OVERSIGHT OF ICE DETENTION FACILITIES: IS DHS DOING ENOUGH?

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT, MANAGEMENT, AND ACCOUNTABILITY

OF THE

COMMITTEE ON HOMELAND SECURITY HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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OVERSIGHT OF ICE DETENTION FACILITIES: IS DHS DOING ENOUGH?

Thursday, September 26, 2019

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
SUBCOMMITTEE ON OVERSIGHT, MANAGEMENT,
AND ACCOUNTABILITY,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:04 p.m., in room 310, Cannon House Office Building, Hon. Xochitl Torres Small [Chairwoman of the subcommittee] presiding.

Present: Representatives Torres Small, Titus, Watson Coleman, and Crenshaw.

Ms. TORRES SMALL. The Subcommittee on Oversight, Management, and Accountability will come to order.

The subcommittee is meeting today to receive testimony on "Oversight of ICE Detention Facilities: Is DHS Doing Enough?"

Good afternoon. We are here to discuss the Oversight of Immigration and Customs Enforcement's detention facilities and whether DHS is doing enough to ensure that ICE's own detention standards are being met.

Before we start, I would like to take a moment to acknowledge some of the challenges the subcommittee had in arranging today's hearing.

We are holding two panels this afternoon because ICE declined to sit on the same panel with Nakamoto, the contractor it chose to conduct inspections on its behalf since 2011.

The Department's lack of cooperation makes it more challenging for Congress to do its job. As I recently stated at a meeting with DHS leaders, it is important to the subcommittee to bring everyone's voices together. That is how we can best identify challenges and find ways to solve them.

This issue is particularly important to me as two of ICE's facilities, the Otero ICE Processing Center and the Cibola County Correctional Center, detain upwards of 1,300 migrants in my home district. I have visited these facilities and I have concerns about some of the conditions of confinement. I am not alone in having these concerns. DHS's own Office of Inspector General last year found that these processes—that ICE's processes—for oversight of confinement were insufficient to sustain compliance with ICE's own standards.

It might be that inspectors are set up to fail. For example, ICE's contractor, which conducts about 100 inspections annually, is responsible for evaluating compliance with up to 42 standards com-

posed of over 600 elements over the course of just a few days. As a result, these inspectors end up missing some clear violations of detention standards, like a phone not working properly.

The OIG also observed inspectors misreporting that detainees knew how to obtain assistance from ICE officers when those detainees had indicated the exact opposite.

Of additional concern is the fact that even when these deficiencies are identified, ICE's processes have not ensured that they are corrected.

For example, ICE has detention service monitors on-site at several detention facilities to monitor compliance with detention standards. However, these monitors told the OIG that when they identify violations they have no means of enforcing corrective action.

Instead of pressuring facilities to correct deficiencies or issuing financial penalties for noncompliance, in some cases ICE grants waivers so the facilities don't have to abide by these standards.

For example, as the OIG reported, from October 2015 to June 2018, ICE only issued two financial penalties and granted 65 waivers, 63 of which of those waivers had no end date.

One of these waivers, at Otero in my district, permitted low-custody individuals with no criminal history to commingle with individuals with more serious criminal records.

The standard that typically keeps these detainees separated is an important one that directly impacts the safety of people in detention.

Finally, I have concerns that inspections by ICE's contractor are announced far in advance, giving facilities ample opportunity to clean things up just in time for inspection.

I understand that the OIG made several recommendations to ICE to correct these issues, and I look forward to hearing what steps ICE has taken and whether they are leading to more sustained compliance with standards.

I also look forward to hearing about the oversight work that the OIG conducts at ICE facilities. The OIG's oversight work in this space has been critical in shining a light on the conditions of confinement. Recent reports have identified serious violations of ICE's standards, including food and service issues endangering the health of detainees and inappropriate segregation practices infringing on detainee safety.

However, the scope of OIG's inspections is limited by its lack of subject-matter experts, like medical doctors to evaluate the quality of medical care.

I am encouraged by the fact that the OIG is developing a plan to contract with such experts who could engage in this oversight work, and I hope to hear that this plan is being put into action.

I want to thank the witnesses who are here today, and I look forward to your testimony.

The Chair now recognizes the Ranking Member of the subcommittee, the gentleman from Texas, Mr. Crenshaw, for an opening statement.

[The statement of Chairwoman Torres Small follows:]

STATEMENT OF CHAIRWOMAN XOCHITL TORRES SMALL

SEPTEMBER 26, 2019

We are here to discuss the oversight of Immigration and Customs Enforcement's detention facilities and whether DHS is doing enough to ensure that ICE's own detention standards are being met. Before we start, I'd like to take a moment to acknowledge some of the challenges the subcommittee had in arranging today's hearing. We're holding two panels this afternoon because ICE declined to sit on the same panel with Nakamoto, the contractor it chose to conduct inspections on its behalf since 2011. The Department's lack of cooperation makes it more challenging for Congress to do its job.

As I recently stated at a meeting with DHS leaders, it's important to this subcommittee to bring voices together at the same table to engage in a problem-solving discussion. This issue is particularly important to me as two of ICE's facilities, the Otero ICE Processing Center and the Cibola County Correctional Center, detain upwards of 1,300 migrants in my home district. Upon visiting these facilities, I have become increasingly concerned about the conditions of confinement. I am not alone in having these concerns.

While ICE has processes in place to conduct oversight of these facilities, DHS's Office of Inspector General last year found that these processes were insufficient to sustain compliance with ICE's own standards. For example, ICE's contractor, which conducts about 100 inspections annually, is responsible for evaluating compliance with up to 42 standards composed of over 600 elements over the course of just a few days. As a result, these inspectors end up missing some clear violations of detention standards, like a phone not working properly. The OIG also observed inspectors misreporting that detainees knew how to obtain assistance from ICE officers when those detainees had indicated that exact opposite. Of additional concern is the fact that even when these deficiencies are identified, ICE's processes have not ensured that they are corrected.

For example, ICE has Detention Service Monitors on-site at several detention facilities to monitor compliance with detention standards. However, these monitors told the OIG that when they identify violations, they have no means of enforcing corrective action. Instead of pressuring facilities to correct deficiencies or issuing financial penalties for noncompliance, in some cases ICE grants waivers so the facilities don't have to abide by certain standards. For example, as the OIG reported, from October 2015 to June 2018, ICE only issued 2 financial penalties and granted 65 waivers—63 of which had no end date. One of these waivers, at Otero in my district, permitted low-custody individuals with no criminal history to comingle with individuals with more serious criminal records. The standard that typically keeps these detainees separated is an important one that directly impacts the safety of migrants in detention.

Finally, I have concerns that inspections by ICE's contractor are announced far in advance giving facilities ample opportunity to clean things up just in time for the inspection. I understand that the OIG made several recommendations to ICE to correct these issues, and I look forward to hearing what steps ICE has taken and whether they are leading to more sustained compliance with standards. I also look forward to hearing about the oversight work that the OIG conducts at ICE facilities. The OIG's oversight work in this space has been critical in shining a light on the conditions of confinement. Recent reports have identified serious violations of ICE's standards, including food service issues endangering the health of detainees and inappropriate segregation practices infringing on detainee rights. However, the scope of OIG's inspections is limited by its lack of subject-matter experts, like medical doctors to evaluate the quality of medical care. I am encouraged by the fact that the OIG is developing a plan to contract with such expert experts who could engage in this oversight work, and I hope to hear that this plan is being put into action.

Mr. CRENSHAW. Thank you, Chairwoman Torres Small.

Thank you to all of our witnesses on both panels for being here today.

I am pleased we are holding this hearing regarding the oversight of ICE detention facilities. It is extremely important.

I am also pleased we were able to work together and resolve some of the problems coordinating witnesses and panels to have the key stakeholders necessary for the productive hearing this issue deserves.

It should be noted that it is long-standing practice not to have the agency and the contractors for that agency on the same panel, which is why we ended up having two different panels.

I am also hopeful that the Office of Civil Rights and Civil Liberties will still provide their testimony prepared for this hearing even though they were disinvited earlier this week.

I hope that in the future that the agency over which we are conducting oversight in this case, ICE, would be the first to be invited to testify.

This is an important issue to examine. I share the Majority's concern regarding the necessity of enforcing the standards for safety and security of ICE detainees. The health and well-being of those detained in the United States is not a partisan issue.

I have been very public in my praise for the Department of Homeland Security and the individuals who work each day to keep our country safe. The men and women of U.S. Immigration and Customs Enforcement have some of the toughest jobs in the Department. ICE is tasked with enforcing U.S. immigration law and removing individuals who pose a threat to the National security, public safety, or seek to exploit our immigration system.

Their job is made even more difficult when they are publicly and unfairly vilified by public figures. The false narratives spread about ICE are utterly reprehensible.

Individuals primarily targeted for removal by ICE include convicted criminals, gang members, repeat immigration violators, and those ordered to be removed by an immigration judge.

As the flow of immigrants increases, the job of ICE becomes even more difficult. They must devote their resources to rooting out those that pose the biggest threat; however, those resources are stretched thin.

The safe and secure detention of individuals prior to removal from the country is one of the most important duties that ICE devotes resources to. Although detention is primarily done through contractors, as the agency responsible for these individuals ICE must ensure that proper care is provided.

ICE must use its oversight authorities as well as its contracting authorities to ensure its detention standards are met. ICE does its own inspections every 3 years and hires private contractors to do inspections annually.

Additionally, ICE has individuals in a number of facilities who are tasked with on-site review of the daily operations.

All this seems like the recipe for conducting vigorous oversight. Unfortunately, however, it seems, as is frequently the case with Government agencies, there was a lack of communication and coordination among the divisions within ICE.

It is my understanding that ICE has agreed with the recommendations of the inspector general's office and is working to address these issues. I look forward to hearing from our witnesses today on how we can ensure ICE detention standards are met in the future.

I yield back the balance of my time.

[The statement of Ranking Member Crenshaw follows:]

STATEMENT OF RANKING MEMBER DAN CRENSHAW

SEPTEMBER 26, 2019

Thank you, Chairwoman Torres Small and thank you to all of our witnesses on both panels for being here today.

I am pleased we are holding this hearing today regarding oversight of ICE detention facilities.

I am pleased we were able to work together and resolve some of the problems coordinating witnesses and panels to have the key stake holders necessary for the productive hearing this issue deserves. I am hopeful the Office of Civil Rights and Civil Liberties will still provide their testimony prepared for this hearing, even though they were disinvited earlier this week.

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Individuals primarily targeted for removal by ICE include convicted criminals, gang members, repeat immigration violators, and those ordered to be removed by an immigration judge. As the flow of immigrants increases, the job of ICE becomes even more difficult. They must devote their resources to rooting out those that pose the biggest threat. However, those resources are stretched thin.

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Ms. TORRES SMALL. Other Members of the committee are reminded that under the committee rules opening statements may be submitted for the record.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

SEPTEMBER 26, 2019

In recent years, the number of people in ICE custody has been steadily rising and now exceeds 50,000. Too often, ICE turns a blind eye to the conditions at its facilities. Indeed, several recent reports have shone a light on deplorable conditions at facilities holding migrants in ICE custody. For example, in California, at the Adelanto ICE Processing Center, an unannounced inspection by the Office of Inspection General (OIG) found a number of disturbing conditions, including: Nooses hanging in several detainee cells, a detainee never leaving his wheelchair for sleep or to brush his teeth for 9 days, and detainees waiting months for basic medical treatment.

In New Jersey, at the Essex County Correctional Facility, the OIG found that cafeteria workers were serving visibly moldy and foul-smelling food to migrant detainees resulting in likely food poisoning. How, one might ask, did these blatant violations of detention standards and, for that matter, human decency, continue under ICE's watch? ICE has processes in place to conduct oversight of these facilities, but the OIG has found, they have been insufficient to ensure compliance with ICE's own standards. Contracted inspectors are stretched too thin and are missing obvious deficiencies during inspections.

Even when deficiencies are identified, many are left uncorrected or the standards themselves are waived. This is unacceptable. While I am encouraged by the work that the OIG is doing to identify and correct deficiencies at ICE detention facilities, the OIG faces constraints in conducting oversight work in a meaningful manner. I recently heard from the newly-confirmed DHS inspector general that the OIG currently lacks the ability to evaluate certain detention standards absent subject-matter experts on staff. The OIG has described the beginnings of a plan to contract with subject-matter experts who could engage in this work, and I hope to hear that this plan is being put into action. I also look forward to hearing more from OIG's witness about the steps ICE must take to ensure its detention facilities comply with its own detention standards.

In closing, I would like to take a moment to share my concern regarding the resistance this subcommittee has faced in conducting oversight on these important issues. While I am pleased that they are here today, the Nakamoto Group has refused several attempts by the committee to engage through meetings or briefings about its work. I would like to remind everyone that ICE pays its contractors, including Nakamoto, with taxpayer dollars. As Congress, it is our responsibility to conduct oversight to ensure they are being spent wisely. Unfortunately, it was only under threat of subpoena that the Nakamoto Group agreed to testify today. I also share Chairwoman Torres Small's disappointment regarding the Department's unwillingness to to sit on this panel with its own contractor, Nakamoto.

What does it say about the Department or its contractor that they refuse to have a seat at the table together and discuss these important issues? Such behavior shows a complete lack of respect for Congress and its oversight responsibilities as well as a disregard for the spirit of bipartisan problem solving that the Chairwoman fosters on this subcommittee. I hope the Department takes the concerns raised here today seriously and acts on them promptly.

Ms. TORRES SMALL. I welcome our first panel of witnesses and thank them for joining today.

Our first witness is Ms. Jenni Nakamoto, president and sole owner of the Nakamoto Group, Inc. Ms. Nakamoto has provided professional and administrative support to the Federal Government and private industry since 1990. Her company contracts with ICE to conduct inspections of ICE's detention facilities.

