ICE DETENTION FACILITIES

Failing to Meet Basic Standards of Care

UNITED STATES HOUSE OF REPRESENTATIVES

Committee on Homeland Security

MAJORITY STAFF REPORT

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EXECUTIVE SUMMARY

One year ago, Chairman Bennie G. Thompson of the Committee on Homeland Security began a review into the conditions of confinement at U.S. Immigration and Customs Enforcement (ICE) detention facilities and whether the Department of Homeland Security (DHS) has the necessary oversight tools in place to ensure that those facilities meet applicable standards. This report provides the results of that review.

Over the course of the ensuing year, Committee staff visited eight ICE detention centers. The visits included touring the facilities, speaking with local ICE and facility leadership, and interviewing migrants who were being detained at those facilities. In addition, the Committee reviewed DHS detention facility inspection reports and received several briefings on issues related to the conditions at detention facilities from officials at DHS and non-governmental organizations.

Based on its investigation, the Committee found:

OVERSIGHT FAILURES: DHS Oversight of ICE Detention Facilities Fails to Effectively Identify and Correct Deficient Conditions

1. Oversight programs are too broad, too infrequent, and preannounced;
2. ICE's contractor is ill-equipped to conduct inspections in a manner that successfully identify deficiencies;
3. DHS has few mechanisms to enforce corrections and rarely uses those mechanisms; and
4. ICE contracts with detention facilities that are poorly equipped to meet the agency's own detention standards.

DHS, including ICE, has several tools at its disposal to identify and correct deficiencies in conditions at ICE detention facilities.

In practice, unfortunately, these tools frequently leave deficiencies unidentified and uncorrected. One of the primary shortcomings with ICE's annual inspection program, for example, is that the inspections cover too much ground in too short a period of time. They are also preannounced ensuring that detention facilities can prepare for the visits knowing exactly when the inspectors are arriving. The Committee also found that the contractor responsible for conducting these inspections fails to operate in a manner that effectively identifies deficiencies. Even when deficiencies are identified, DHS has few mechanisms available to enforce corrective action, and those that are available are rarely used.

In addition to these failures in oversight, the Committee also discovered a concerning pattern of ICE contracting with facilities that are poorly equipped to meet ICE's own detention standards. This includes facilities, particularly in Louisiana, that had a well-publicized history of abuses prior to contracting with ICE. It also includes those facilities that have had longstanding contracts with ICE but have demonstrated an inability to comply with standards that affect the health and safety of detainees even after being repeatedly called out for violating those standards by DHS's own inspection processes.

Unfortunately, ICE appears to prioritize obtaining bed space over the wellbeing of detainees in its custody.

DEFICIENCIES AT ICE FACILITIES: ICE Facilities Are Generally Clean, But Frequently Fail to Meet Basic Standards of Care

1. With some egregious exceptions, the facilities visited by the Committee were generally clean;
2. ICE detainees frequently face deficient medical, dental, and mental health care;
3. Detention facilities often misuse and abuse segregation; and
4. Detainees face challenges accessing legal services, case information, and interpreter/translation services.

Throughout the report, the Committee identifies particularly egregious examples of the violations of the standards of care owed to those held in ICE custody. For example, individuals held at one facility complained of standing water left to fester in the housing units creating unsanitary conditions and a breeding ground for mosquitos. With respect to the medical care provided to detainees, the Committee found that ICE and its contracted facilities frequently demonstrate an indifference to the mental and physical care of the migrants in their custody. The Committee encountered several staff working at detention facilities that diminished the seriousness of suicide attempts as well as evidence of detainee medical issues going untreated. The Committee also found evidence that ICE's facilities improperly used segregation as retaliation and in a manner that failed to meet ICE's standards. Accordingly, the Committee asked the Government Accountability Office (GAO) for a more in depth review of ICE's use of segregation. Finally, one of the most frequent complaints Committee staff heard from detainees was that they faced significant barriers in (1) obtaining information about their immigration cases and accessing legal services and (2) accessing interpreter/translation services.

While the Committee cannot speak to the conditions of facilities outside the scope of its review, the evidence uncovered was glaring in its demonstration of patterns of violations that persist across the country, different contractors, and types of detention facilities.

BACKGROUND

A. Overview

In the summer of 2019, at the direction of Chairman Bennie G. Thompson, House Committee on Homeland Security Majority staff began visiting ICE detention facilities to review the conditions for migrant detainees. As part of this review, staff visited eight facilities that, as the chart below illustrates, represent a diverse array of the more than 200 detention facilities used by ICE (i.e., location, type, and size of facility).

Name	Location	Average Daily Population (ADP)[1]	Owner/Operator	Type of Facility[2]
Tallahatchie County Correctional Facility	Tutwiler, MS	148	CoreCivic	USMS IGA
Adams County Detention Center	Natchez, MS	1,294	CoreCivic	IGSA
River Correctional Center	Ferriday, LA	579	Concordia Parish/ LaSalle	IGSA
LaSalle ICE Processing Center	Jena, LA	1,290	LaSalle Parish/GEO Group	DIGSA
Adelanto ICE Processing Center	Adelanto, CA	1,709	City of Adelanto/GEO Group	DIGSA
Otay Mesa Detention Center	San Diego, CA	1,199	CoreCivic	USMS CDF
Otero County Processing Center	Chaparral, NM	1,009	Otero County/ Management & Training Corporation	USMS CDF
Worcester County Jail	Snow Hill, MD	92	Worcester County	IGSA

1. The ADP is based on numbers made publicly available by ICE. The numbers are current as of Aug. 3, 2020. See https://www.ice.gov/facility-inspections.
2. ICE operates several different types of facilities. Over 90 percent of the facilities are operated under agreements with state and local governments and house about half of ICE's total detention population, together with, or separately from, other confined populations. The remaining facilities house exclusively ICE detainees and are operated by a mixture of private contractors and ICE, state, and local government employees. The types of facilities visited by the Committee include:
-Dedicated Intergovernmental Service Agreements (DIGSA): Facilities owned by state and local governments or private entities, operated under agreements with state and local governments, that exclusively house ICE detainees.
-Nondedicated Intergovernmental Service Agreements (IGSA): Facilities owned by state and local governments or private entities, operated under agreement by state and local governments, that house ICE detainees in addition to other confined populations (e.g., inmates), either together or separately.
-U.S. Marshals Service (USMS) Intergovernmental Agreements (IGA) and Contract Detention Facility (CDF): Facilities owned and operated by state and local governments or private entities under agreement or contract with USMS within the Department of Justice to house federal prisoners until they are acquitted or convicted. ICE takes out task orders against the USMS intergovernmental agreement and contracts to house immigration detainees at these facilities, either together with or separately from other populations.

In addition to these site visits, the Committee received and reviewed inspection reports and other DHS records related to the conditions at ICE detention facilities. Over the course of the last year, Committee staff also received several briefings on issues related to the conditions at detention facilities from officials with ICE, CRCL, the DHS Office of Inspector General (OIG), GAO, and non-governmental organizations.

