in June 2018. The OIG also found that the OPR Office of Detention Oversight “uses effective methods and processes to thoroughly inspect facilities and identify deficiencies.”

ICE remains committed to continually enhancing civil detention operations to promote a safe and secure environment for detainees and staff. The goal of ICE detention standards is to ensure that detainees are treated humanely, protected from harm, provided appropriate medical and mental health care, and receive the rights and protections to which they are entitled. These standards protect detainees by maintaining high standards of facility cleanliness; practices for safety and security; guidelines for issuing and exchanging clothing, bedding, and linens; and policies and procedures for grievances.

The draft report contained one recommendation, with which ICE concurs. Attached find our detailed response to the recommendation. ICE previously submitted technical comments under a separate cover for OIG’s consideration.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions. We look forward to working with you again in the future.

Attachment



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Attachment: Management Response to Recommendation Contained in Project No. 19-031-ISP-ICE

OIG recommended that the Acting Director of ICE:

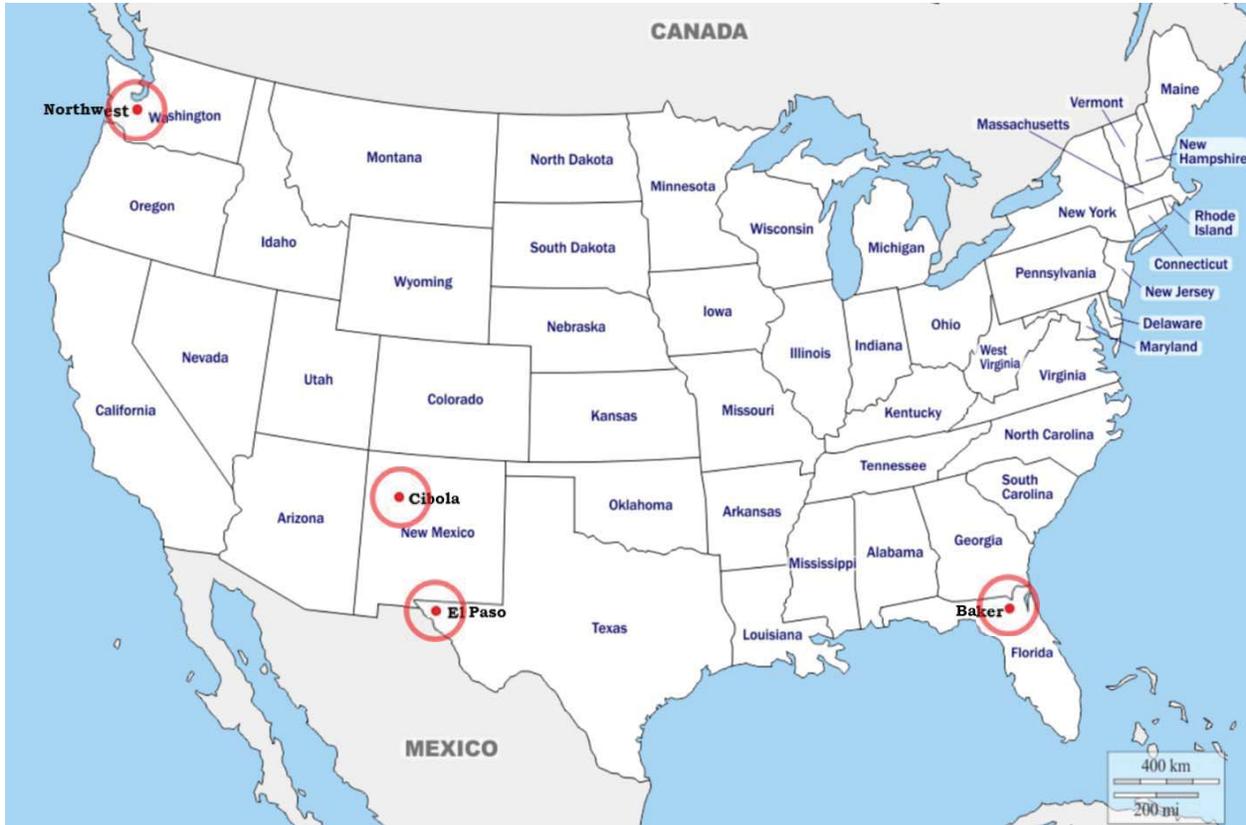
Recommendation: Ensure Enforcement and Removal Operations field offices overseeing the detention facilities covered in this report address identified issues and ensure facility compliance with relevant detention standards.

Response: Concur. ICE's ERO Field Operations will ensure that local field office personnel review the assessments and resolve identified issues by September 30, 2020. ERO Field Operations also worked with ERO Custody Management to arrange for Special Assessment Reviews (SARs) to be conducted at each of the detention facilities covered in this report once the field office reviews are complete. As with prior SARs conducted to respond to OIG findings, these SARs will review each of the issues identified by the OIG unannounced inspections to document that each has been addressed, as appropriate. ICE will provide copies of the SAR reports to OIG to document facility compliance with ICE's detention standards as part of its request for recommendation closure. Estimated Completion Date: December 31, 2020.



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Appendix C
Locations of Facilities Visited



Source: OIG developed.



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Appendix D
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Appendix E
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