Our second witness, Ms. Katherine Hawkins, is the senior legal adviser for the Constitution Project at the Project On Government Oversight. Her work focuses on National security, immigration, and human rights. Prior to her work at POGO, she served as a National security fellow for Open the Government.

Without objection, the witnesses' full statements will be inserted in the record. I now ask each witness to summarize her statement for 5 minutes, beginning with Ms. Nakamoto.

STATEMENT OF JENNI NAKAMOTO, FOUNDER AND PRESIDENT, THE NAKAMOTO GROUP, LLC

Ms. NAKAMOTO. I want to first apologize. Sorry. Thank you for the invitation to appear before this committee. I want to first apologize for what appeared to be our resistance to come to this hearing to discuss the details of our work with ICE. Our contract has a clause within the contract, Federal regulations, that forbids disclosure of these details and we were hesitant to get involved at the risk of our contract.

The Nakamoto Group is a woman-owned, minority-owned small disadvantaged business headquartered in Frederick County, Maryland. My great-grandparents immigrated to the United States from Japan.

My maternal grandparents were both born in California, making them United States citizens. After Pearl Harbor, the Presidential order was issued to incarcerate all Japanese regardless of their citizenship status. My maternal family were living in California and had to relinquish all of their property, including any businesses that they had. They were given one trash bag to fill of personal items to take with them and had to leave everything else behind.

Our family was spread out to various internment camps across the country. My maternal grandparents were incarcerated in a Japanese internment camp in Arizona. They were there long enough to meet, fall in love, get married, have a baby, my mother, and become pregnant again with my aunt.

Since they had to start over, they were offered employment at a food processing factory before they were released, and they chose to move to a small town called Seabrook in southern New Jersey, where ultimately I was born.

My father was born and raised in Hilo, Hawaii. My grandfather returned to Japan soon after he was born. My father was the youngest in a large broken home and he was raised by several of his older brothers.

My father served for more than 20 years in the United States Army. He served 2 tours during Vietnam and served on what was one of the first all Japanese American Green Beret units.

Upon his retirement from Fort Ritchie, Maryland, we relocated to Frederick, where I grew up. Because my parents did not have a lot of money, I worked during high school and have been working since I was 15 years old.

Shortly after high school, I was able to obtain a secretarial job with the Government at the Department of Health and Human Services. I worked there for over 6 years before leaving to work for 3 other successful minority-owned Government contracting firms. I learned about Government contracting during those 7 years and I decided to take a chance and start my own company.

I started this company in 2003. It was the same year that I lost my late husband to police suicide. I still volunteer for his Fraternal Order of Police and have volunteered for them for over 20 years, serving as their executive assistant to the executive board.

The Nakamoto Group was certified in the Small Business Administration's 8(a) program in 2004. We successfully graduated certification in 2013.

The first contract awarded to my company was in 2004 to maintain a hotline entitled Insure Kids Now, which is a hotline that provides either free or low-cost health care to kids through State Children's Health Insurance Program within the United States and its territories. We still maintain that contract after 15 years, and it now includes another hotline entitled 311–BABY, which helps expectant and new mothers, providing information via phone and text.

For the last 15 years, we have obtained logistics contracts with the Food and Drug Administration and the Department of Health

and Human Services. From 2006 to 2007, we had a contract with the Food and Drug Administration to help them hire Hispanics to increase diversity within their work force. We continue to provide logistics support for FDA's CDER advisory committees.

Our most current and long-standing logistics contracts have been with the Office of Rural Health Policy to run logistics for their National Advisory Committee on Rural Health and Human Services. We also provided logistics for several of their policy meetings regarding telehealth in rural America from 2010 to 2013.

In 2005, we obtained a contract with the now-dissolved Office of the Federal Detention Trustee, which was a department under the Department of Justice. We won a place within a blanketed purchase agreement to provide detention expert support services to the Office of the Federal Detention Trustee.

Using performance-based detention standards, we sent teams to provide expert specialized service consultation by conducting facility reviews of non-Federal contract jails and detention facilities which house U.S. Marshal Service and Immigration and Customs Enforcement detainees.

In 2007, we were asked to attend a meeting at ICE headquarters where we were asked to perform on-site monitoring services and provide monthly technical assistance and included full-time monitors for 40 of the largest ICE detention facilities, and monthly, quarterly, biannual reviews of other small ICE detention facilities. The goal was to ensure that the facilities were in compliance with the standards.

ICE piggybacked on that existing contract that we had at the time at the Department of Justice and we did this type of work for them from 2007 to 2010.

Ms. TORRES SMALL. Ms. Nakamoto, your time is up. If you want to include a few seconds of concluding remarks or we can just—the rest can be entered into the record.

Ms. NAKAMOTO. OK.

[The prepared statement of Ms. Nakamoto follows:]

STATEMENT OF JENNI NAKAMOTO

SEPTEMBER 26, 2019

Madam Chairwoman Small, Mr. Crenshaw, thank you for the invitation to appear before this committee.

The Nakamoto Group is a woman-owned, minority-owned small disadvantaged business, headquartered in Frederick County, Maryland. My great-grandparents immigrated to the United States from Japan. My maternal grandparents were both born in California making them United States citizens. After Pearl Harbor, a Presidential order was issued to incarcerate all Japanese regardless of their citizenship status. My maternal family were living in California and had to relinquish all of their property including any businesses that they had. They were given one trash bag to fill of personal items to take with them and had to leave everything else behind. Our family was spread out to various internment camps across the country. My maternal grandparents were incarcerated in a Japanese internment camp in Arizona. They were there long enough to meet, fall in love, get married, have a baby, my mother, and become pregnant again with my Aunt. Since they had to start over, they were offered employment at a food processing factory before they were released and they chose to move to a small town called Seabrook in Southern New Jersey, where ultimately I was born.

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in the United States Army, served 2 tours during Vietnam and served on what was one of the first all Japanese-American Green Beret units.

Upon his retirement from Ft. Ritchie, Maryland, we relocated to Frederick, Maryland, where I grew up. Because my parents did not have a lot of money, I worked during high school and have been working since I was 15 years old. Shortly after high school, I was able to obtain a secretarial job in the Government at the Department of Health and Human Services. I worked there for 6 years before leaving to work for 3 other successful minority-owned Government contractor firms. I learned about Government contracting during those 7 years and I decided to take a chance and start my own company.

I started this company in 2003. It was the same year that I lost my late husband to police suicide. I still volunteer for his Fraternal Order of Police Lodge No. 91 and have volunteered for them over 20 years serving as the executive assistant to the executive board.

The Nakamoto Group, Inc. was certified in the Small Business Administration's 8(a) program in 2004, and successfully graduated the certification in 2013. The first contract awarded to my company was in 2004, to maintain a hotline entitled Insure Kids Now, which is a hotline that provides either free or low-cost health care to kids through the State's Children's Health Insurance Program, within the United States and its territories. We still maintain that contract after 15 years and now it also includes another hotline entitled 311–Baby which helps expectant and new mothers by providing information via phone. 311–BABY also works in conjunction with a program called text4baby that text messages throughout the pregnancy and up to age one. The information provided helps inform where the mother is within her pregnancy and the baby milestones up to age 1. It also provides helpful detailed biweekly tips such as what the mother may be feeling, how big the baby should be, check-ups, poison control, vaccinations, nutrition with suggestions on what to eat to stay healthy for mother and child.

For the last 15 years, we have obtained logistics contracts with the Food and Drug Administration and the Department of Health and Human Services. From 2006–2007 we had a contract with the Food and Drug Administration to help them hire Hispanics to increase diversity within their workforce. We continue to provide logistics support for FDA's Center for Drug Evaluation Research (CDER) advisory committees.

Our most current and long-standing logistics contracts has been with the Office of Rural Health Policy to run logistics for their National Advisory Committee on Rural Health and Human Services. We also provided logistics support for several of their policy meetings regarding telehealth in rural America from 2010–2013.

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In 2007, we were asked to attend a meeting at ICE Headquarters where we were asked to perform on-site monitoring services and to provide monthly technical assistance and included full-time monitors for 40 of the largest ICE detention facilities and Monthly, Quarterly, and bi-annual reviews of other smaller ICE detention facilities. The goal was to ensure that the facilities were in compliance with the standards. ICE piggy-backed onto the existing contract we had at the time with the Department of Justice and we did this type of work for them from 2007–2010. In 2009, we won a full and open competition to perform these same duties for 5 years. However, after year 1, in 2010, the Government chose not to exercise any more years of the contract and instead chose to in-source that program. In effect, terminating our contract. As a result, Nakamoto laid off over 150 employees and absorbed over $100,000.00 worth of contract closing costs. Due to those costs, I was on the brink of losing my company altogether. We stayed afloat only because of the hard work of the few determined and dedicated staff that I had left.

Also in 2007, my company was approached by ICE and the Juvenile Family Residential Unit (JFRMU) to help them coordinate a cadre of experts: A former senior Federal official with experience in providing health care services to indigent women and children, a daycare provider, licensed social worker, medical doctor, Educator with a Ph.D., Juvenile corrections expert, to create the standards for JFRMU and to inspect the family residential facilities. We held that contract from 2007–2015.

I am telling you my story to ensure that the correct story goes on record today. Recently, because of our association with the Department of Homeland Security

(DHS), I have been personally attacked via social media and news outlets; attacks that have disparaged my Mother, who passed away in 2008; myself; and my heritage. We have been victimized by inaccurate accountings of our work, I can only guess, for the purpose of discrediting ICE.

Fortunately, the facts speak for themselves and we have factually refuted every negative assertion against us. Nevertheless, some have chosen to ignore the facts and continue to reference disproven allegations for their political purposes and to further their agenda against ICE. Because of my background and upbringing, I insist that this company be diverse and multi-cultural for employees and clients alike, always ensuring that the principles of fairness and equity are our priorities.

We have less than 15 full-time employees and 45 part-time employees at any given time. The majority of my employees, who are inspectors, have an average of over 35 years of detention monitoring experience. In the years since 2003, we have worked hard and have succeeded in building a reputation of a conscientious company that provides great value and service to our clients.

As president of the company, I involve myself with overseeing the various employees that manage our contracts, provide our administrative support, and perform human resource and budgetary functions. I do not necessarily work day-to-day with any specific contract. The ICE annual inspection contract has a very specific statement of work that provides the direction and methods for us to conduct inspections. We have no room or opportunity for variance from the provisions of the contract. I have submitted the statement of work as part of my testimony and ask the committee Members to refer to that document for any specific tasks or instructions that are required of us. Because we deal with multiple contracts at any given time, I am not able to memorize any one contract; but rather explore specifics when required to do so to address questions from the contract managers. That being said, should you have questions about specific duties or requirements of the Statement of Work, the answers should be therein. If not, I must defer to ICE, as we have no direction or discretion outside of the Statement of Work.

Facilities are inspected under 1 of 3 different sets of ICE immigration standards. We use the set as specified by the contract between each individual facility and ICE. We may inspect as many as 42 standards with as many as 680 components, and never less than 39 standards with 641 components. Every requirement of every standard is inspected no less than annually at every qualifying facility. Qualifying facilities are primarily those who house ICE detainees for longer than 72 hours and house more than 50 ICE detainees. ICE requires an exhaustive inspection of processes, policies, services, and privileges during every inspection. They also demand that the results are documented as required by the Statement of Work. While the standards do not specifically address every aspect of a facility operation, the great majority of potential liabilities are scrutinized. Those issues not specifically covered by a component within a standard are always reviewed by my inspectors. Those issues not specifically covered by the standards are included in a general sense, as quality of life issues, and reported on as such.

In 2017, we were asked by the Immigration Health Service Corp. to also provide an additional medical expert to review the medical records to determine whether or not the detainees held at the facility have had access to medical services in accordance with best practices.

To the question posed within the title of this hearing, "Oversight of ICE Detention Facilities: Is DHS Doing Enough?" From our perspective, YES, ICE is efficient and thorough in their oversight of detention facilities as far as the annual inspection contract goes, which is the extent of our knowledge.

This concludes my statement. Thank you.

Ms. TORRES SMALL. Ms. Hawkins.

STATEMENT OF KATHERINE HAWKINS, SENIOR LEGAL ANALYST, PROJECT ON GOVERNMENT OVERSIGHT (POGO)

Ms. HAWKINS. Chairwoman Torres Small, Ranking Member Crenshaw, and Members of the subcommittee, thank you for the opportunity to testify today.

I am a senior legal analyst for the Constitution Project at the Project on Government Oversight. POGO is a nonpartisan watchdog that investigates Government abuses of power.

As part of that work, my colleagues and I have done a series of investigations into conditions in ICE detention. We found evidence

of inadequate medical care, inadequate mental health care, and overuse of solitary confinement. These are chronic problems, but they have grown worse as ICE has detained more and more people.

ICE detention centers are subject to various forms of oversight by DHS. There are annual inspections by the Nakamoto Group, on-site monitors, inspections by different offices within ICE, and inspections by the DHS Inspector General and the Office of Civil Rights and Civil Liberties. This sounds like a lot of inspections, but the system is failing to ensure compliance with ICE's own detention standards.

The Nakamoto Group's inspections occur most often and are the only ones that can trigger a loss of a detention facility's contract, but they often fail to uncover serious violations. Other inspections are more thorough, but they often remain hidden from Congress and the public and ICE fails to make changes they recommend.

As a result, inhumane and unsafe conditions can persist for years. In some cases, the violations rise to the level of deliberate indifference to detainees' medical needs, which is unconstitutional.

To illustrate the problems, I will describe our findings on 3 of ICE's largest detention facilities.

In September 2018, the DHS Inspector General reported on an unannounced inspection of the Adelanto Detention Center in California. They found sheets braided into nooses in 15 detainees' cells, inadequate medical care, and overuse of solitary confinement.