B. Access Challenges

The Committee faced a range of challenges in conducting this review. First, in order to help ensure that staff were granted sufficient access to ICE's detention facilities, the Committee notified ICE's Office of Congressional Relations (OCR) about two weeks prior to seven of the eight visits.[1] Staff found that as a result of this advance notice, facilities took steps to prepare for the visit by improving conditions. For example:

- One housing unit toured at the Adelanto ICE Processing Center (Adelanto) had the smell of fresh paint. A guard in the unit acknowledged that the area had just recently been painted.[2]
- At the LaSalle ICE Processing Center (LaSalle), CoreCivic officials arrived at the facility prior to the Committee's arrival and instituted a major clean up—planting fresh flowers, painting the walls, and installing new shower curtains.[3]
- At the Otero County Processing Center (Otero), migrant detainees told staff that individuals held in solitary cells were returned to the general population just prior to the Committee's arrival.[4]
- Migrants detained at the River Correctional Center (River) informed staff that a guard was placed in an area within a housing unit that typically had no guard present.[5]

Aware that arranging a pre-planned tour guided by ICE or contract facility personnel does not offer the most accurate picture of typical conditions, the Committee arranged to speak with individuals detained at every facility visited. In total, Committee staff spoke with more than 400 detained individuals.

During site visits, the Committee faced varying degrees of cooperation with respect to access to the facilities and detainees. Some detention facilities, like Worcester, provided as much time as the Committee needed to tour the facility and speak with detainees. Others put up roadblocks. At Otero, for example, local ICE officials informed Committee staff that the time would be limited to two hours because the Committee failed to coordinate the visit with the local El Paso Field Office. However, the Committee had followed proper procedures by planning the visit with ICE OCR. Nonetheless, the time at the facility was reduced in a manner that did not permit staff to view solitary units or thoroughly speak with migrant detainees.[6] Similarly, while visiting River, staff could not view the inside of any housing unit except briefly through an open door.

With respect to access to detained individuals, cooperation from facilities was also mixed. Some facilities provided a reasonably private space that permitted detainees to speak freely, such as Adams County Correctional Center (Adams) and Adelanto. Others, like

1. The Committee also conducted a visit to the Worcester County Detention Center (Worcester) providing ICE with only the 48 hours' notice required pursuant to Section 532 of the Consolidated Appropriations Act of 2020.
2. *Committee Staff Visit to the Adelanto ICE Processing Center*, Oct. 2, 2019.
3. *Committee Staff Visit to the LaSalle ICE Processing Center - Jena*, Aug. 28, 2019.
4. *Committee Staff Visit to the Otero County Processing Center*, Dec. 3, 2019.
5. *Committee Staff Visit to the River Correctional Center*, Aug. 27, 2019.
6. *Visit to Otero*, Dec. 3, 2019.

Otero, required a guard nearby as a "safety precaution." In these instances, migrants said they felt less comfortable speaking openly and honestly about the conditions. ICE also rejected the Committee's request to speak with individuals who specifically requested to meet with staff through their attorneys. For example, at LaSalle, the Committee asked to speak with an individual who was being held in medical segregation. ICE informed staff that the migrant had no interest in meeting.[7] After the visit, the individual communicated that he was never informed Committee staff were present.

These challenges undoubtedly made the Committee's oversight work more difficult. Without full cooperation from ICE and its contractors, Congress cannot effectively evaluate conditions at ICE detention facilities. Moving forward, ICE must put transparency—both to Congress and the general public—at the forefront of its detention operations.

7. *Visit to LaSalle*, Aug. 28, 2019.

FINDINGS

A. DHS OVERSIGHT OF ICE DETENTION FACILITIES FAILS TO EFFECTIVELY IDENTIFY AND CORRECT DEFICIENT CONDITIONS

DHS, including ICE, has several tools at its disposal to identify and correct deficiencies in conditions at ICE detention facilities. However, the Committee has identified several shortcomings with these tools that leave deficiencies unidentified and uncorrected. As the Committee experienced, pre-announced facility inspections, like those conducted by ICE's contractor, fail to paint an accurate picture of typical conditions. Furthermore, the contractor conducting the bulk of inspections for nearly the last decade has demonstrated a lack of credibility and competence. Finally, even when deficiencies are identified, many DHS oversight entities have no enforcement mechanism to require correction. And the enforcement mechanisms that are available to ICE are rarely used.

1. Oversight Tools Are Not Set Up to Effectively Identify Deficiencies

Within ICE there are several internal mechanisms for conducting oversight of detention facilities. For example, there are two types of inspections conducted by the agency's Detention Management Division:

1. Contracted Annual Inspections: Since 2011, ICE has contracted with The Nakamoto Group, Inc. (Nakamoto) to conduct inspections at every facility that detains migrants for more than 72 hours and has an average daily population greater than 50.[8] Facilities that meet these criteria are inspected annually. To conduct these inspections, Nakamoto sends about five inspectors to review up to 42 different detention standards over the course of three days.[9]
2. Office of Detention Oversight (ODO): ICE also conducts its own inspections of detention facilities. ICE considers these to be more "deep dive" inspections that cover 8-16 standards and involve about 10 inspectors reviewing those standards on site over three days. Facilities are subject to these inspections once every three years. ODO conducts about 20-30 facility inspections annually.[10]

These inspections, particularly those conducted by Nakamoto, are not effective at fully identifying deficiencies at ICE detention facilities.

i. Inspections are Too Broad and Too Infrequent

One of the primary problems with Nakamoto's inspections is that they are too broad and too brief to effectively examine the conditions at detention facilities. Committee staff heard this directly from the Officer-in-Charge at Adelanto, who indicated that the scope of Nakamoto's inspection was so unreasonably large that Nakamoto could not have effectively examined the conditions at a facility that size.[11] The OIG raised similar concerns at a September 2019 hearing before the Subcommittee on Oversight, Management, & Accountability (OMA Subcommittee). At the hearing, the DHS OIG Assistant Inspector General (AIG) for Special Reviews and Evaluations, Diana Shaw,

8. As of August 3, 2020, that included about 95 facilities, according to ICE's *Dedicated and Non Dedicated Facility List*. *See* https://www.ice.gov/facility-inspections.
9. *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (OIG-18-67), Dept. Of Homeland Security Office Of Inspector General, June 26, 2018.
10. *Id.* ICE also permits facilities that detain individuals for less than 72 hours to conduct self-inspections after completing a satisfactory annual inspection. The local field office reviews the results of the self-inspections.
11. *Visit to Adelanto*, Oct. 2, 2019.

testified that "ICE's contract with Nakamoto is much too broad to ensure thorough inspections."[12]

Nakamoto's failure to identify deficiencies has had detrimental effects on the care of those in ICE's custody. As discussed in greater detail below, in May 2019, Nakamoto conducted an inspection at Cibola County Correctional Center (Cibola) shortly before an inspection was conducted by an ICE Health Service Corps (IHSC) Field Medical Coordinator (FMC).[13] While the Nakamoto inspection found no deficiencies related to the health care of detainees, the FMC identified significant deficiencies that ultimately led to the transfer of detainees for their own safety. Similarly, in 2018, Adelanto passed its Nakamoto inspection. Most notably, Nakamoto found no deficiencies with respect to medical care. However, a contemporaneous inspection conducted by CRCL found systemic issues related to the medical care of detainees that resulted in "medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees."[14]