The next month, the Nakamoto Group conducted its own previously-announced inspection of Adelanto. Nakamoto not only found that Adelanto was in compliance with 40 of 40 ICE detention standards, but accused the inspector general of writing an erroneous and inflammatory report. They dismissed the nooses as a housekeeping violation, not a suicide risk, disregarding the fact that an Adelanto detainee used a bed sheet to hang himself in March 2017.

We recently uncovered a third investigation of Adelanto by the Office of Civil Rights and Civil Liberties, or CRCL. CRCL visited Adelanto in December 2015 and November 2017. In 2015, CRCL had warned ICE that Adelanto's medical leadership was not competent. In 2017, they found no evidence that corrections were made to address this issue. This led to, in their words, inadequate detainee medical care that resulted in medical injuries, including bone deformities and detainee deaths.

CRCL also found that mentally ill detainees were being placed in solitary confinement instead of being treated, sometimes for shocking lengths of time.

Overuse of solitary is a problem throughout the ICE system. Sometimes it has fatal consequences, as it did for 2 men who committed suicide at the Stewart Detention Center in Georgia in May 2017 and July 2018. Both Jean Carlo Jimenez-Joseph and Efrain De La Rosa suffered from schizophrenia. Instead of receiving psychiatric treatment, both were placed in solitary confinement for weeks as their symptoms grew more and more alarming. Both hanged themselves in their isolation cells.

Despite the 2 deaths, Nakamoto Group inspectors found that Stewart was in compliance with all 39 applicable ICE detention standards in both 2017 and 2018.

Inadequate medical care led to another death at the ICE Detention Center in Aurora, Colorado. Kamyar Samimi went into methadone withdrawal when he arrived there. For 2 weeks his symptoms grew worse and worse, but the medical staff believed he was faking or exaggerating them, even when he became too weak to sit up.

There were many other credible reports of medical neglect at Aurora, including one case where a detainee's untreated bedsores became so severely infected that his leg had to be amputated.

Despite all this evidence, Nakamoto Group inspectors found that Aurora was in compliance with 41 of 41 applicable detention standards in both 2017 and 2018.

Let me close with some steps Congress can take to improve oversight of ICE detention.

No. 1, Congress should require DHS to impose financial consequences for documented violations of detention standards no matter which type of inspection uncovers them.

No. 2, in 2017, DHS suspended a policy that limited detention of individuals known to be suffering from serious physical or mental illness who are disabled, elderly, pregnant, or nursing, or whose detention is otherwise not in the public interest. Congress should require DHS to reinstate it.

No. 3, Congress should place binding restrictions on DHS's ability to transfer funds in order to expand detention.

No. 4, Congress should strengthen the authority and transparency of the Office of Civil Rights and Civil Liberties.

Thank you very much. Happy to take any questions.

[The prepared statement of Ms. Hawkins follows:]

PREPARED STATEMENT OF KATHERINE HAWKINS

SEPTEMBER 26, 2019

Chairwoman Torres Small, Ranking Member Crenshaw, and Members of the subcommittee, thank you for the opportunity to testify today on oversight of immigration detention centers.

I am Katherine Hawkins, a senior legal analyst for The Constitution Project at the Project On Government Oversight. The Project On Government Oversight (POGO) is a nonpartisan independent watchdog that investigates and exposes waste, corruption, and abuse of power, and when the Government fails to serve the public or silences those who report wrongdoing. We champion reforms to achieve a more effective, ethical, and accountable Federal Government that safeguards Constitutional principles.

As part of that work, my colleagues and I have done a series of investigations into conditions in Immigration and Customs Enforcement (ICE) detention centers.[1] I will briefly explain our findings and suggest actions Congress can take to improve oversight of these facilities.

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[1] Nick Schwellenbach, "Confidential Report Warned ICE of 'Inhumane' Use of Solitary Confinement," Project On Government Oversight, September 12, 2019. *https://www.pogo.org/investigation/2019/09/confidential-report-warned-ice-of-inhumane-use-of-solitary-confinement/;* Nick Schwellenbach, Mia Steinle, Katherine Hawkins, and Andrea Peterson, "Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months," Project On Government Oversight, August 14, 2019. *https://www.pogo.org/investigation/2019/08/isolated-ice-confines-some-detainees-with-mental-illness-in-solitary-for-months/;* Katherine Hawkins, "Medical Neglect at a Denver Immigration Jail," Project On Government Oversight, May 21, 2019. *https://www.pogo.org/investigation/2019/05/medical-neglect-at-a-denver-immigration-jail/;* Katherine Hawkins, "Outsourced Oversight," Project On Government Oversight, March 12, 2019. *https://www.pogo.org/investigation/2019/03/outsourced-oversight/;* Ken Silverstein, "Death Valley: Profit and Despair Inside California's Largest Immigrant Detention Camp," Project On Government Oversight, December 22, 2018. *https://www.pogo.org/investigation/2018/12/death-valley-profit-and-despair-inside-californias-largest-immigrant-detention-camp/*.

POGO'S INVESTIGATIONS OF ICE DETENTION FACILITIES

We found serious flaws in ICE's inspection and oversight system and inhumane conditions in ICE detention centers, including the Adelanto, Aurora, and Stewart facilities. Department of Homeland Security (DHS) and ICE documents reveal inadequate medical care, inadequate mental health care, and overuse of solitary confinement.

These problems are chronic, but they have grown worse with the rapid expansion of ICE detention over the last 2½ years. ICE is currently detaining over 52,000 people, in a patchwork of over 200 facilities across the country.[2] This is an increase of over 51 percent from an average daily population of 34,376 in fiscal year 2016.[3]

ICE detention facilities range in size from county jails that hold only a few immigration detainees at a time, to large facilities dedicated exclusively to immigration custody that hold well over 1,000 people. All facilities that hold over 10 ICE detainees are subject to various forms of oversight by DHS. These include annual inspections by an ICE contractor, the Nakamoto Group; inspections by ICE's Office of Detention Oversight; reviews of detainee deaths by ICE's Office of Professional Responsibility; unannounced inspections by the DHS Office of Inspector General; and onsite investigations of detention conditions by DHS's Office for Civil Rights and Civil Liberties (CRCL).

While this may appear to be a rigorous system of inspection and oversight, the system is failing to adequately protect detainees or ensure that facilities comply with detention standards. The Nakamoto Group's inspections, which occur most frequently and can trigger loss of detention facility's contract with ICE, often fail to uncover serious violations. Other inspections are more thorough, but remain hidden from Congress and the public, and ICE fails to implement their recommendations.[4]

As a result, inhumane and unsafe conditions persist for years, sometimes with fatal consequences.

This is not only wrong, but potentially unconstitutional. The Bill of Rights applies to everyone in the United States, not only to citizens. The Supreme Court has held that deliberate indifference to a prisoner's serious medical needs violates the Eighth Amendment's prohibition on cruel and unusual punishment, and circuit courts have held that excessive use of solitary confinement is cruel and unusual. ICE detention is civil, rather than criminal, which means that detainees cannot be subjected to any harmful treatment for the purpose of punishment.

The following are some examples from POGO's investigations of systemic failures in ICE's oversight of detention facilities.

Inadequate Inspections and Mental Health Care at Adelanto

This spring, POGO reported on a dispute between Nakamoto Group inspectors and the Department of Homeland Security inspector general regarding conditions at the Adelanto Detention Facility in California.[5]

In September 2018, the DHS inspector general released an alarming report about conditions uncovered at Adelanto during an unannounced inspection in May 2018. Inspectors found braided bedsheets, which they called "nooses," in 15 of the 20 cells they visited; seriously inadequate medical care; and improper use of solitary confinement.[6]

Weeks later, in October 2018, the Nakamoto Group conducted its own scheduled inspection of Adelanto. Nakamoto inspectors found that Adelanto was in compliance with 40 of 40 ICE detention standards, just as they had in 2017. They dismissed the nooses as a "housekeeping infraction," and accused the inspector general of writ-

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[2] Emily Kassie, "Detained: How the US built the world's largest immigrant detention system," *The Guardian,* September 24, 2019. *https://www.theguardian.com/us-news/2019/sep/24/detained-us-largest-immigrant-detention-trump*.

[3] Kate Morrissey, "Operator moves to expand detention center for migrants in San Diego County," *Los Angeles Times,* June 24, 2018. *https://www.latimes.com/local/lanow/la-me-ln-detention-center-expansion-20180624-story.html*.

[4] Department of Homeland Security Office of Inspector General, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,* OIG–18–67 (June 26, 2018). *https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf*.

[5] Hawkins, "Outsourced Oversight" [see note 1].

[6] Department of Homeland Security Office of Inspector General, *Management Alert—Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California,* OIG–18–86 (September 27, 2018). *https://www.oig.dhs.gov/sites/default/files/assets/2018-10/OIG-18-86-Sep18.pdf*.

ing an "erroneous" and "inflammatory"[7] report—although an Adelanto detainee had, in fact, used a bedsheet to hang himself in March 2017.[8]

Earlier this month, POGO reported on a third investigation of Adelanto, by the Office for Civil Rights and Civil Liberties, obtained through an on-going Freedom of Information Act lawsuit.[9] That document was even more disturbing than the inspector general's report, because it demonstrated that violations at Adelanto had gone unaddressed for years.

CRCL reported that in November 2017, it had conducted an investigation into conditions at Adelanto as a follow-up to a prior investigation in December 2015. CRCL wrote,

"In 2015, CRCL clearly informed Adelanto that clinical leadership was not competent and that problematic medical care was occurring as a result. In 2017—2 years since the 2015 on-site—the experts found no evidence that corrections were made to address this issue. The failure to hire an effective and qualified clinical leader 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 the safety of other detainees."[10]

CRCL recommended that until new medical leadership could be put in place, "at-risk detainees should immediately be removed from the facility and transferred to other facilities with well-functioning medical programs."[11]

CRCL made equally stark findings with regard to mental health care and the overuse of segregation, particularly for detainees with serious mental illness. CRCL's mental health expert wrote that "at the time of our on-site, 26 of the 50 detainees in segregation had serious mental disorders (such as Schizophrenia or other primary psychotic disorders)," and documented "shockingly high" lengths of stays in segregation. These included one detainee who cumulatively spent over 904 days in solitary.[12]

ICE did not respond to our request for comment on the CRCL report. An ICE spokesperson told another reporter that ICE "disagreed with much of" CRCL's review, citing Nakamoto's October 2018 inspection.[13] Moreover, we cannot find evidence that any of the problems with medical and mental health care at Adelanto have been corrected.

Excessive Use of Solitary Confinement

Adelanto is not the only immigration detention facility that has used solitary confinement as a substitute for adequate treatment of detainees suffering from severe mental illness. In August, POGO published a report that examined records of over 6,500 solitary confinement placements across the ICE detention system, from January 2016 to May 2018. We found that "about 40 percent of the records show detainees placed in solitary have mental illness. At some detention centers, the percentage is much higher."[14]

Placing detainees with severe mental illness in segregation instead of providing adequate treatment can have fatal consequences, as illustrated by 2 recent suicides at the Stewart Detention Center in Lumpkin, Georgia. As POGO reported in August:

"Jean Jimenez-Joseph was taken into ICE custody around the beginning of March 2017. In the months before, he had been involuntarily hospitalized multiple times

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[7] Memorandum from Lead Compliance Inspector, The Nakamoto Group, Inc., to Assistant Director for Detention Management, about "Annual Detention Inspection of the Adelanto ICE Processing Center East," October 11, 2018, 2–3. *https://www.ice.gov/doclib/facilityInspections/adelantoEastCa_CL_10_11_2018.pdf*

[8] Hawkins, "Outsourced Oversight" [see note 1].

[9] Schwellenbach, "Confidential Report Warned ICE of 'Inhumane' Use of Solitary Confinement" [see note 1].

[10] Memorandum from Veronica Venture and Dana Salvan-Dunn, Office for Civil Rights and Civil Liberties, to Enforcement and Removal Operation Executive Associate Director Matthew Albence, about Adelanto Correctional Facility Complaints, April 25, 2018, 2. *https://www.pogo.org/document/2019/09/dhs-office-for-civil-rights-and-civil-liberties-review-of-adelanto-sent-to-ice-in-april-2018/*.

[11] Memorandum from Veronica Venture and Dana Salvan-Dunn about Adelanto Correctional Facility Complaints, 2. [see note 10].

[12] On-Site Investigation Report—Adelanto Correctional Facility, November 2017, 3, enclosed in Memorandum from Veronica Venture and Dana Salvan-Dunn about Adelanto Correctional Facility Complaints [see note 10].

[13] Schwellenbach, "Confidential Report Warned ICE of 'Inhumane' Use of Solitary Confinement" [see note 1].

[14] Schwellenbach et al., "Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months" [see note 1].

for schizophrenia and psychosis, and made repeated threats of and attempts at suicide. Jimenez-Joseph's family has alleged in a lawsuit that contrary to agency policies, when ICE officers took custody of him, initially at a county jail, they did not transfer over his 'prior detention records, medical records, and his vitally necessary prescription medication for schizophrenia and psychosis.'

"He was transported to ICE's Stewart Detention Center. There, according to the lawsuit, Jimenez-Joseph eventually did receive an antipsychotic medication but he repeatedly requested that the dosage be increased because 'the voices in his head were getting worse.'

"But due to 'systemic, chronic understaffing' at Stewart, the lawsuit states, particularly for medical and mental health positions, this never occurred. Instead, he was placed in solitary confinement multiple times as his psychiatric symptoms worsened, including for the 20 days before he died. Jimenez-Joseph hanged himself shortly after midnight on May 15, 2017. According to the lawsuit, on the eve of his death, there were ample warnings that his psychological state was dire. The lawsuit states, 'Jean had written "Hallelujah The Grave Cometh" in large, dark letters on the wall' of his solitary confinement cell.

"Efraín De La Rosa, another detainee with a history of severe schizophrenia and psychosis, hanged himself in solitary confinement at Stewart in July 2018. An employee of ICE's Health Service Corps wrote in an email to agency leadership later that year that De La Rosa 'could have been saved' if ICE had responded adequately to 'a total of 12 SEN [Significant Event Notifications] reports prior to his death, depicting suicidal ideation and psychosis.' "[15]

The official ICE review of Jimenez-Joseph's death corroborates his attorney's allegations.[16] De La Rosa's death review still has not been made public.

Nakamoto Group inspectors found that Stewart was in compliance with 39 of 39 applicable detention standards in both 2017 and 2018.[17]

Inadequate Medical Care at Aurora

In May, POGO published an investigation of inadequate medical care at the Aurora Contract Detention Center in Colorado, which a Government source alleged had contributed to the death of Kamyar Samimi in December 2017.[18] Soon after we published our report, ICE released its internal review of Samimi's death, which confirmed our source's account.[19]

Samimi, an Iranian citizen who received a U.S. green card in 1979, was arrested by ICE in November 2017 based on a 12-year-old drug possession conviction.[20] He had been prescribed methadone treatment for opioid addiction for years. In ICE custody, he was abruptly cut off from the drug, and began experiencing increasingly severe withdrawal symptoms. According to the internal review of Samimi's death, medical staff at Aurora never physically examined Samimi, nor did they evaluate his symptoms using a standard medical assessment for opioid withdrawal. They also dismissed his increasing and eventually fatal physical and mental deterioration—including "tremors, pain and weakness, nausea and vomiting, refusing meals, inability to sit up in bed or in a wheelchair, incontinence and signs of dehydration"—as "malingering and seeking drugs."[21] Multiple detention officers told investigators they did not believe Samimi was faking his symptoms, and that "all officers were troubled by what they perceived was a lack of care and concern for Samimi."[22]

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[15] Schwellenbach et al., "Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months" [see note 1].

[16] Erin Donaghue, "ICE review found failures in care of mentally ill detainee who died by suicide," CBS News, August 22, 2019. *https://www.cbsnews.com/news/jean-carlos-jimenez-joseph-ice-review-documented-failures-in-care-of-mentally-ill-detainee-who-died-by-suicide/*.

[17] Memorandum from Lead Compliance Inspector of The Nakamoto Group, Inc., to Assistant Director for Detention Management about "Annual Detention Inspection of the Stewart Detention Center," May 3, 2018, 2. *https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA_CL_05_03_2018.pdf*.

[18] Hawkins, "Medical Neglect at a Denver Immigration Jail" [see note 1].

[19] ICE Office of Professional Responsibility, Detainee Death Review—Kamyar Samimi, May 22, 2018. *https://www.documentcloud.org/documents/6019213-Samimi-Death-Review.html*.

[20] ICE Office of Professional Responsibility, Detainee Death Review—Kamyar Samimi, 1–2 [7–8 in PDF] [see note 19].

[21] Memorandum from Office of Professional Responsibility Assistant Director Jennifer Fenton to Enforcement and Removal Operations Executive Associate Director Matthew Albence, about "Findings—Death of ICE Detainee Kamyar Samimi, May 22, 2018. *https://www.documentcloud.org/documents/6019213-Samimi-Death-Review.html*

[22] Creative Corrections, *Detainee Death Review: Kamyar Samimi Healthcare and Security Compliance Review,* March 6, 2018, 58–9 [103–4 in PDF]. *https://www.documentcloud.org/documents/6019213-Samimi-Death-Review.html*.

We found numerous other credible reports of inadequate medical care at Aurora, including one case in which a detainee's untreated bedsores became so severely infected that his leg had to be amputated.[23]

Nakamoto Group inspectors found that Aurora was in compliance with 41 of 41 applicable detention standards in both 2017 and 2018.[24]

RECOMMENDATIONS

In closing, POGO offers a non-exhaustive set of recommendations for improved oversight of ICE detention facilities.

1. As previously recommended by the inspector general's office, DHS should revise its methodology for annual inspections to ensure that the inspection procedures are adequate to evaluate actual conditions at facilities.[25] DHS should consider whether to replace its annual contract inspections with increased resources for in-house inspections by the Office of Detention Oversight. Finally, DHS should impose financial penalties for violations of detention standards regardless of whether they are uncovered by CRCL experts, spot checks by the inspector general, detainee death reviews, or annual inspections.
2. Given ICE's pattern of providing inadequate mental health and medical care to individuals in custody, Congress should reinstitute and codify the Department of Homeland Security's previous policy limiting detention of individuals: "who are known to be suffering from serious physical or mental illness, who are disabled, elderly, pregnant, or nursing, who demonstrate that they are primary caretakers of children or an infirm person, or whose detention is otherwise not in the public interest."[26]
3. Congress should place binding restrictions on DHS's ability to transfer funds in order to expand ICE detention capacity. ICE has increased the number of people it detains by over 50 percent in the last 2½ years. It is detaining over 10,000 more people than its appropriated budget allows,[27] an expansion that has clearly outstripped the agency's capacity to provide adequate oversight of detention conditions.
4. Congress should strengthen the authority of the Department of Homeland Security's Office for Civil Rights and Civil Liberties to maximize its effectiveness and transparency. POGO would be happy to provide more detailed recommendations for increasing CRCL's effectiveness to Members of Congress and their staffs upon request.
5. Congress should ensure that the DHS Office of Inspector General has sufficient resources to continue its unannounced inspections of ICE and Customs and Border Protection detention facilities.
6. Members of Congress and their staffs should visit detention facilities, and these visits should include interviews with detainees.
7. Congress should pass legislation ensuring that Members cannot be denied access to immigration detention facilities.
8. Congress should request, by subpoena if necessary, and publicly release copies of
   - Reports from on-site investigations by the Office for Civil Rights and Civil Liberties, including recommendations by the office's subject-matter experts; and
   - Detainee death reviews by the ICE Office of Professional Responsibility and the ICE Health Service Corps.
9. Congress should require ICE to conduct investigations and publicly release death reviews for individuals who are released from immigration custody during or shortly before their final hospitalization. Congress should seek information

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[23] Hawkins, "Medical Neglect at a Denver Immigration Jail" [see note 1].

[24] Memorandum from Lead Compliance Inspector, The Nakamoto Group, Inc., to Assistant Director for Detention Management about "Annual Inspection of the Aurora Ice Processing Center," October 4, 2018, 2. *https://www.ice.gov/doclib/facilityInspections/denverCdfCo__CL__10__04__2018.pdf*.

[25] Department of Homeland Security Office of Inspector General, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,* 15 [see note 4].

[26] Memorandum from Secretary of Homeland Security Jeh Charles Johnson to Acting Director of Immigration and Customs Enforcement Thomas S. Winkowski et al., about "Policies for the Apprehension, Detention and Removal of Undocumented Immigrants," November 20, 2014, 5. *https://www.dhs.gov/sites/default/files/publications/14__1120__memo__prosecutorial__discretion.pdf*.

[27] Letter from Senator Chris Van Hollen et al. to Senator Mitch McConnell et al. about diversion of DHS funds, September 13, 2019. *https://www.vanhollen.senate.gov/imo/media/doc/Van__Hollen__CR__and__ICE-CPB__Transfers%20__Letter__to__Leadership.pdf*.

about previous cases of detainees who died soon after their release from ICE custody, including Teka Gulema, Mariee Juárez, Jose Luis Ibarra Bucio, and Johana Medina León.[28]

10. Congress should pass legislation to ensure that the private corporations that participate in the ICE detention system are subject to Freedom of Information Act requests.

Thank you again for the opportunity to testify. I am happy to take your questions.

Ms. TORRES SMALL. I thank all the witnesses for their testimony.

I will remind each Member that he or she will have 5 minutes to question the panel, and I now recognize myself for questions.

Ms. Nakamoto, thank you for being here today, and I recognize your concern about the contracts, but your ICE contract does not prohibit you from testifying at this Congressional hearing, correct?

Ms. NAKAMOTO. Correct. It is just—but this is public.

Ms. TORRES SMALL. Thank you.

As I noted in my opening statement, you are responsible for—Nakamoto inspectors are responsible for reviewing 42 standards that include over 600 elements in just a few days. The OIG is not the only or even the first entity to raise concerns about that process. In fact, more than 3 years ago, the Homeland Security Advisory Council recommended that ICE move away from a broad checklist for inspections.

Ms. Nakamoto, does ICE's current statement of work allow your company to conduct thorough inspections?

Ms. NAKAMOTO. They do. All of my staff have to not only go through the checklist, but they have to know the standards. They have to know the actual information within the standards, within the components within those standards.

Ms. TORRES SMALL. The 600 elements in 3 days, you have enough time to get that done?

Ms. NAKAMOTO. Yes.

Ms. TORRES SMALL. You have enough inspectors?

Ms. NAKAMOTO. Yes.

Ms. TORRES SMALL. OK. You don't need a narrower scope to make sure you are verifying all of those items?

Ms. NAKAMOTO. No. The 3 days on-site are to perform interviews with detainees, staff, and to see the facility itself. The rest of our report writing, we are pulling all of it together, happens after we leave.

Ms. TORRES SMALL. How then do you explain the reports in the OIG report that, for example, a phone wasn't working and they just neglected to check and see if there was a phone—if the phone directed them to or gave them the ability to make a complaint?

Ms. NAKAMOTO. I don't—I don't know all of—I don't have the OIG report memorized, but I know that my staff checked into it.

Ms. TORRES SMALL. What about A-file documentation being reported as complete without actually checking the A-file?

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[28] Tina Vasquez, "Report: In-Custody Deaths of Immigrants Were 'Preventable,'" *Rewire News,* March 2, 2016. *https://rewire.news/article/2016/03/02/report-custody-deaths-immigrants-preventable/;* Joel Rose, "A Toddler's Death Adds To Concerns About Migrant Detention," *NPR,* August 28, 2018. *https://www.npr.org/2018/08/28/642738732/a-toddlers-death-adds-to-concerns-about-migrant-detention;* Amy Taxin, "Family seeks answers in immigrant's death after detention," Associated Press, April 10, 2019. *https://www.apnews.com/8775303f79ee4d44a5959c34a8f3d99d;* Sam Levin, "Trans woman who died after illness in US custody had asked to be deported, family says," *The Guardian,* June 12, 2019. *https://www.theguardian.com/us-news/2019/jun/12/trans-woman-death-us-custody-ice-deportation.*

Ms. NAKAMOTO. My staff check the files according to the standards.

Ms. TORRES SMALL. You are disputing the OIG report on that?

Ms. NAKAMOTO. I am not disputing it. I am telling you that my staff know what they have to look at within the standards.

Ms. TORRES SMALL. What about CDL licenses being reported as existing without confirming the documentation?

Ms. NAKAMOTO. I don't agree with that. My staff always check for the—the credentials that are required within the standards are always checked by the staff.

Ms. TORRES SMALL. The OIG was incorrect in making that observation?

Ms. NAKAMOTO. I believe—I guess, if they said that we didn't, then——

Ms. TORRES SMALL. What about only in interviewing detainees who speak English or using a guard to interpret in Spanish, someone who is in charge of guarding the facility?

Ms. NAKAMOTO. I think there is different ways to find out information of what is going on at the facility, and some of the interview process is informal, some of it is formalized. We have, in fact, since the OIG report came out, we have since formalized the interview process as they suggested.

Ms. TORRES SMALL. Have you formalized the process for making sure that you have enough Spanish-speaking inspectors?

Ms. NAKAMOTO. Yes. We have a language line that we are also able to use at any facility.

Ms. TORRES SMALL. In terms of Spanish-speaking inspectors and certifying that they do actually speak Spanish, do you have a system for that?

Ms. NAKAMOTO. I don't understand what you are asking me.

Ms. TORRES SMALL. OK. So you don't have a system for establishing if someone—if an inspector actually does speak Spanish, if they are claiming to?

Ms. NAKAMOTO. We have about a quarter of our staff that speaks Spanish.

Ms. TORRES SMALL. It says they speak Spanish. How do you confirm it?

Ms. NAKAMOTO. They ask the detainees questions in Spanish.

Ms. TORRES SMALL. But you don't—do you speak Spanish?

Ms. NAKAMOTO. I do not.

Ms. TORRES SMALL. Can you then determine that they are using correct language?

OK. Just quickly to move on, ICE has concurred with OIG's recommendations for finding—redefining the scope of work. Why hasn't Nakamoto?

Ms. NAKAMOTO. Why hasn't Nakamoto——

Ms. TORRES SMALL. Concurred with those—the recommendation to revise the statement of work.

Ms. NAKAMOTO. To revise the statement of work?

Ms. TORRES SMALL. So that you have more time or are more targeted in your—in evaluating those elements?

Ms. NAKAMOTO. I mean, we have been doing this for a long time. We do this for other agencies. The same amount of time is on-site.

It is—there is—I don't—we have never said that we needed more time.

Ms. TORRES SMALL. Thank you.

I will recognize my colleague, Mr. Crenshaw from Texas, for 5 minutes.

Mr. CRENSHAW. Thank you, Chairwoman.

I am going to follow up with that exact line of questioning about the more time issue, because it seems from our perspective that Nakamoto inspectors said to, I believe, the inspector general that there is more time required. Is that not what you have heard?

Ms. NAKAMOTO. That there is more time?

Mr. CRENSHAW. More time per inspection. More time for inspection in order to meet the criteria for all of those bullet points that you have to hit.

Ms. NAKAMOTO. I mean, we have—my staff have not complained about the amount of time that they have. They have to—they have the 3 days on-site and that is how long it is.

Mr. CRENSHAW. They haven't complained to you specifically about it? Because it is—from other reports they have said that. So it is at least something to think about or at least get feedback from your own staff on, I believe, because there does seem to be quite a few requirements that perhaps there is not enough time to look into.

If that is the case, then restructuring the requirements is certainly in line. Four days instead of 3 days is not exactly a huge stretch of the imagination. It is something we could easily do.