Testimony before the OMA Subcommittee also revealed some deficiencies with the ODO inspections. While ODO does a better job at identifying deficiencies, AIG Shaw noted that its inspections "are relatively infrequent, making it difficult for ODO to ensure that facilities are addressing all deficiencies."[15]

ii. Advance Notice of Inspections Provides Warning

When the Committee conducted its pre-announced visits, ICE facilities used the advanced warning to improve the conditions within the facility. In testimony before the OMA Subcommittee, Nakamoto's president acknowledged the ineffectiveness of pre-announced inspections, stating that you can better "determine the true conditions of a facility if you are unannounced."[16] Yet ICE facilities have even more advance notice for their annual Nakamoto inspections than the two weeks the Committee provided. At LaSalle, for example, there was a sign in the entrance lobby counting down the days to its upcoming Nakamoto inspection months away.[17]

Unfortunately, the terms of ICE's new Statement of Work, which sets out the requirements and responsibilities for the inspection contractor, still requires that notice be given in advance of ICE detention facility inspections.[18]

iii. ICE Contractor Ill-Equipped to Conduct Inspections

In preparing for and holding the OMA Subcommittee hearing on ICE oversight of detention facilities, it became abundantly clear that Nakamoto is ill-equipped to conduct inspections on behalf of ICE. In conduct-

12. *Oversight of ICE Detention Facilities: Is DHS Doing Enough?:* Hearing before the Subcommittee on Oversight, Management, & Accountability, 116th Cong. (2019) (testimony of Diana Shaw).
13. The IHSC provides direct health care services to detainees held at 21 detention facilities. FMCs conduct inspections of all ICE detention facilities to examine the conditions specifically as they relate to the medical care of detainees.
14. *Adelanto Correctional Facility Complaint Nos. 17-03-ICE-0103, 16-06-ICE-0627, 17-07-ICE-0456, 17-08-ICE-0299, 17-09-ICE0356, 17-09-ICE-0407, 17-09-ICE- 0366, and 17-10-ICE-0401*, Dept. of Homeland Security Office of Civil Rights and Civil Liberties, Apr. 25, 2017.
15. *Oversight of ICE Detention Facilities: Is DHS Doing Enough?:* Hearing before the Subcommittee on Oversight, Management, & Accountability, 116th Cong. (2019) (testimony of Diana Shaw).
16. *Oversight of ICE Detention Facilities: Is DHS Doing Enough?:* Hearing before the Subcommittee on Oversight, Management, & Accountability, 116th Cong. (2019) (testimony of Jenni Nakamoto).
17. *Visit to LaSalle*, Aug. 28, 2019.
18. ICE's inspection contract with Nakamoto expired in the Fall of 2019. *Annual Detention Facilities Inspection Program Statement of Work & Technical Exhibit 9*, ICE Enforcement and Removal Operations Detentions Standards Compliance Unit, Nov. 19, 2019. ICE has issued several extensions to that contract as it delayed and amended the request for bids on the inspection contract. As of June 3, 2020, ICE anticipated that the new contract would be awarded in July 2020. According to ICE, the award of the contract experienced further delays due to discussions with offerors, and the new anticipated award date was August 31, 2020. *Email from ICE Office of Congressional Relations*, July 15, 2020.

ing its oversight work, the Committee requested a staff-level briefing with Nakamoto. Even after providing the company with a signed letter from Chairman Thompson requesting a briefing, Nakamoto refused.[19] When Nakamoto was invited to testify before the OMA Subcommittee, it similarly refused to attend and only relented under threat of a Congressional subpoena.

Nakamoto's testimony before the Committee and statements in a meeting with the OMA Subcommittee Chairwoman raised further concerns about the company's competence. For example, Nakamoto's inspection contract requires it to conduct interviews with detainees in their native language. However, the OIG found that Nakamoto inspectors selected detainees for interviews by first asking whether they spoke English.[20] In its meeting with the OMA Subcommittee Chairwoman, Nakamoto asserted that it has at least one inspector who is fluent in Spanish during every inspection. When asked how they ascertain that an employee is fluent in Spanish, Nakamoto's Chief Operating Officer responded that he knows someone is fluent by his or her ethnicity and last name.[21] In testimony before the Subcommittee, the president of the company also acknowledged that Nakamoto has no process in place to certify the fluency of its inspectors.[22]

Ms. Nakamoto was unable to answer basic questions at the hearing about her company's inspections, the Statement of Work with ICE, or the standards that apply to the facilities. For example, she was asked to provide information about the standards that apply to the use of solitary confinement in ICE detention, but she could not provide even the most general information about those standards.[23]

Furthermore, evidence suggests that Nakamoto does a poor job of conducting inspections and fails to operate in a manner that would best identify deficiencies. For example, the OIG noted a pattern of Nakamoto inspectors relying on what they are told by ICE officials and facility contractors rather than examining the evidence themselves.[24] In 2017, the OIG observed Nakamoto taking facility employees at their word that employees had commercial driver's licenses without checking the records.[25] Two years after the OIG released its findings and recommendations, the Committee found evidence of this same problem. In an October 2019 inspection report on River, Nakamoto noted that inspectors received several complaints about the quantity of food provided to detainees.[26] Instead of observing the portions served to detainees, Nakamoto accepted the word of the food service department that "the portions served are well within the required amount."[27] This review not only occurred after the OIG's reports but also after the OMA Subcommittee raised several of these concerns in a public hearing.

Nakamoto clearly has not taken these concerns seriously. The Committee also questions ICE's judgment for continuing to do business with this contractor.

19. *Letter from Chairman Thompson to Jenni Nakamoto, President, The Nakamoto Group, LLC*, Aug. 1, 2019.
20. OIG-18-67.
21. *Nakamoto meeting with Oversight, Management, & Accountability Subcommittee Chairwoman,* Sept. 26, 2019.
22. *Oversight of ICE Detention Facilities: Is DHS Doing Enough?:* Hearing before the Subcommittee on Oversight, Management, & Accountability, 116th Cong. (2019) (testimony of Jenni Nakamoto).
23. *Id.*
24. OIG-18-67.
25. *Id.*
26. *Annual/180 Day Follow-Up Detention Inspection of the River Correctional Center,* The Nakamoto Group, Oct. 24, 2019.
27. *Id.*

2. Deficiencies Frequently Go Uncorrected

There are other oversight tools available to ICE and DHS that are more effective in identifying deficiencies; however, there is little guarantee that those deficiencies get corrected. Those additional tools include:

1. Detention Service Managers (DSMs): DSMs are ICE employees who work at select facilities to monitor compliance with detention standards. As of December 2017, there were about 35 DSMs overseeing 54 detention facilities.[28]
2. IHSC Inspections: FMCs conduct annual inspections at every contract facility to assess the conditions specifically related to medical care.
3. DHS CRCL: Pursuant to statute, the Compliance Branch of CRCL reviews and investigates civil rights and civil liberties complaints filed regarding DHS policy, programs, and activities, including ICE detention facilities.[29]

Unfortunately, these oversight tools have few enforcement mechanisms to ensure compliance with law and policy. The enforcement mechanisms that do exist, such as canceling contracts or issuing financial penalties, are seldom used.