But aside from the time difference, do your employees, do your inspectors come to you with any other issues regarding the inspection process? Is it not clear enough? OK, we have already established you think they have enough time, but what else?

Ms. NAKAMOTO. We work very closely with ICE. My team works very closely with ICE. If there is any issues that come up, then we have a good relationship with letting ICE know what the issues are.

Mr. CRENSHAW. What about the OIG report? Just generally speaking, do you think that report is valid? You don't have to go into specifics, because, like you say, you don't have it in front of you, but generally speaking, what issues do you agree with or disagree with in that report?

Ms. NAKAMOTO. I think that what they see at the time that they are there or what they looked at could be different from what we are looking at. We are looking at things from a different perspective because our team kind-of knows what to look for when they go on-site, so they—based off of whatever they are seeing, based off of their past experience, our team has, you know, over 35 years' experience in detention management, so they know kind-of what they are looking at when they walk into a room.

Mr. CRENSHAW. OK. Ms. Hawkins, I will go to you, because you said some things that were very shocking. For instance, the nooses. You said that you all found nooses which the Nakamoto Group did not find.

You want to expand on that? Are you implying—how many nooses are we talking about? What is the implication there?

Ms. HAWKINS. Sure. So just as a point of clarification, that was—I was conveying the OIG report's findings.

Mr. CRENSHAW. OK. Do you know how many nooses we are talking about, what the implication of that is?

Ms. HAWKINS. I think it was 15 or 20. I do think that——

Mr. CRENSHAW. OK. You proceeded to connect that to suicide. So the implication is that there is like—that there is almost a factory line of nooses being created for suicides. Probably not the case, right?

Ms. HAWKINS. Yes.

Mr. CRENSHAW. But that was the implication in your statement.

Ms. HAWKINS. So my statement was brief, but if you look at the report my organization did on this dispute——

Mr. CRENSHAW. Would it be maybe logical to think that the sheets were being braided for the reasons that Nakamoto Group claimed they were, which was privacy within the cells? Is that possible?

Ms. HAWKINS. Yes. I think——

Mr. CRENSHAW. Would it be important to maybe clarify that when we say something like there is a bunch of nooses found in a facility?

Ms. HAWKINS. Yes.

Mr. CRENSHAW. I mean, it is a pretty important clarification, right?

Ms. HAWKINS. Yes, if I could respond, please.

My organization said that and the inspector general said that they were primarily used for privacy. But——

Mr. CRENSHAW. Just an important clarification, because this stuff gets really out of hand.

You also mentioned some suicides in other facilities, which are absolutely terrible. Were you connecting the—were there deficiencies that were noted later which were not caught by the inspectors that were directly connected to those incidents?

Ms. HAWKINS. Yes.

Mr. CRENSHAW. Like what?

Ms. HAWKINS. I think chronic understaffing of medical care and mental health care.

Mr. CRENSHAW. According to ICE standards or according to your standards?

Ms. HAWKINS. According to ICE standards.

Mr. CRENSHAW. OK. So do you have any more detail on exactly what we are talking about here?

Ms. HAWKINS. I would refer you to the detainee death review for the Jimenez-Joseph case, which became public recently. I don't know if the detainee death review for the other detainee who committed suicide at Stewart is publicly available. I would definitely encourage the committee to request a copy of that to get details on that.

Mr. CRENSHAW. OK. Thank you.

Ms. TORRES SMALL. Thank you.

The Chair recognizes for 5 minutes the gentlewoman from New Jersey, Mrs. Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Chair.

Thank you very much for being here. Thank you for your testimony.

Ms. Nakamoto, how many employees do you have that are inspectors?

Ms. NAKAMOTO. I have about 45 part-time employees.

Mrs. WATSON COLEMAN. Could you put your microphone on, please?

Ms. NAKAMOTO. I am sorry. Sorry. Sorry.

We have 45 part-time employees and 12 full-time employees.

Mrs. WATSON COLEMAN. How many facilities do you have a contractual relationship with ICE to do whatever it is that I am going to ask you that you do? How many facilities?

Ms. NAKAMOTO. So our contract is with ICE.

Mrs. WATSON COLEMAN. For how many facilities?

Ms. NAKAMOTO. As many as they ask us to inspect.

Mrs. WATSON COLEMAN. Do you have any limit in your contract that says you were being contracted to do 50 of the 200 facilities or whatever?

Ms. NAKAMOTO. The way they do it is in intervals and we inspect at least about 120 a year.

Mrs. WATSON COLEMAN. Of facilities?

Ms. NAKAMOTO. Facilities.

Mrs. WATSON COLEMAN. With 45 part-time inspectors and 12 full-time?

Ms. NAKAMOTO. Uh-huh.

Mrs. WATSON COLEMAN. What are the credentials of these inspectors and the experience that they are supposed to have?

Ms. NAKAMOTO. They have to have—there is a—within our Statement of Work it declares what the credentials have to be.

Mrs. WATSON COLEMAN. What I am asking you, what do they have to be?

Ms. NAKAMOTO. They have to have 10 years' experience in a correctional setting. They have to be wardens. We have wardens. We have superintendents of corrections. We have——

Mrs. WATSON COLEMAN. Do they actually do the inspections or do they oversee other inspections that are done?

Ms. NAKAMOTO. No, they actually do the inspections.

Mrs. WATSON COLEMAN. So what is this 3-day limitation? Is this something that the contract calls for? Is this something that you all decided was the best practice? Is this——

Ms. NAKAMOTO. It is within the contract. We have a similar contract with the Department of Justice and it is the same thing.

Mrs. WATSON COLEMAN. When does your contract run out with ICE?

Ms. NAKAMOTO. It just—I believe March 2020.

Mrs. WATSON COLEMAN. March.

What is the value of your contract?

Ms. NAKAMOTO. I don't have that in front of me.

Mrs. WATSON COLEMAN. What do you estimate it to be about?

Who do you have with you on staff?

Ms. NAKAMOTO. I am sorry?

Mrs. WATSON COLEMAN. Who is with you from your staff?

Ms. NAKAMOTO. My vice president and my chief financial officer.

Mrs. WATSON COLEMAN. Can your chief financial officer be able to whisper in your ear what the value of your contract is?

Ms. NAKAMOTO. Three million dollars.

Mrs. WATSON COLEMAN. That is a lot of money. OK.

Ms. Hawkins, some of the—first of all, you are only testifying about the OIG report, nothing that you or your organization have seen for yourself, right?

Ms. HAWKINS. One of my colleagues has gone to Adelanto, but my reporting relies mainly on Government documents and a whole lot of phone interviews.

Mrs. WATSON COLEMAN. OK. So in the facilities that you mentioned there was inadequate mental health services, inadequate other health care services, inadequate food, and inadequate something else, I don't remember, just something else. Are any of those the facilities that the Nakamoto Group has a contract to inspect?

Ms. HAWKINS. Yes. They are some of ICE's largest facilities, so I think they are inspected on an annual basis.

Mrs. WATSON COLEMAN. OK.

Ms. Nakamoto, in 2009 ICE detention facilities, they frequently failed inspections, and beginning in 2009 appropriations law precluded DHS from continuing contracts for facilities if the 2 most recent overall performance ratings, evaluations received are less than adequate.

In the last 5 years, are you aware of any of the over 72-hour facilities that has received an overall final rating of less than 2, adequate? Less than adequate? Did your inspections——

Ms. NAKAMOTO. Are you asking me if we have any——

Mrs. WATSON COLEMAN. I am asking you if you have knowledge of any of these facilities—of any facilities that you all are responsible for inspecting that has received an overall final rating of less than adequate.

Ms. NAKAMOTO. Yes.

Mrs. WATSON COLEMAN. How many?

Ms. NAKAMOTO. Six this year alone.

Mrs. WATSON COLEMAN. What did do you with those findings?

Ms. NAKAMOTO. We put them in the report and submit it to ICE.

Mrs. WATSON COLEMAN. What has happened in those facilities?

Ms. NAKAMOTO. Well, one that I know off of the top of my head had a follow-on that we went back after they established a corrective action plan and our team goes back in after so many days and we have to go in and inspect it again.

Mrs. WATSON COLEMAN. Let me ask you a question real quick. Do you know——

Ms. TORRES SMALL. I apologize.

Mrs. WATSON COLEMAN. I have 16 seconds—19 seconds——

Ms. TORRES SMALL. Actually you are 20 over.

Mrs. WATSON COLEMAN. Oh, over. Oh.

Ms. TORRES SMALL. I am sorry. Thank you so much, Mrs. Watson Coleman.

Mrs. WATSON COLEMAN. Thank you. I yield back.

Ms. TORRES SMALL. The Chair recognizes for 5 minutes the gentlewoman from Nevada, Ms. Titus.

Ms. TITUS. Thank you. I will yield some time to Mrs. Watson Coleman so she can finish her question.

Mrs. WATSON COLEMAN. Thank you to my colleague.

I just wanted to know any of these facilities were facilities that had 2 ratings, 2 sequential ratings of less than adequate. If so, are they not supposed to lose their ability to serve in this capacity and, to your knowledge, have any of them? That is my question. Thank you.

Ms. NAKAMOTO. I don't know. I could get that information and submit it for the record.

Mrs. WATSON COLEMAN. Thank you.

Ms. NAKAMOTO. I don't have that information in front of me.

Mrs. WATSON COLEMAN. Thank you.

Thank you.

Ms. TITUS. Reclaiming my time. Thank you.

Ms. Hawkins, last month your organization POGO released a report on the increased use of solitary confinement or segregation, it is called by ICE. According to the report, the Henderson Detention Center, which is in southern Nevada, was among the top 15. They used segregation 121 unique times, 121 unique placements, and 16 of those placements lasted more than 75 days.

I wonder if you could explain what ICE detention standards dictate regarding the use of segregation and if you are aware of any waivers that were granted by ICE for compliance with the standards?

Ms. HAWKINS. Thank you for your question. I can probably speak more generally to ICE's waiver process and segregation standards than specifically in regard to the Hendersonville facility.

Ms. TITUS. OK.

Ms. HAWKINS. In general, in 2013 ICE directed that facilities reform their practice on segregation, improve reporting on when vulnerable detainees are placed in segregation or anyone is placed for a long period, and try to use it only as a last resort.

They also recommended that facilities try to—when a detainee is held in administrative segregation, protective custody, or for health reasons or other reasons that are not punishment for a disciplinary infraction, that they should receive the same privileges that detainees in the general population receive, which would mean they don't spend 23 hours locked in their cell.

We have found, speaking to former ICE officials and inspectors and others, that that exception has—that has not been implemented. Most facilities say that it is just not practical for them to give people privileges in administrative segregation. You know, most ICE facilities are jails, and county jails, you know, they just continue to have segregation, meaning solitary. So that provision isn't being adequately implemented.

Ms. TITUS. So is that when they grant a waiver? Are there any standards for granting waivers?

Ms. HAWKINS. I don't know if—I think I would need to examine the more detailed inspections on the use of solitary. I don't know if there in—I know that on DHS's website there is now a list of waivers, and I don't know if it is one of those or if it is just a general practice where it is found to be technically compliant with the standard, because the detention standards do tend to have some flexibility in their language.

Ms. TITUS. Is there something, Ms. Nakamoto, that you check when your inspectors go out to look into the use of solitary confinement?

Ms. NAKAMOTO. We do. There are standards—within ICE standards, there are standards that are for segregation. Our staff go through and ensure that the standards are within compliance at the facilities.

Ms. TITUS. Do you find those numbers kind-of high, 121 placements and 16 of them lasted more than 75 days over just a year and a half?

Ms. NAKAMOTO. Well, segregation and solitary confinement are not the same.

Ms. TITUS. OK. Well, how about explaining to me what the difference is?

Ms. NAKAMOTO. Well, segregation is—there is different variances of segregation. It could be for disciplinary, it could be for administrative. There is different types. Then within those types, there is different components within the standards.

Ms. TITUS. It doesn't seem to me you know very much about this business.

My time is up.

Ms. TORRES SMALL. We will do another round. I would appreciate it if folks would stay if they have other questions.

I want to follow up on announced versus unannounced visits.

Ms. Nakamoto, when you conduct an inspection for ICE, how much notice does a facility get?

Ms. NAKAMOTO. I believe—60 days? Thirty days.

Ms. TORRES SMALL. Ms. Hawkins, when conducting an inspection of a detention facility, is it better to announce the visit ahead of time or to conduct the inspection unannounced?

Ms. HAWKINS. Other things being equal, it is better to conduct an unannounced inspection. There is, as you mentioned in your opening statement, there is a tendency to clean things up before the inspectors arrive.

One caveat to that. I know that the Office of Inspector General conducts unannounced inspections that have been very valuable in bringing poor conditions to light.

The Office of Civil Rights and Civil Liberties does tend to announce their inspections further in advance, but they do so in part because they bring independent experts along. So part of why they announce the inspection is to request that medical files be pulled for the medical inspector to interview, to make sure that they are able to speak with the clinical staff. They are doing a really in-depth look. They do many fewer inspections than Nakamoto Group does.

So there can be a place for inspections announced in advance, but if it is going to be a quick check to, you know, check the food, check the cleanliness of the cells, things of that nature, it is much better to be unannounced.

Ms. TORRES SMALL. Thank you, Ms. Hawkins.

Committee staff recently visited a few ICE detention facilities in Mississippi and Louisiana. Staff heard from detainees that prior to their arrival, walls were painted, new curtains were put up, and even flower beds were placed outside.

Do you think it is wise to give facilities advanced notice when conducting these inspections, Ms. Nakamoto?

Ms. NAKAMOTO. Well, currently we have another contract with the U.S. Marshals Service where we don't announce.

Ms. TORRES SMALL. Do you think that is better?

Ms. NAKAMOTO. We just do what the—that contract does unannounced visits, and these are unannounced inspections, and this contract does announced inspections. It is ICE's—we kind-of do what it says in our contract. So they announce. That is there——

Ms. TORRES SMALL. Given your experience inspecting facilities, do you find that you more regularly determine the true conditions of a facility if you are unannounced?