For example, the OIG found that over the course of a two and a half year period, even though ICE identified thousands of failures to comply with detention standards, it only issued two financial penalties.[30] With respect to DSMs, AIG Shaw testified before the OMA Subcommittee that "[DSMs] have no authority to compel implementation of [corrective] action."[31]

Similarly, the Committee found that FMCs who discover and report deficiencies relating to the health and safety of detainees have no enforcement mechanism to require change. As described in greater detail below, in May 2019, an FMC identified deficiencies related to the medical care at Cibola. After two months passed, the same FMC found that none of his recommendations had been addressed and the conditions at the facility had worsened.

Similarly, DHS CRCL issues in-depth reports that often find serious abuses, but the office has no means of enforcing corrective action. CRCL conducts inspections with subject matter experts and provides its findings and recommendations in reports to ICE. However, ICE can "non-concur" with any finding. In those cases, CRCL's work product is considered deliberative and redacted from public disclosure, which generally only occurs following a Freedom of Information Act Request.[32]

CRCL leadership explained to Committee staff that even when its findings are final, the office does not have the resources or authorities to enforce change. For example, in 2015, CRCL conducted an investigation of Adelanto and noted that clinical leadership was not competent, and that medical care was problematic as a result. Two years later, CRCL returned for another investigation and reported the following:

> *In 2017 - two years since the 2015 onsite - the experts found no evidence that corrections were made to address this issue. The failure to hire an effective and qualified clinical leader*

28. OIG-18-67.
29. *See* 6 U.S.C. § 345 and 42 U.S.C. § 2000ee-1.
30. *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards* (OIG-19-18), Dept. of Homeland Security Office of Inspector General, Jan. 29, 2019.
31. *Oversight of ICE Detention Facilities: Is DHS Doing Enough?*: Oversight, Management, & Accountability Subcommittee, 116th Cong. (2019) (testimony of Diana Shaw).
32. Public accountability is a critical aspect of oversight, which is why the Committee passed H.R. 4713, *The Department of Homeland Security Office of Civil Rights and Civil Liberties Act*. The legislation, among other things, requires CRCL to report to Congress on the findings of its investigations.

contributed to the inadequate detainee medical care that resulted in medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to other detainees at [Adelanto].[33]

The Committee visited Adelanto as part of its review in 2019 and was met with resistance when asking about these findings. When pressed, Adelanto leadership continued to reject CRCL's findings that health care leadership put detainees at risk and did not believe that fundamental or systematic change was necessary.[34] Unfortunately, CRCL is powerless to force a facility like Adelanto to make those changes.

The Committee is encouraged by two actions that CRCL states it is pursuing in Fiscal Year 2020. First, CRCL will begin to publish all of its final reports (albeit with the above described redactions) on its website. Second, the office plans to conduct follow-up visits to see whether corrective action has been taken to address previously identified deficiencies.[35]

3. Use of Facilities Ill-Equipped to Meet Standards

Many, if not most, of the migrants we spoke with entered the U.S. legally by presenting themselves at a port of entry to claim asylum. They are only in detention as an administrative matter while their asylum claims are pending. Nonetheless, the facilities feel like prisons. Many were built and initially used as Federal, state, or county correctional facilities and some are still used for that purpose. Unfortunately, during the Committee's review, it became apparent that ICE prioritizes obtaining bed space over the wellbeing of detainees. For example, due to criminal justice reforms, Louisiana's state correctional system has recently seen a dramatic decrease in the number of state criminals in detention. While it is understandable that those prison contractors would seek a new source of revenue, ICE contracted with facilities that have had a history of neglect and abuse, including those operated by LaSalle Corrections. In 2016, a reporter working as a guard at the Winn Correctional Facility exposed rampant violence and medical neglect.[36] As of August 3, that same facility housed an average daily population of more than 1,500 migrants.[37] ICE also holds individuals at the Richwood Correctional Center, where guards were previously convicted for covering up a use of force incident.[38] Selecting these facilities demonstrates a lack of judgment on ICE's part and may expose detainees to unnecessary risk of harm.

[D]uring the Committee's review, it became apparent that ICE prioritizes obtaining bed space over the wellbeing of detainees

Equally as concerning is that ICE continues to utilize facilities that demonstrate a pattern of violating the agency's own detention standards. Adelanto is a perfect example. In 2014, ODO conducted an inspection of the facility and identified non-compliance with 11 of 17 detention standards reviewed. ODO described de-

33. *Adelanto Correctional Facility,* Dept. of Homeland Security Office of Civil Rights and Civil Liberties, Apr. 25, 2018.
34. *Visit to Adelanto*, Oct. 2, 2019.
35. *DHS CRCL meeting with Oversight, Management, & Accountability Subcommittee Chairwoman,* Mar. 12, 2020.
36. Noah Lanard, *ICE is Sending Asylum-Seekers to the Private Prison Where Mother Jones Exposed Abuse*, Mother Jones, June 11, 2019.
37. *Dedicated and Non Dedicated Facility List,* Immigration and Customs Enforcement, https://www.ice.gov/facility-inspections (accessed Sept. 1, 2020).
38. Janet McConnaughey, *Private Prison ex-sergeant guilty in chemical spray cover up*, The Associated Press, Nov. 29 2018.

ficiencies in the areas of food service, funds/personal property, grievance system, law libraries, legal materials, sexual abuse, assault prevention/intervention, and telephone access.[39] As previously noted, in 2015 and 2017, CRCL found major violations that could lead to the injury of those in custody. Then in 2018, the OIG found unsafe conditions with nooses hanging in housing units, improper use of segregation, and untimely and inadequate medical care.[40] It is disturbing that ICE considers Adelanto a reasonable place to hold migrants.

During the Committee's review, staff also found that migrants were being held at a facility where ICE's own standards were not yet applicable. In 2019, Adams County Correctional Center (Adams) lost a bid to continue housing inmates with the Federal Bureau of Prisons (BOP). ICE worked with BOP to modify the contract so that ICE could house detainees there while ICE negotiated a new contract. However, as was the case during our visit, without a contract between ICE and CoreCivic to house detainees at Adams, ICE detention standards did not apply. When asked about this, Adams staff indicated that they had trained their staff on ICE standards even though they were under no obligation to do so.[41] Again, ICE was in such a rush to fill beds that they were willing to sacrifice their own standards rather than waiting a few more weeks to finalize a new contract.

Finally, as found by the DHS OIG, when facilities cannot meet ICE's standards, ICE frequently waives those standards.[42] For example, ICE's standards only permit strip searches to take place under limited circumstances. However, the Worcester facility received a waiver to permit detainees to undergo full strip searches any time they leave the facility (e.g. for a court appearance). The warden acknowledged that this waiver was sought because she did not want ICE detainees treated differently than the county inmates held at the facility.[43]

B. WITH SOME EXCEPTIONS, ICE FACILITIES VISITED BY COMMITTEE STAFF MET STANDARDS FOR CLEANLINESS

Migrants held in ICE's custody should be detained in conditions that meet reasonable standards of cleanliness.[44] ICE standards require, depending on the contract, "facility cleanliness and sanitation… at the highest level" [45] or that facilities "maintain[] high facility standards of cleanliness and sanitation."[46] Given the fact that the contractors operating these facilities generate tens if not hundreds of millions of annual revenue ***per*** facility, providing such a clean environment should not be a challenge; yet, in some cases, the Committee found that facilities failed to meet this basic standard and relied on free detainee labor to keep certain areas clean.

In general, the facilities visited by the Committee met this standard. At Adams, for example, the detainees indicated they were satisfied with the cleanliness (even though the facility was made to appear cleaner than typical prior to the Committee's visit).[47]

39. *Immigration Detention in California*, California Dept. of Justice, Feb. 2019.
40. *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG-18-86), Dept. of Homeland Security Office of Inspector General, Sept. 27, 2018.
41. *Committee Staff Visit to the Adams County Detention Center*, Aug. 27, 2019.
42. OIG-18-67.
43. *Committee Staff Visit to the Worcester County Detention Center*, Feb. 24, 2020.
44. ICE's detention standards require that cleanliness of the facility be maintained. *See Performance-Based National Detention Standards 2011 (PBNDS 2011)* and *National Detention Standards (NDS) 2019*. *PBNDS 2011* specifies, furthermore, that the cleanliness must be maintained "at the highest level."
45. *PBNDS 2011* at 19.
46. *NDS 2019, Standard 1.1.*
47. *Visit to Adams*, Aug. 27, 2019.

However, there were concerning exceptions to this rule. For example, while Committee staff were unable to properly examine the housing unit at River, the picture painted by those living there was a bleak one. Migrants described stagnant pools of water sitting in the housing area for extended periods of time. The space was generally described as humid with wet floors, no privacy, and cramped. Migrants noted that these conditions seemingly led to mosquito infestations in the housing units.[48] Nakamoto's October 2019 inspection confirmed many of these concerns. Nakamoto found River's housing unit sanitation levels to be "below-average" and noted that showers were leaking into the sleeping areas. It also found that restroom cleanliness was "well below average." Finally, Nakamoto raised a safety concern that detainees had several ropes and strings hanging from their beds. Despite these serious sanitary and safety concerns, Nakamoto still found that River "met standards."[49]

Migrants described stagnant pools of water sitting in the housing area for extended periods of time

The Committee also heard a frequent complaint from detainees that it was their responsibility to clean the housing units. At LaSalle, the Administrator of the facility (equivalent to a warden) bragged about a "cleanest dorm" contest. He boasted that migrants could earn popcorn, sports drinks, or an extra movie over the weekend as a prize.[50] Furthermore, at the Tallahatchie County Correctional Facility (Tallahatchie) and the Otay Mesa Detention Center (Otay Mesa), despite contracts that generate $31 million and $120 million annual revenue respectively[51], migrants also complained that they received no pay for the cleaning work they completed yet were expected to keep housing units clean with materials provided by the facility.[52]

Individuals held by ICE in detention being forced to clean their own housing units not only contradicts ICE's own detention standards, but also appears to be an effort on the part of facility contractors to maximize their own profits. The facility operators and owners can afford to maintain "facility cleanliness and sanitation… at the highest level" [53] or "maintain[] high facility standards of cleanliness and sanitation"[54] on their own without depending on free labor.

C. MEDICAL CARE PROVIDED TO DETAINEES IS DEFICIENT

Individuals held by ICE in administrative detention deserve to have their health and safety protected. Unfortunately, ICE and its contracted facilities frequently demonstrate an indifference to the mental and physical care of the migrants in their custody. This manifested itself in a number of ways, including dismissing concerns raised by the Committee, ignoring medical issues raised by detainees, offering poor mental health care services, and, in one case, allowing medical care to deteriorate to the point that it became necessary to transfer detainees to different facilities. More recently,

48. *Visit to River*, Aug. 27, 2019.
49. *Annual/180 Day Follow-Up Detention Inspection of the River Correctional Center*, The Nakamoto Group, Oct. 24, 2019.
50. *Visit to Lasalle,* Aug. 28, 2019.
51. *Truth in Testimony Form*, CoreCivic, July 13, 2020.
52. *Committee Staff Visit to the Tallahatchie County Correctional Facility,* Aug. 26, 2019; *Committee Staff Visit to the Otay Mesa Detention Center,* Oct. 3, 2019.
53. *PBNDS 2011* at 19.
54. *NDS 2019, Standard 1.1.*

ICE's failures have manifested in the form of inadequate response to the COVID-19 pandemic.

1. Indifference to the Health Needs of Detainees and Non-Compliance with ICE Detention Standards

The Committee encountered ICE officials and contract employees who diminished past suicide attempts. For example, at LaSalle, the head of the medical unit explained that the facility had not encountered any "serious" suicide attempts but only instances of cut wrists or towels around necks.[55] Officials at River and Otero similarly dismissed suicide attempts as "superficial" and attention seeking "gestures" to get special treatment or send a political message.[56]

As previously noted, Adelanto was the subject of two consecutive CRCL reports that found medical care at the facility was inadequate and would lead to further harm among the detainees.[57] When asked about these prior CRCL reports, the Officer-in-Charge at Adelanto feigned ignorance about their findings claiming that he could not answer questions because there are too many reports to keep track of. Even after detailing the specific findings in the report, the Officer refused to acknowledge any systemic problems even though ICE had concurred with these particular CRCL findings.[58]

This indifference also manifested itself in the care provided to the detainees themselves. The Committee repeatedly heard from detainees that their medical complaints were frequently dismissed. The most common complaint was that, whatever the issue, detainees would be given common pain relievers unless the symptoms were emergent. At LaSalle, migrants described a system that depended on non-medically trained people to make health care decisions. For example, if a person was experiencing pain, the guard in the housing unit might tell them to wait to go to the doctor until the morning. Even if they made it to see health professionals, migrants at LaSalle described medical personnel making fun of their complaints.[59] Migrants held at Otay Mesa also recalled being told to prioritize "one problem at a time" and not raise multiple concerns when visiting health professional. And they had to wait days for a trip to the hospital for treatment or examinations.[60] Migrants at Adelanto similarly complained about having to wait months to receive medical care for medical issues.

Two cases highlight how poor medical care can be at ICE facilities:

55. *Visit to LaSalle*, Aug. 28, 2019.
56. *Visit to Otero*, Dec. 3, 2019.
57. *See supra* at 8-9.
58. *Visit to Adelanto*, Oct. 2, 2019.
59. *Visit to LaSalle*, Aug. 28, 2019.
60. *Visit to Otay Mesa,* Oct. 3, 2019.

POOR CARE OF DETAINEE WITH FOOD ALLERGY

While visiting River, Committee staff raised the case of a detainee with a life-threatening peanut allergy who had recently been detained at the facility. While held at River, the detainee went into anaphylactic shock four times over the course of four months before medical professionals ordered a blood test to determine the extent of his allergy. The Director of Nursing at River demonstrated a lack of basic care and responsibility for the health of those in custody when discussing the case. The Committee was dismayed to learn that there were no protocols or procedures in place to prevent the migrant from accessing food that could potentially kill him. He was given a yellow band to wear on his arm to alert others of his allergies, but could still access any food from the kitchen or commissary. Even when he was placed in solitary, he was somehow still permitted to order peanut butter from the commissary, and the facility permitted those foods to be delivered to him. Shockingly, the Director of Nursing took zero responsibility for these failures and placed the blame on the migrant for eating the food "knowing what it was."[61]

Displaying an utter lack of concern for a migrant's health, when asked whether he could be issued an EpiPen or similar life-saving device, the Director was stunned by the suggestion because she said that giving out such a product would be dangerous to the health and safety of detainees and guards.[62]

Limiting the health risk to a migrant with a major food allergy like this is not difficult. At Adams, for example, staff were aware of policies to develop a roster of individuals with allergies and have special meals prepared and provided directly to them, so they would not have the opportunity to access allergens.[63] Officials running River are either being negligent in their care or have willfully disregarded the health and safety of those in their custody. River is operated by LaSalle Corrections—the organization previously noted as having a history of abuse and misconduct at its facilities.