Ms. NAKAMOTO. I think so.

Ms. TORRES SMALL. Thank you.

I will yield the rest of my time and recognize the gentleman from Texas for 5 minutes, Mr. Crenshaw.

Mr. CRENSHAW. Thank you, Madam Chairwoman.

Ms. Nakamoto, have you ever recommended that a facility no longer be utilized by ICE or made specific recommendations about what must be improved at a facility? Just trying to get a sense of the process there.

Ms. NAKAMOTO. OK. So what we do is we provide a recommendation based on whether or not the facility met the standards, the components within the standards met the standards.

To answer Ms. Titus' question, I believe, none of the failed 2 consecutive inspections, we have never had that, but we have had where all of the detainees were removed after a failed inspection. So we recommend on every—all of our reports—what the final recommendation is based on however many components they met or did not meet.

Mr. CRENSHAW. OK. What were some of the more serious examples that you would cite? It is good for everybody to understand the——

Ms. NAKAMOTO. Like life safety issues, medical issues, their food safety, food. Those are the major things. If there is a life safety issue, then it would——

Mr. CRENSHAW. What would be an example of a life safety issue?

Ms. NAKAMOTO. Well, I don't know the standards by heart, but if there is—there are certain rules within the life safety issue that—or the life safety standards that—like, for example, fire drills. They are supposed to do fire drills a certain way, a certain time, a certain amount of times throughout the year.

Mr. CRENSHAW. OK.

Ms. NAKAMOTO. So, I mean, that is just like an example of one of the things that they have——

Mr. CRENSHAW. OK.

Mr. NAKAMOTO [continuing]. Their safety inspector has to go through.

Mr. CRENSHAW. The reason I asked, for example, is because it is important to realize when you say the words life safety, that can mean something very extreme. When you say fire drills, it is a little less extreme. So I am just really trying to—that is what I am trying to get at, some examples here.

Ms. NAKAMOTO. OK.

Mr. CRENSHAW. If you don't have any, we don't have any.

Going back to the scope, I mean, one of the main problems, it seems, and one of the reasons there was a report in the first place is because the Office of Detention and Oversight finds additional deficiencies in the same facilities that the Nakamoto Group did not. You have a much broader scope than they do.

Can you speak to that? Is that the right way to do things? Should the scopes be similar? Is it better that they are different in order to—because there is overlap? What is your general take on the scope of inspection for Nakamoto Group as per the contract?

Ms. NAKAMOTO. Well, comparing our inspection compared to their inspection, it is my understanding that their inspection is more targeted based off of something that we—if our report says that it doesn't—they don't meet the standards within this many standards or whatever, then they send their team in. But there the difference is is that they are sending in more people to inspect for less standards and less components because it is a more targeted inspection of——

Mr. CRENSHAW. I see. Does that make your job more difficult when you have a much broader scope?

Ms. NAKAMOTO. I don't think it makes our job difficult. We have access to those reports. If there has been an ODO inspection at the facility we are going to, we get their report so we can see whatever findings they found to make sure that they have——

Mr. CRENSHAW. Yes. I guess the question is about thoroughness, you know. If your scope is so much more broad than ODO's, is there a lack of depth within the inspection that is subsequent to that scope?

Ms. NAKAMOTO. I think the scope, for our scope of work, it talks to the whole amount of standards, all of the ICE detention standards. They created all of these standards, and they all must be reviewed annually. The targeted inspections are just that, targeted, so they are only looking at a certain——

Mr. CRENSHAW. I see. You are saying that you are comparing apples and oranges——

Ms. NAKAMOTO. Yes.

Mr. CRENSHAW [continuing]. To an extent?

OK. Thank you.

Thank you, Madam Chair. I yield the rest of my time.

Ms. TORRES SMALL. Thank you.

The Chair now recognizes for 5 minutes the gentlewoman from New Jersey, Mrs. Watson Coleman.

Mrs. WATSON COLEMAN. Thank you.

Ms. Nakamoto, your inspections are annual, which means that these facilities know that you are coming just once a year, right, and you are there for 3 days?

Ms. NAKAMOTO. Yes.

Mrs. WATSON COLEMAN. Do you go like clockwork? Is it a year from the time you went before? They can sort-of anticipate when you are coming even if you don't call them and tell them?

Ms. NAKAMOTO. We receive our schedule from ICE.

Mrs. WATSON COLEMAN. Oh, OK.

Tell me—can you tell me really quickly, can you list the other Federal agencies you have a similar contract with, some of which

you do inspections without notifying people in advance? What other agencies do you have contracts with?

Ms. NAKAMOTO. U.S. Marshals Service.

Mrs. WATSON COLEMAN. And? That is it?

Ms. NAKAMOTO. Yes.

Mrs. WATSON COLEMAN. That is the only other one?

Ms. NAKAMOTO. Yes.

Mrs. WATSON COLEMAN. OK.

In a December 2018 letter to Members of the Senate, you quite aggressively disputed some of OIG's reporting. In fact, the letter pulls quotes from your inspection of the Adelanto facility directly in response to some of the OIG findings. For example, you allege that the OIG's findings in the Adelanto facility regarding hanging nooses, or whatever you want to call them, and inadequate dental care was inaccurate and an embarrassment to their office and ICE.

Is it part of your contract with ICE to refute findings that the OIG or other groups find in their inspections of facilities? That is a yes or a no.

Ms. NAKAMOTO. No.

Mrs. WATSON COLEMAN. You also said in your letter that: Our reports can only include that which was verified while we were on-site notwithstanding any changes that may have occurred before or after the inspection.

If your inspectors were at Adelanto in October 2018, how could you then dispute that which was observed by the OIG 5 months earlier?

For example, you claim the OIG was wrong in noting that a detainee in a wheelchair had not left his wheelchair since his recent arrival and had not accessed any of the hygiene products in the bag given to him. But your inspectors were not present for that inspection, so how could you possibly claim that the OIG's findings were not true?

Ms. NAKAMOTO. Because my staff went back and looked at the actual records.

Mrs. WATSON COLEMAN. Did you see the man sitting in the wheelchair, or had he been moved?

Ms. NAKAMOTO. They asked——

Mrs. WATSON COLEMAN. Five months later, ma'am, 5 months later.

Finally, your letter says that DHS ICE detention program has dedicated significant resources—and they certainly have—to ensure the proper care of ICE detainees in compliance with the standards.

Do you think that it is appropriate for your company to make that kind of statement that suggests ICE is doing everything properly, even though I know that you are particularly a beneficiary of their resources? Do you believe that that is a reasonable position for you to take? It is kind-of a yes or a no.

Can I take your silence as a yes or a no?

Ms. Hawkins, are you familiar with the Nakamoto letter?

Ms. HAWKINS. Yes, I am.

Mrs. WATSON COLEMAN. Did you all have a position on whether or not it raised concerns about their objectivity?

Ms. HAWKINS. It did strike me as strange to see a criticism of a previous inspection in the Nakamoto inspection.

I looked into this a bit when I wrote an article on ICE inspections which was published earlier this year, and one of the criticisms that Nakamoto made of the OIG inspections were that OIG didn't have people with experience in detention or corrections. When I asked around, people said, well, that is true, it is possible that OIG got certain details wrong or misunderstood things.

But then—so that is why it was so striking to see the reports from the Office of Civil Rights and Civil Liberties, which were from before both the OIG report and the subsequent Nakamoto report. If anything, they were more critical than the OIG was.

Mrs. WATSON COLEMAN. Thank you. I yield back.

Ms. TORRES SMALL. Thank you both for your testimony.

I am now going to welcome our second panel of witnesses, and thank you for joining us today.

Our first witness is Ms. Diana Shaw, assistant inspector general for special reviews and evaluations at the DHS Office of the Inspector General. Prior to serving in this role, Ms. Shaw served—oh, OK. I am sorry. I apologize. We will wait until you are seated.

All right. Thank you so much. I apologize for the early jump start here.

I now welcome our second panel of witnesses, and thank you for joining today.

Our first witness is Ms. Diana Shaw, assistant inspector general for special reviews and evaluations at the DHS Office of Inspector General. Prior to serving in this role, Ms. Shaw served in several leadership positions within the OIG, including AIG for legal affairs, acting counsel to the IG, director of the special reviews group, and acting AIG for external affairs.

Our second witness, Mr. Tae Johnson, is the assistant director for custody and management, enforcement and removal operations at ICE. Mr. Johnson began his career with former Immigration and Naturalization Service in 1992. Since transferring to ICE headquarters in 2007, he has served in a number of leadership roles, including as chief of staff for the Office of Detention Policy.

Without objection, the witnesses' full statements will be inserted into the record. I now ask each witness to summarize his or her statements for 5 minutes, beginning with Ms. Shaw.

STATEMENT OF DIANA R. SHAW, ASSISTANT INSPECTOR GENERAL, SPECIAL REVIEWS AND EVALUATIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HOMELAND SECURITY

Ms. SHAW. Chairwoman Torres Small, Ranking Member Crenshaw, and Members of the subcommittee, thank you for inviting me to discuss OIG's recent work regarding oversight of ICE detention facilities.

ICE is responsible for overseeing the administrative detention of tens of thousands of removable aliens. As of this summer, ICE had approximately 54,000 beds occupied across approximately 200 detention facilities Nation-wide. These facilities are governed by standards that aim to establish consistent conditions of confinement in the ICE detention system.

In an effort to ensure compliance with these standards, ICE has developed a multi-layered approach to detention oversight, which

includes a combination of on-site monitoring and inspections performed by ICE personnel and contracted service providers.

These oversight activities have resulted in the identification and correction of numerous instances of noncompliance with detention standards. However, the volume of new and repeat deficiencies identified through the OIG's independent inspections raises questions about the overall effectiveness of ICE's multi-layered oversight approach.

Since fiscal year 2016, the OIG has been conducting unannounced inspections of ICE detention facilities. These unannounced inspections have identified a range of deficiencies, including unreported security incidents, dangerous mishandling of food, dilapidated physical conditions, and unaddressed security risks.

For instance, the OIG staff found that staff at the Essex County correctional facility in New Jersey had failed to report to ICE a loaded handgun discovered by a detainee in a facility bathroom. At the Adelanto Processing Center in California, a facility at which at least 7 suicide attempts by hanging were made in less than a year, OIG inspectors observed braided bed sheets, referred to as nooses by center staff and detainees, in 15 of the 20 cells we visited.

Serious issues like these raise questions about the effectiveness of ICE's multi-layered approach and prompted the OIG to review the entities involved in providing oversight at each layer.

At one layer is the Nakamoto Group, a private company with which ICE contracts to annually inspect facilities holding ICE detainees. At the time of our review, Nakamoto was inspecting about 100 facilities per year to evaluate compliance with 39 to 42 detention standards.

ICE's Office of Detention Oversight, or ODO, provides another layer of oversight. At the time of our review, ODO was inspecting approximately 30 facilities per year to determine compliance with 15 to 16 core standards.

Finally, ICE stations detention service managers, or DSMs, on-site at select facilities to continuously monitor compliance with standards.

The OIG's work has revealed shortcomings within each layer of the system. For instance, the inspection scope outlined in ICE's contract with Nakamoto is much too broad to ensure thorough inspections. As a result, Nakamoto's inspections do not always fully examine actual conditions at the facilities or identify all compliance deficiencies.

In contrast, ODO inspections are narrower in scope and use effective methods to thoroughly inspect facilities. However, ODO's inspections are relatively infrequent, making it difficult for ODO to ensure that facilities are addressing all deficiencies.

Finally, while the DSMs providing on-site monitoring at facilities frequently identify deficiencies and propose corrective actions, they have no authority to compel implementation of those actions. As a result, it falls to ICE field offices, some of which may be resistant to working with the DSMs, to implement necessary changes.

The challenges the OIG has identified at each layer of ICE's oversight system render the overall approach less effective than it otherwise could be. Meanwhile, ICE continues to spend millions of

dollars on detention oversight without achieving comprehensive, consistent compliance.

ICE can and should be doing more. For instance, ICE does not fully utilize tools available to it to drive compliance among its contractors. Our recent review of ICE's management of detention contracts found that ICE is failing to use quality assurance tools and impose consequences for contract noncompliance. Moreover, we found that instead of holding facilities accountable through available financial penalties, ICE frequently issued waivers to deficient facilities, exempting them from having to comply with detention standards.

Until ICE fully implements appropriate corrective action, ICE's multi-layered approach to oversight will not be as effective as it needs to be.

Ms. Chairwoman, this concludes my testimony, and I am happy to answer any questions you or the subcommittee may have.

[The prepared statement of Ms. Shaw follows:]

PREPARED STATEMENT OF DIANA R. SHAW

SEPTEMBER 26, 2019

Chairwoman Torres Small, Ranking Member Crenshaw, and Members of the subcommittee, thank you for inviting me here today to discuss oversight of U.S. Immigration and Customs Enforcement (ICE) detention facilities and the results of the Department of Homeland Security (DHS) Office of Inspector General's (OIG) recent reviews of ICE programs and efforts aimed at detention oversight. My testimony today will focus on the OIG's recent evaluations and inspections of ICE detention facilities and its oversight of those facilities, and our related recommendations for improvement.

While ICE has developed a multi-layered approach to detention oversight, the shortcomings and challenges the OIG's work has identified render ICE's overall approach less effective than it otherwise could be. Until ICE fully addresses the issues identified in our work, it will continue to struggle to ensure comprehensive, consistent compliance with detention standards.

BACKGROUND ON OIG REVIEWS OF ICE DETENTION FACILITIES AND DETENTION FACILITY OVERSIGHT

ICE Enforcement and Removal Operations (ERO) apprehends removable aliens, detains these individuals when necessary, and removes them from the United States. ICE detainees are held in civil, not criminal, custody. ICE detention is administrative in nature, aimed to process and prepare detainees for removal. At the end of fiscal year 2017, ICE held nearly 38,000 detainees in custody. As of the summer of 2019, ICE had approximately 54,000 beds occupied Nation-wide.