61. *Visit to River*, Aug. 27, 2019.
62. *Id.*
63. *Visit to Adams*, Aug. 27, 2019.

LACK OF MEDICAL CARE THREATENS THE HEALTH AND SAFETY OF DETAINEES

Events at Cibola demonstrate significant failures on ICE's part to protect the health of migrants in custody.[64] In May 2019, an FMC conducted an inspection of the medical conditions and identified deficiencies and recommended corrective action to be taken within 60 days.[65] Months passed without any corrective action taken by the facility operator, CoreCivic. According to ICE, the FMC reached out to CoreCivic on several occasions but received no response.

The FMC subsequently conducted an unannounced inspection on August 5, 2019. He told Congressional staff during a briefing that the "place was a mess." He found that ***at least 300 sick call submissions by detainees*** had gone unanswered over the course of about 90 days. He also found that individuals with chronic conditions were not receiving the necessary care or medication.[66]

CRCL also conducted an inspection in August 2019 in response to complaints about the conditions at Cibola. CRCL inspectors similarly found that there was a backlog of 300 unanswered sick calls and that the care for individuals with chronic conditions was insufficient. CRCL made a total of 40 findings, including that the facility failed to have proper quarantine procedures in place for individuals with communicable diseases and that mental health care was inadequate.[67]

In a briefing with Committee staff, then-ICE Assistant Director for Custody Management Tae Johnson explained that no immediate action was taken because ICE Headquarters was not made aware of the serious nature of the problems until December when it immediately began making plans to transfer individuals to different facilities.[68] This assertion was false. Not only was ICE Headquarters aware of the conditions, but according to CRCL, Mr. Johnson himself participated in the exit conference that occurred upon the conclusion of CRCL's field work in September 2019, during which CRCL disclosed the serious nature of the deficient conditions.[69] Nonetheless, ICE waited another four months before even contemplating whether to remove detainees from a facility they were told was unsafe.[70] Such a delay put the health and safety of hundreds of migrants at risk.

ICE eventually came to similar conclusions about the medical care at Cibola in a Contract Discrepancy Report issued on February 4, 2020. That report found that Cibola had been in violation of the applicable detention standards in the following ways:

- Medical staff failed to document treatment plans for detainees evaluated by mental health providers;
- Detainees with chronic conditions did not receive an assessment within the required two days;
- Detainees did not receive health assessments within 14 days of arrival;
- For two months, detainees only received symptom screenings for tuberculosis;
- Detainees referred for mental health evaluation, did not receive a screening within 72 hours;
- Medical staff received no training on how to use certain emergency equipment provided to them; and
- Sick call requests were handled by security personnel.[71]

Based on the identified violations, the available penalties included a withholding or deduction of up to 20 percent of a monthly invoice amount until the Contract Officer determined that the facility was in compliance with the relevant standards.[72] On several occasions, beginning in March 2020, the Committee sought information regarding whether ICE pursued any penalties against CoreCivic. As of September 16, 2020, the Committee had not received a response.

64. Committee staff did not visit Cibola, but gained information about the conditions through conversations with ICE, DHS CRCL, and IHSC.
65. *ICE Briefing to Committee Staff*, Feb. 6, 2020.
66. *ICE Briefing to Congressional Staff*, Jan. 23, 2020.
67. *DHS CRCL Meeting with OMA Subcommittee Chairwoman*, Mar. 12, 2020.
68. *ICE Briefing to Committee Staff*, Feb. 6, 2020.
69. *DHS CRCL Meeting with OMA Subcommittee Chairwoman*, Mar. 12, 2020.
70. *ICE Briefing to Committee Staff*, Feb. 6, 2020.
71. *Contract Discrepancy Report, Cibola County Correctional Center*, Immigration and Customs Enforcement, Feb. 4, 2020.
72. *Id.*

2. Deficient Mental Health Care

Unfortunately, throughout the Committee's visits, migrants made several complaints about access to mental health care services. Many indicated that they could not access mental health care services or that they were not even aware what was available.

Several migrants held in detention raised a concern that they could be placed on suicide watch for raising mental health concerns. At Otero, any staff member, whether or not that individual was medically trained, could place a detainee on suicide watch. The detainee would then have to be evaluated by medical staff within a certain period of time to determine whether the individual needed to remain on suicide watch. When Committee staff spoke with individuals in detention, many indicated that this policy made them reluctant to raise mental health issues because they feared that an untrained guard would overreact and place them on suicide watch.[73]

The Committee also found that the mental health care of those individuals held in segregation is lacking. For example, at Otero, migrants noted that a "welfare check" while in segregation might just be a knock on the door. In many cases, they said, there are little to no actual checks on the migrant's mental or physical health.[74] A review conducted by the Project on Government Oversight (POGO) confirms many of these concerns. POGO's review of data received through a Freedom of Information Act request found that about 40 percent of those placed in segregation suffer from some form of mental illness. POGO also identified three individuals who committed suicide while being held in segregation. In one of those cases, an email from an IHSC employee noted that the individual "could have been saved," but was "not being treated with psychotropic medication; instead he was remanded to segregation."[75]

3. Limited Dental Care

The dental care provided to individuals in ICE custody demonstrates one of many areas where ICE's standards do not go far enough. Applicable standards provide that:

1. Emergency dental treatment ***shall be*** provided for immediate relief of pain, trauma and acute oral infection; and
2. Routine dental treatment ***may be*** provided to detainees in ICE custody for whom dental treatment is inaccessible for prolonged periods because of detention for over six months.[76]

Migrants at Otero and Otay Mesa complained that they had to be detained at the facility for more than a year to receive any routine dental care, which ultimately makes the need for emergency dental care more likely. [77] Even where facilities instituted policies requiring requested routine dental care after six months, both staff and detainees indicated that the clock started with the arrival at the facility. In other words, every time a migrant was transferred to a new facility, which could occur with some frequency, the six-month clock started over.

4. Failure to Adequately Protect Detainees from COVID-19

As of September 2020, six migrants have died in ICE

73. *Visit to Otero*, Dec. 3, 2019.
74. *Id.*
75. *Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months,* Project on Government Oversight, Aug. 14, 2019.
76. *PBNDS 2011* at 271; *NDS 2000* at 115.
77. *Visit to Otay Mesa,* Oct. 3, 2019; *Visit to Otero*, Dec. 3, 2019.

custody from COVID-19, and more than 5,000 have tested positive, suggesting that ICE has not adequately protected the health of detainees during the pandemic. From providing insufficient hygiene and cleaning products to migrants, failing to track positive cases among contract workers, and not having sufficient personnel protective equipment (PPE), ICE has set the stage for outbreaks at its facilities.

To have safe and sanitary conditions, migrants held in ICE custody need access to basic hygiene products like soap, shampoo, and toothpaste, particularly during the COVID-19 pandemic when lacking such access could result in the virus's spread. While the Committee's visits occurred before the outbreak of COVID-19, evidence suggests that facilities were not equipped to limit the spread of the disease. Furthermore, ICE's response to the pandemic has been inadequate and has placed both detainees and workers at risk for contracting and spreading this deadly virus.

ICE's response to the pandemic has been inadequate and has placed both detainees and workers at risk for contracting and spreading this deadly virus

Nearly all detainees who met with Committee staff stated that upon their arrival to an ICE detention facility, they received a packet that included personal hygiene products. However, migrants frequently found those products difficult to have replaced. Individuals held at River said that they would have to make several requests before receiving replacement items.[78] At Otay Mesa, a housing unit had a drawer full of replacement items; however, migrants noted that access to those items depended on whether the guard on duty was willing to hand them out.[79]

Migrants in ICE custody also frequently complained that they were required to pay to replace basic hygiene items. At Otay Mesa, several individuals described a month where the replacement items ran out and they had to purchase their own toilet paper and toothpaste.[80] Others at LaSalle and Otero also indicated that products like soap and deodorant had to be purchased.[81]

In order to access basic hygienic products, detainees have to depend on the good will of guards or their own personal commissary account, which they might only be able to fill by entering a work program that pays ***one dollar a day***. According to many migrants, the cost of basic hygiene products at the commissary could range from three to five dollars. Therefore, a migrant held at Otero might have to work five days before having enough funds to purchase deodorant.

The status quo raises doubts that detainees have access to the basic products that might end up saving their lives. These concerns have been realized in recent months following reports that migrants are not being given access to the products necessary to protect themselves from COVID-19. For example, women held at LaSalle have come forward claiming that they went several days without access to soap and have had

78. *Visit to River*, Aug. 27, 2019.
79. *Visit to Otay Mesa,* Oct. 3, 2019.
80. *Id.*
81. *Visit to LaSalle*, Aug. 28, 2019; *Visit to Otero*, Dec. 3, 2019.

inadequate access to other cleaning supplies.[82] Since these concerns were raised, at least 29 migrants held at that facility have tested positive for the virus.[83]

Federal courts are beginning to conclude that the conditions at ICE facilities are putting migrants at risk for exposure to COVID-19. In a lawsuit seeking the release of detainees at Adelanto, plaintiffs alleged that there were insufficient cleaning procedures and that detainees lacked access to hand sanitizer, gloves, and masks. A judge found that the conditions at the facility created "a massive risk of COVID-19 infection."[84] Another judge recently found that ICE's care of migrants at the Krome Service Processing Center, Broward Transitional Center, and Glades County Detention Center rose to "deliberate indifference" to the condition of its detainees and ordered the release of detainees.[85] The court found, in particular, that ICE failed to provide migrants with soap or institute social distancing policies that would protect migrants from exposure to the virus.[86]

Especially during this crisis, ICE must ensure that every migrant in its custody has access to the basic items (like soap and hand sanitizer) that will help protect them from contracting this deadly disease.

D. MISUSE OF SEGREGATION

1. Background on Use of Solitary in ICE Detention

In the detention context, what is commonly known as solitary (placing a person in a unit separate from the general population), is referred to as segregation.[87] In ICE detention, there are two types of segregation: disciplinary and administrative. Disciplinary segregation is punitive and may only be used when a disciplinary panel makes a finding that the detainee is guilty of a prohibitive act or rule violation as set forth in ICE's offense categories.[88] Administrative segregation is non-punitive and may be used for several reasons, including to ensure the immediate safety and security of detainees or others, for detainees who appear in danger of self-harm, or for detainees who seek or require protection or otherwise request separate housing.[89]

Migrants at Otero similarly told Committee staff that guards frequently used threats of segregation to gain compliance with orders

2. Threats and Retaliation

The most common concern raised by migrants we spoke with was that placement in segregation is frequently used as a form of threat or retaliation to assert control and gain compliance. For example, individuals held at River complained that guards threatened placing detainees in segregation for engaging in per-

82. Noah Lanard, *The Women Asked ICE for Soap. They Got Pepper Sprayed Instead*, Mother Jones, Apr. 22, 2020.
83. *COVID-19 ICE Detainee Statistics by Facility*, Immigration and Customs Enforcement, https://www.ice.gov/coronavirus#wcm-survey-target-id (accessed Sept. 17, 2020).
84. Martin Estacio, *Federal judge orders immediate release of 250 immigrant detainees held in Adelanto amid coronavirus concerns*, Victorville Daily Press, Apr. 25, 2020. The Ninth Circuit Court of Appeals has stayed the order to release detainees pending the Government's appeal. Chantal De Silva, *Appeals Court Blocks Judge from Forcing ICE to Release California Detainees Over Coronavirus Outbreak*, Newsweek, May 6, 2020.
85. Monique Madan, *Federal Judge Orders ICE to Release Detainees from South Florida Detention Centers*, Miami Herald, Apr. 30, 2020.
86. *Id.*
87. For the purpose of this report, the Committee will use the term segregation.
88. *PBDNS 2011* and *NDS 2000*.
89. *Id.*

missible acts that detention staff considered disruptive, like submitting too many medical requests.[90] Migrants at Otero similarly told Committee staff that guards frequently used threats of segregation to gain compliance with orders.[91]

With respect to the use of segregation as retaliation, the Committee heard from several migrants that segregation was used as a tool to punish individuals on hunger strikes. At River, an individual indicated that he was placed in segregation for several days after engaging in a hunger strike that lasted less than a week. He said that he was told by guards that he was being punished because he was perceived as the leader of a form of impressible protest.[92] At Otero, the Committee also heard from migrants who indicated that they had been placed in segregation as punishment for engaging in a hunger strike. When Otero officials were asked about these hunger strikers in detention, they acknowledged that such individuals had been held in segregation for up to 28 days, but they claimed that the discipline was for other reasons.[93]

3. Processes that Fail to Protect the Rights of Detainees

ICE standards set forth the conditions under which a person may be placed in disciplinary or administrative segregation. As previously noted, disciplinary segregation can only be used after a finding by a disciplinary review panel. In 2018, the OIG found that Adelanto was improperly placing detainees in disciplinary segregation prior to a finding by the panel.[94] During the Committee's visits, this practice was acknowledged as commonplace at a number of facilities. For example, at Otay Mesa, officials explained that following an incident of misconduct, detainees were immediately placed in disciplinary segregation pending a decision by the review panel. Facility staff provided the example of a fight where one person was clearly the aggressor and the other the victim. Still, both would be placed in disciplinary segregation until the panel made determinations about the facts and punishment.[95]

This is a violation of ICE standards and possibly basic due process rights, and ICE must do a better job of monitoring and limiting such improper practices.