During our reviews, these beds were spread across more than 200 facilities, only 5 of which ICE owns. ICE contracts for use of the other 200 facilities through contracts with private entities, inter-governmental service agreements (IGSA), or intergovernmental agreements. For example, at the end of fiscal year 2017, ICE maintained 8 Contract Detention Facilities, or facilities owned and operated by private companies and contracted directly by ICE, and 87 IGSAs, or facilities, such as local and county jails, housing ICE detainees (as well as other inmates).

ICE began operating its detention system under the *National Detention Standards* (NDS), issued in 2000 to establish consistent conditions of confinement, program operations, and management expectations in immigration detention. Along with stakeholders, ICE revised the NDS and developed *Performance-Based National Detention Standards 2008* (PBNDS 2008) to improve safety, security, and conditions of confinement for detainees. With its *Performance-Based National Detention Standards 2011* (PBNDS 2011), ICE aimed to enhance immigration detention conditions while maintaining a safe and secure detention environment for staff and detainees. ICE also uses Family Residential Standards for Family Residential Centers holding families and juveniles. ICE's detention facility contracts and agreements identify the detention standards that apply to those facilities.

As early as 2006, when the OIG first reported on inadequate treatment of ICE detainees in its facilities,[1] and more recently, in response to Congressional mandates, concerns raised by immigrant rights groups, and complaints to the OIG Hotline, the OIG has conducted inspections of detention facilities to evaluate compliance with ICE detention standards. We generally limit the scope of our inspections to the relevant standards for health, safety, access to medical and mental health care, grievances, classification and searches, use of segregation, use of force, and language access. We focus on the elements of the detention standards that can be observed and evaluated by OIG staff who do not have specialized training in the fields of medicine, mental health, or corrections. In addition to a physical inspection of areas used by detainees, during our visits to facilities we also review written documentation and interview ICE and detention facility staff members and detainees. Our public reports about these inspections discuss facility conditions at the time of our visits, and include analysis and conclusions based on our direct observations, review of documentary evidence, and interviews.

The OIG's inspections in 2016 and 2017 raised concerns about detainee treatment and care. For example, in March 2017, we issued a Management Alert after an unannounced inspection of the Theo Lacy Facility (TLF) in Orange, California, raised serious concerns, some that posed health risks and others that violated PBNDS 2008 and resulted in potentially unsafe conditions at TLF.[2] We recommended that ICE take immediate action to ensure compliance with PBNDS 2008 and strengthen its oversight of TLF. ICE concurred with our recommendations.

Our unannounced inspections of detention facilities in fiscal year 2016 also gave rise to significant concerns about the treatment and care of detainees at 4 of the facilities visited.[3] For instance, some facilities had misclassified some detainees with high-risk criminal convictions and, as a result, housed them with low-risk detainees. At one facility, all detainees entering the facility were strip-searched in violation of ICE standards. We also observed potentially unsafe and unhealthy detention conditions, including delayed medical care, mold on walls and showers, and spoiled food.

ICE'S INSPECTIONS AND MONITORING OF DETENTION DO NOT LEAD TO SUSTAINED COMPLIANCE OR SYSTEMIC IMPROVEMENTS

The deficiencies and concerns identified in our detention facility inspections raised questions about the effectiveness of ICE's oversight of these facilities. ICE uses a multi-layered approach to oversight of detention facilities, with various entities—including ICE ERO, ICE's Office of Professional Responsibility (OPR), and private contractors—conducting inspections and on-site monitoring to determine compliance with ICE detention standards. We reviewed the adequacy of these oversight activities, as well as ICE's use of contracting tools to hold detention facilities to applicable detention standards. In 2018, we published a review evaluating whether ICE's immigration detention inspections ensure adequate oversight and compliance with detention standards. Our report found deficiencies in both types of immigration detention inspections ICE uses, as well as in ICE's post-inspection follow-up processes.[4]

ICE uses two inspection types to examine detention facility conditions: (1) Inspections performed by a private company, Nakamoto Group, Inc. (Nakamoto), contracted by ICE ERO Custody Management, and (2) inspections performed by personnel and contractors from ICE's Office of Detention Oversight (ODO) within ICE OPR. ICE also uses Detention Service Managers (DSMs) to provide on-site monitoring of day-to-day facility conditions, and report on and seek to correct issues as they arise.

In conducting our review, we evaluated policies, procedures, and inspections practices. We also observed Nakamoto and ODO inspections and reviewed a judgmental sample of both types of inspection reports. We concluded that neither type of inspection nor the on-site monitoring ensure consistent compliance with detention standards or promote comprehensive deficiency corrections.

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[1] *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities* (OIG–07–01).

[2] *Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California* (OIG–17–43–MA). Management Alerts are a unique product issued by DHS OIG in relatively rare circumstances in which we identify an issue so serious that we deem it necessary to report on the issue before completing our standard inspection or review process. In such instances, we prepare a "Management Alert" to notify the Department of the issue so it can take immediate action to mitigate and/or correct the situation.

[3] *Concerns about ICE Detainee Treatment and Care at Detention Facilities* (OIG–18–32).

[4] *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (OIG–18–67).

We found that the inspections performed by Nakamoto do not fully examine actual conditions or identify all compliance deficiencies, because the Nakamoto inspection scope is too broad and inspection practices are not consistently thorough. Also, although ICE provides Nakamoto with the scope for the inspections, detention review summary forms, and inspection checklists, it does not provide clear procedures for evaluating detention conditions. In contrast, ODO inspections are narrower in scope and use effective methods and processes to thoroughly inspect facilities and identify deficiencies, but the inspections are too infrequent to ensure the facilities implement all corrections.

Moreover, ICE does not adequately follow up on identified deficiencies and, at the time of our review, did not have a comprehensive process to verify that facilities had implemented all the corrective actions. Without holding facilities accountable for correcting deficiencies, the usefulness of both Nakamoto and ODO inspections was further diminished.

In addition, ICE ERO field offices, which are responsible for implementing corrective actions, do not provide consistent support for the DSMs who work on-site and monitor detention conditions in more than 50 facilities. Thus, while DSMs, who identify thousands of deficiencies though their work, have the expertise to propose corrective actions, they do not have the authority to implement them. The lack of consistent support for DSMs hinders implementation of needed changes.

ICE DOES NOT FULLY USE CONTRACTING TOOLS TO HOLD DETENTION FACILITY CONTRACTORS ACCOUNTABLE FOR FAILING TO MEET PERFORMANCE STANDARDS

Another way in which ICE could hold detention facilities to applicable detention standards is through contracting tools. We reviewed how ICE manages and oversees its contracts with the contracted detention facilities housing ICE detainees.[5] Between fiscal year 2016 and fiscal year 2018, ICE paid more than $3 billion to the contractors operating these facilities. We found that ICE is failing to use quality assurance tools and impose consequences for contract noncompliance, such as failure to meet performance standards. Moreover, instead of holding facilities accountable for noncompliance through financial penalties, ICE frequently issued waivers to facilities with deficient conditions, effectively exempting them from having to comply with certain detention standards.

In fact, ICE generally is not imposing financial penalties, even for serious deficiencies such as significant understaffing, failure to provide sufficient mental health observations, and inadequate monitoring of detainees with serious criminal histories. From October 2015 to June 2018, various inspections and DSMs found 14,003 deficiencies at the 106 contract facilities we focused on for our review. Deficiencies included those that jeopardize the safety and rights of detainees, such as failing to notify ICE about sexual assaults and failing to forward allegations regarding misconduct of facility staff to ICE ERO. Despite the quantity and seriousness of the deficiencies, ICE only imposed financial penalties twice.

ICE also has no formal policies and procedures to govern the waiver process, thereby allowing officials to grant waivers without clear authority, and failing to ensure key stakeholders have access to approved waivers. In some cases, officials may violate Federal Acquisition Regulation requirements because they seek to effectuate unauthorized changes to contract terms. Further, contract facilities may be exempt from compliance with otherwise applicable detention standards indefinitely, as waivers generally do not have an end date and ICE ERO does not reassess or review waivers after it approves them.[6]

RESULTS OF OIG'S RECENT UNANNOUNCED INSPECTIONS OF ICE DETENTION FACILITIES

Continuing the OIG's program of unannounced inspections of ICE detention facilities, we recently issued Management Alerts regarding our findings from unannounced inspections of the Essex County Correctional Facility in Newark, New Jersey (Essex Facility)[7] and the Adelanto ICE Processing Center in Adelanto, California (Adelanto Center).[8] We issued these reports because, in the course of our re-

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[5] *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards* (OIG–19–18).

[6] Following the OIG's reporting on the issue of ICE's use of waivers, Congress passed the *Consolidated Appropriations Act, 2019—House Report 116–9,* which established that the "ICE Director shall have sole authority to approve waivers, and shall notify the Committees of such waivers within 3 business days of such approval."

[7] *Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey* (OIG–19–20).

[8] *Management Alert—Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG–18–86).

view, we identified significant health and safety risks that violated ICE standards and required immediate action by ICE.

At the Essex Facility, one of the issues we identified was unreported security incidents. According to ICE standards, the Essex Facility must report to ICE any incidents involving detainees. However, the facility failed to do so following a detainee's discovery and reporting of a guard's loaded handgun left in a facility staff bathroom that the detainee was cleaning. This marked the fourth time in less than a year that the facility failed to notify ICE of incidents involving detainees, and raised serious concerns about the facility's ability to handle security issues.

Interviews with detainees and facility management revealed facility leadership completed a review of the incident, but did not interview the detainee who found the weapon. Rather, facility leadership reported to us that they told the detainee not to discuss the matter with anyone else. The review documented by the facility does not mention that the detainee found and reported the loaded weapon.

During our site visit, we notified ICE of the incident and ICE later issued a contract discrepancy report. The discrepancy report outlined this incident as the fourth time in less than a year that the Essex Facility had failed to notify ICE of detainee-related incidents. On February 27, 2019, ICE imposed a 5 percent deduction of invoiced amounts, the highest penalty allowed under the contract.

Our inspections also revealed health and safety concerns at both the Essex Facility and the Adelanto Center. At the Essex Facility, we observed extreme mishandling of meats, which can spread salmonella, listeria, and E. coli, leading to serious foodborne illnesses. We also observed facility staff serving potentially spoiled meat to detainees. Over a 7-month period in 2018, detainees filed approximately 200 kitchen-related grievances (about 12 percent of all grievances filed) with comments such as:

- "For dinner, we were served meatballs that smell like fecal matter. The food was rotten."
- "The food that we received has been complete garbage, it's becoming impossible to eat it. It gets worse every day. It literally looks like it came from the garbage dumpster; I have a stomach infection because of it and the nurse herself told me it was caused by the food."[9]

We observed violations of the ICE standards at the Adelanto Center that were equally concerning, including braided bedsheets—referred to as "nooses" by center staff and detainees—hanging from vents in 15 of the 20 cells we visited.[10] Interviews with detainees provided a variety of reasons for braiding and hanging bedsheets, with one detainee noting, "I've seen a few attempted suicides using the braided sheets by the vents and then the guards laugh at them and call them 'suicide failures' once they are back from medical." In fact, in March 2017, a 32-year-old male died at an area hospital after being found hanging from his bedsheets in an Adelanto Center cell. In the months after this suicide, ICE compliance reports documented at least 3 suicide attempts by hanging at the Adelanto Center, 2 of which specifically used bedsheets. Media reports based on 9–1–1 call logs indicate at least 4 other suicide attempts at the Adelanto Center from December 2016 to July 2017.[11] In total, these reports represent at least 7 suicide attempts at the Adelanto Center from December 2016 to October 2017. Nation-wide, self-inflicted strangulation accounts for 4 of the 20 detainee deaths reported between October 2016 to July 2018, according to ICE news releases.

In addition to the serious issues highlighted in our reports on the Essex Facility and the Adelanto Center, our program of unannounced inspections identified other instances of noncompliance with standards at these facilities, as well as two others: the LaSalle ICE Processing Center in Louisiana, and the Aurora ICE Processing Center in Colorado.[12] Overall, our inspections of the 4 detention facilities revealed violations of ICE's detention standards and raised concerns about the environment in which detainees are held. Although the conditions varied among the facilities and not every problem was present at each, our observations, interviews with detainees and staff, and reviews of documents revealed several common issues. All 4 facilities had issues with expired food, which puts detainees at risk for food-borne illnesses. At 3 facilities, we found that segregation practices violated standards and infringed

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[9] *Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey* (OIG–19–20).

[10] *Management Alert—Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG–18–86).

[11] Paloma Esquivel, *'We don't feel OK here': Detainee deaths, suicide attempts and hunger strikes plague California immigration facility,* LOS ANGELES TIMES (Aug. 8, 2017), *http://www.latimes.com/local/lanow/la-me-ln-adelanto-detention-20170808-story.html.*

[12] *Concerns about ICE Detainee Treatment and Care at Four Detention Facilities* (OIG–19–47).

on detainee rights. Two facilities failed to provide recreation outside detainee housing units. Bathrooms in 2 facilities' detainee housing units were dilapidated and moldy. Our observations confirmed concerns identified in detainee grievances, which indicated unsafe and unhealthy conditions to varying degrees at all of the facilities we visited.