4. Additional GAO Review

While there is anecdotal evidence that facilities are abusing and misusing segregation, a full analysis of the extent of this problem is outside the scope of the Committee's review. Accordingly, Chairman Thompson has requested that GAO conduct a programmatic review of ICE's use of segregation.[96]

E. DETAINEES FACE CHALLENGES GAINING ACCESS TO CASE INFORMATION, LEGAL SERVICES, AND INTERPRETER SERVICES

1. Deportation Officers Largely Unavailable

One of the only ways that migrants can get information about their pending cases (determining whether they will be deported or granted some status to remain lawfully in the country) is through the ICE Deportation Officers (DO) managing their cases. Yet one of the most common complaints the Committee heard

90. *Visit to River*, Aug. 27, 2019.
91. *Visit to Otero*, Dec. 3, 2019.
92. *Visit to River*, Aug. 27, 2019.
93. *Visit to Otero*, Dec. 3, 2019.
94. OIG-18-86, at 5-6.
95. *Visit to Otay Mesa,* Oct. 3, 2019.
96. *Letter from Chairman Thompson to the Honorable Gene L. Dodaro, Comptroller General, U.S. GAO*, Aug. 20, 2019.

from individuals in ICE custody was that they either did not know how to communicate with their DO, had never met their DO, attempted to communicate but never heard anything back, or communicated and received responses with little to no information.

For example, detainees at Adams had documents delivered by "runners" who couldn't answer questions about individual cases.[97] At LaSalle, staff showed off the tablets that detainees could use to submit questions to ICE, but migrants indicated they frequently did not receive a response. ICE leadership in the New Orleans Field Office, which oversees these facilities, acknowledged that their staff was stretched thin due to the recent expansion to several new facilities in the region. Unfortunately, they could not articulate any plans to increase staffing levels to meet the new demand.[98]

Other migrants complained that contact with DOs was effectively non-existent so there was no opportunity to have questions about a case answered. At Adelanto, migrants complained about waiting up to a year and a half before having any contact with a DO.[99] Others held at Otero also indicated that they had never once met their DO.[100]

Worcester was the standout exception to this rule and appears to be a model with respect to providing information to detainees about their cases. At Worcester, an ICE Deportation Officer made himself available every Thursday to meet with detainees with questions. Migrants confirmed that this opportunity was available and that they were able to get questions answered in a timely manner.[101]

2. Constrained Access to Legal Services and Information

Access to legal information and services is critical for migrants in detention. Especially for those making asylum claims, the process is not a simple one and may require multiple levels of appeal. Since the nature of detention offers limited opportunities for migrants to effectively pursue their immigration case, it is important that facilities offer migrants access to legal resources in order to properly pursue their claims.

Many facilities Committee staff visited emphasized that legal services organizations provided weekly or bi-weekly presentations about the legal rights associated with their immigration cases. However, migrants generally felt that these presentations were unhelpful because there were typically long waitlists to attend, and they were often unable to attend until after they already had important hearings or credible fear interviews.[102]

During tours, all facilities (except for Otero) showed Committee staff the law libraries. These ranged dramatically in quality from large rooms with many books and multiple computers to a small space with a computer to access legal research websites. River, the location with the smallest of the legal libraries, said that any detainee could access the library by request, one at a time, Monday through Friday, by appointment. However, several individuals held at the facility informed the Committee that their requests to access the law library had never been granted. Without access to legal information, the ability to understand the

97. *Visit to Adams*, Aug. 27, 2019.
98. *Id.*; *Visit to LaSalle*, Aug. 28, 2019.
99. *Visit to Adelanto*, Oct. 2, 2019.
100. *Visit to Otero*, Dec. 3, 2019.
101. *Visit to Worcester*, Feb. 24, 2020.
102. *Visit to LaSalle*, Aug. 28, 2019; *Visit to Adelanto*, Oct. 2, 2019; *Visit to Otay Mesa,* Oct. 3, 2019. A credible fear interview is the first step in a migrant's asylum claim. The interview is conducted by United States Citizenship and Immigration Services personnel who determine whether the migrant meets initial threshold requirements to make a successful asylum claim.

immigration court process is effectively eliminated.[103]

In one instance, the Committee learned of concerning actions taken at Otero that severely hindered the ability to assert legal rights. One advocacy organization was working with a detainee on a hunger strike who was also being held in segregation. On two separate occasions, the organization sent attorneys to meet with the individual so they could potentially represent him, but in both instances the attorneys were turned away after being told the migrant did not want to meet with them.[104] Not unlike what the Committee experienced after requesting to meet with certain migrants, this individual subsequently told the organization that he was never informed of attorneys coming to meet with him.

Otero also instituted a pen and paper ban during visits with non-attorneys. On its face, this seems insignificant; however, migrants often depend on families and friends on the outside to collect and file legal paperwork on their behalf.[105] By banning pen and paper in the facilities, friends and families of detainees are unable to note vital information and these migrants are further disadvantaged when pursuing their immigration case.

3. Difficulties Accessing Interpreter/Language Services

All of the services provided to migrants in detention are meaningless if detainees are unable to understand the information provided to them. For example, upon arrival at a new detention facility, every migrant receives a "Detainee Handbook." The book contains important information about rights, responsibilities, rules, and the potential punishments for breaking those rules. At the facilities visited by the Committee, they are made available in English and Spanish only. Detainees who speak other languages are left in the dark unless they affirmatively request a translation, which could take weeks to provide.[106]

Migrant detainees also described the difficulties in accessing interpreter services, which most frequently come in the form of a "language line" that the facility calls to have a professional interpreter. Even staff acknowledged that it could take time to get an interpreter on the phone that spoke a rarer language. With respect to daily interactions, interpreter services are sparsely if ever used. Migrants at Otay Mesa noted that those who did not speak English or Spanish faced additional derision and abuse by guards. They speculated that because those migrants were unable to follow instructions that they could not understand, guards treated them poorly.[107]

Even the Committee faced challenges accessing interpreter services used by ICE detention facilities. For example, while meeting with a group of migrants at Otay Mesa who spoke several different languages, there was only one phone available to use for interpreter services. [108]

103. *Visit to River*, Aug. 27, 2019.
104. *Freedom for Immigrants briefing to Committee Staff*, Dec. 5, 2019.
105. *Id.*
106. *Visit to River*, Aug. 27, 2019; *Visit to LaSalle*, Aug. 28, 2019.
107. *Visit to Otay Mesa,* Oct. 3, 2019.
108. *Id.*

CONCLUSION

The Committee's review of the conditions at ICE detention facilities confirms that ICE does not do enough to ensure that its own standards of confinement are met. The repeated violations of medical care standards at Adelanto and ICE's failure to act promptly in the face of dire conditions at Cibola are glaring evidence of this. The Committee's review of conditions at ICE facilities also revealed ongoing problems with cleanliness, use of segregation, and access to legal and language services. The spread of COVID-19 has further highlighted how the failures to meet these standards of care are a matter of life and death.

Unfortunately, during the Committee's review, it became apparent that ICE prioritizes obtaining bed space over the wellbeing of detainees.

Accordingly, ICE must establish processes to better identify and correct deficiencies at its detention facilities. ICE should also reevaluate the capability of certain facilities and contractors to meet the standards. Instead of waiving certain standards and prioritizing bed space, ICE should cease doing business with those contractors that are unable to meet basic standards of health and safety.