ICE HAS TAKEN ACTION TO ADDRESS OIG RECOMMENDATIONS AIMED AT IMPROVING OVERSIGHT OF ICE DETENTION

Since fiscal year 2017, we have made 10 recommendations to improve ICE's oversight of detention and 7 recommendations aimed at improving detention conditions. In response to these recommendations, ICE has implemented a number of changes and has initiated others, some of which are nearing completion, including:

- With respect to oversight of detention facilities, we recommended that ICE develop a follow-up inspection process for select facilities where ODO identifies egregious or numerous deficiencies.[13] ICE reported in May 2019 that it has begun the follow-up inspection process and has issued 2 completed reports from follow-up inspections conducted in fiscal year 2018. ICE also provided a schedule for fiscal year 2019 follow-up inspections.
- In response to our recommendation that ICE conduct a full review of the Adelanto ICE Processing Center and the GEO Group, Inc.'s management of the facility to ensure compliance with PBNDS 2011,[14] ICE provided documentation in March 2019 that it has completed a Special Assessment Review of the Adelanto facility, identified deficiencies, and completed corrective actions.
- In response to our recommendation regarding the waiver process (and consistent with the Department of Homeland Security Appropriations Act, 2019 (H.R. 6776)), ICE drafted a Detention Standards Waiver Policy, which will require that the ICE director have sole authority to approve waivers. Additionally, in May 2019, ICE made a complete list of all 181 waivers available on ICE's public website.[15]

Although ICE has been responsive to our recommendations and is taking steps in the right direction, challenges remain. Fully implementing changes and resolving the underlying issues that make ICE detention oversight challenging will require a multi-year commitment and depend heavily on adequate funding and staffing.

ON-GOING OIG WORK RELATED TO ICE DETENTION

In fiscal year 2020, the OIG will continue its on-going program of unannounced inspections of facilities holding ICE detainees. We will report on the results of the fiscal year 2019 inspections later this year. We are happy to brief you and your staff on the results of these inspections when they are finalized.

Chairwoman Torres Small, this concludes my testimony. I am happy to answer any questions you or other Members of the subcommittee may have.

APPENDIX A.—LIST OF OIG REPORTS

OIG REVIEWS OF ICE DETENTION FACILITIES AND DETENTION FACILITY OVERSIGHT

Report Number	Report Title	Date Issued	Status of Recommendations
OIG–07–01.	Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities.	December 2006.	12 Recommendations; all Closed.
OIG–17–43–MA.	Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California.	March 2017	3 Recommendations; all Closed.

[13] *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (OIG–18–67).

[14] *Management Alert—Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG–18–86).

[15] ICE, Facility Inspections, *https://www.ice.gov/facility-inspections.*

OIG REVIEWS OF ICE DETENTION FACILITIES AND DETENTION FACILITY OVERSIGHT—Continued

Report Number	Report Title	Date Issued	Status of Recommendations
OIG–18–32.	Concerns about ICE Detainee Treatment and Care at Detention Facilities.	December 2017.	1 Recommendation; Resolved and Open.
OIG–18–67.	ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements.	June 2018 ...	5 Recommendations; 1, 2, 4, and 5 are Resolved and Open; Recommendation 3 is Closed.
OIG–18–86.	Management Alert—Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California.	September 2018.	1 Recommendation; Closed.
OIG–19–18.	ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards.	January 2019.	5 Recommendations; 1, 2, 3, and 4 are Resolved and Open; Recommendation 5 is Closed.
OIG–19–20.	Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey.	February 2019.	1 Recommendation; Resolved and Open.
OIG–19–47.	Concerns about ICE Detainee Treatment and Care at Four Detention Facilities.	June 2019 ...	1 Recommendation; Resolved and Open.

Ms. TORRES SMALL. Thank you.

I now recognize Mr. Johnson to summarize his statement for 5 minutes.

STATEMENT OF TAE JOHNSON, ERO ASSISTANT DIRECTOR FOR CUSTODY MANAGEMENT, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. JOHNSON. Chairwoman Torres Small, Ranking Member Crenshaw, and distinguished Members of the subcommittee, thank you for the opportunity to testify today regarding ICE's oversight of its detention facilities.

ICE's Enforcement and Removal Operations manages and oversees the Nation's immigration detention system, one of the most highly transient and diverse populations of any detention or correctional system in the world. Detainees placed in ICE custody represent virtually every Nation on Earth, have various security classification and threat levels, and often arrive in ERO custody with complex detention and medical needs.

ERO takes the health, safety, and general welfare of its detained population extremely seriously and is committed to continually evaluating and improving the care detainees receive. Through a robust inspections program, the agency ensures detention facilities used to house ICE detainees do so in accordance with ICE National

detention standards, which are often much more rigorous than those that apply to other detained populations. These standards were promulgated in cooperation with ICE stakeholders, the American Correctional Association, and representatives of non-Governmental organizations to ensure that all individuals in ICE custody are treated with dignity and respect and provided the best possible care.

ICE uses 3 sets of detention standards for its adult detained population, the National Detention Standards, NDS 2000, Performance-Based National Detention Standards, PBNDS 2008, as well the PBNDS 2011. All ICE detention standards must specify the living conditions appropriate for detainees and help to ensure a safe and secure environment and cover such areas as medical care, food service, environmental health and safety, segregation, access to legal and religious services, as well as visitation.

ICE's requirements exceed industry standards, which is evident from the large number of local jails who are unwilling to meet ICE's more rigorous requirements and have instead elected to detain other populations.

PBNDS 2011 was recently revised in 2016 to include important updated standards on disability identification, assessment, and accommodation, as well as medical care for women.

To ensure ICE's detention facilities meet the requisite standards, ICE provides oversight through a multi-layered inspections and monitoring program. ICE conducts annual and biannual inspections of all facilities over a certain population and utilizes a self-inspection process for facilities with small populations or those that house detainees for under 72 hours.

Additionally, the ICE Office of Detention Oversight, the DHS CRCL, and the DHS OIG all conduct reviews and inspections and have open access to ICE detention facilities.

ICE has also enlisted the services of the Nakamoto Group to inspect facilities around the country. This includes annual inspections, preoccupancy inspections, special reviews as ordered by ICE using the applicable detention standards.

Contract inspectors typically spend 3 days auditing each facility, and in addition to an environmental health and safe subject-matter expert, they also employ the services of a health professional and a detainee rights subject-matter expert.

When deficiencies are found during any type of inspection, ERO works with field offices and facilities to ensure timely and corrective actions are implemented.

ICE greatly appreciates the work conducted by the OIG regarding the inspection process and carefully evaluates its recommendations. In a June 26, 2018, report entitled "ICE's Inspection and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements," the IG made 5 recommendations with which ICE concurred and which have been used to implement improvements to our inspections process.

In response to OIG's finding, ICE is reevaluating the existing inspection scope and methodology in the statement of work for its inspections contract to ensure inspections procedures are adequately and appropriately resourced to fully evaluate detention conditions.

ICE has also created a quality assurance team consisting of seasoned Federal employees to perform quality assurance reviews of ICE's contract inspections during each annual inspection. ICE is also developing follow-up inspections processes for select facilities where egregious or numerous deficiencies are identified, updating and enhancing current procedures to ensure verification of all corrective actions, including better tracking of all corrective actions by facility and responsible field office, as well as developing protocols for ERO offices to require facilities to implement formal corrective action plans resulting from deficiencies identified from its on-site monitors.

ICE understands that immigration——

Ms. TORRES SMALL. Mr. Johnson.

Mr. JOHNSON. Yes?

Ms. TORRES SMALL. Your time has expired. If you want to conclude with a sentence.

Mr. JOHNSON. Sure. Thank you for the opportunity to testify today regarding this important matter, and I look forward to answering any questions you guys may have. Thanks.

[The prepared statement of Mr. Johnson follows:]

PREPARED STATEMENT OF TAE JOHNSON

SEPTEMBER 26, 2019

INTRODUCTION

Chairwoman Torres Small, Ranking Member Crenshaw, and distinguished Members of the subcommittee, thank you for opportunity to testify today regarding U.S. Immigration and Customs Enforcement (ICE) oversight of its detention facilities. ICE Enforcement and Removal Operations (ERO) manages and oversees the Nation's immigration detention system, one of the most highly transient and diverse populations of any detention or correctional system in the world. Detainees placed into ICE ERO custody represent virtually every Nation on earth, have various security classifications and threat levels, and often arrive in ERO custody with complex detention needs, including medical care. ERO takes the health, safety, and general welfare of its detained population extremely seriously and is committed to continually evaluating and improving the care detainees receive.

ICE DETENTION STANDARDS

ERO detains individuals to ensure their presence for immigration proceedings and for removal from the United States after they are subject to an executable final order of removal. Detention is an important and necessary part of immigration enforcement, and ICE ERO provides a range of comprehensive services to ensure the welfare of all those in its custody. Through a robust inspections program, the agency ensures detention facilities used to house ICE detainees do so in accordance with ICE National detention standards, which are often much more rigorous than those that apply to other detained populations. These standards were promulgated in cooperation with ICE stakeholders, the American Correctional Association (ACA), and representatives of non-governmental organizations (NGO's) to ensure that all individuals in ICE custody are treated with dignity and respect and are provided with the best possible care.

ICE utilizes a Nation-wide network of detention facilities, including 5 ICE-owned, contractor-operated Service Processing Centers (SPCs), 8 privately-owned and/or operated Contract Detention Facilities (CDFs), 12 Intergovernmental Service Agreement (IGSA) facilities which are dedicated to housing ICE detainees, and approximately 200 shared-use IGSAs.

ICE uses 3 sets of detention standards for its adult-detained population Nationwide the National Detention Standards (NDS) 2000, Performance-Based National Detention Standards (PBNDS) 2008, and PBNDS 2011. All ICE detention standards specify the living conditions appropriate for detainees and help to ensure a safe and secure environment and cover areas such as medical care, food service, environmental, health and safety, the use of segregated housing, access to legal and reli-

gious resources, and visitation. These standards are included in contracts or agreements with both publicly- or privately-operated detention facilities and exceed industry standards—which is evident from the number of local jails who are unwilling to meet ICE's more rigorous requirements and have instead elected to detain other populations.

When ICE was formed, the agency operated its detention system under a set of National Detention Standards (NDS), which were based upon the policies and procedures that existed at the time of its issuance in September 2000. The NDS were drafted to govern every aspect of the detention operations at the ICE-owned SPCs and CDFs and were designed to establish consistent conditions of confinement, programming, and management expectations within the agency's detention system. For many of the requirements, local jails needed to meet the objective of the standard. ICE subsequently undertook a revision of these standards to more clearly delineate the results or outcomes to be accomplished by adherence to their requirements. PBNDS 2008 revised the NDS to outline the results or outcomes to be achieved and to improve the safety, security, and conditions of detainee confinement. PBNDS 2008 prescribed both the expected outcome of each detention standard and the expected practices required to achieve them. Four new standards were added under PBNDS 2008: Searches of Detainees; Sexual Abuse and Assaults Prevention and Intervention; News Media Interviews and Tours; and Staff Training.

In keeping with its commitment to improve the immigration detention system, ICE further revised its detention standards in 2011. PBNDS 2011 reflect ICE's ongoing effort to tailor the conditions of immigration detention to its unique purpose while maintaining a safe and secure detention environment for staff and detainees and represent an important step in detention reform. They were drafted with the input of many ICE personnel across the Nation, as well as the perspectives of DHS's Office for Civil Rights and Civil Liberties (CRCL) and various NGO's. PBNDS 2011 were crafted to improve medical and mental health services, increase access to legal services and religious opportunities, improve communication with detainees with limited English proficiency, improve the process for reporting and responding to complaints, reinforce protections against sexual abuse and assault, and increase recreation and visitation. PBNDS 2011 was recently revised in 2016 to include important updated standards on disability identification, assessment, and accommodation, as well as medical care for women. These facilities vary in size, composition, operator, and contract mechanism, and different versions of these 3 sets of National detention standards currently apply to ICE's various detention facilities, as provided for in the applicable contract or agreement.

ICE DETENTION FACILITY INSPECTIONS

The safety, health, and rights of individuals in ICE's custody are paramount, and ICE remains committed to continually improving detention operations to promote a safe and secure environment for both detainees and staff. To ensure ICE's detention facilities meet the requisite standards, ICE and DHS provide oversight through a multi-layered inspections program. ICE conducts annual or biennial reviews of all facilities over a certain population and utilizes a self-inspection process for facilities with very small populations or where detainees are held under 72 hours. At many ICE facilities, oversight is also provided by on-site ICE detention service managers who work full-time at detention facilities to monitor conditions. Additionally, the ICE Office of Detention Oversight (ODO), the DHS CRCL and the DHS Office of Inspector General (OIG), all conduct reviews and inspections and have open access to ICE detention facilities.

ICE ensures that its facilities comply with existing policies and standards through its comprehensive and multi-layered inspections program, which provides assurance that detainees in ICE custody are housed in the least restrictive environment consistent with the safety and security of the detained population and orderly facility operations. The annual detention inspection, conducted by an independent third-party contractor, ensures that facilities remain in compliance with ICE's standards and that any deficiencies noted are resolved by facility management, while periodic follow-up inspections help ensure on-going compliance throughout the year.

Contractually, ICE has enlisted The Nakamoto Group, Inc. to conduct inspections for facilities around the United States that house ICE detainees. This includes annual inspections, pre-occupancy inspections, and special inspections as ordered by ICE using the applicable set of detention standards. Contract inspectors typically spend 3 days auditing each facility, and in addition to an environmental health & safety subject-matter expert, each inspection team includes a health professional (i.e., physician, physician's assistant, registered nurse, or nurse practitioner) and a Detainee Rights subject-matter expert. When deficiencies are found during any type

of inspection or review, ERO works with the field offices and facilities to ensure timely corrective actions are implemented and maintained.

ICE has also developed and utilizes a standardized checklist during its inspections to ensure that the most critical elements of the various detention standards are always assessed. This detailed checklist helps inspection teams focus on the most critical elements of the ICE detention standards, about 700 key areas that ensure conditions are appropriate. The ICE detention standards have about 4,000 measurable requirements in total. While the checklist allows for a more standardized review process, it also provides an opportunity for data to be captured in a way that allows for comparative analysis and monitoring of trends and eliminates human errors associated with memory issues and/or attention deficits.

Further, in addition to the checklist, inspectors are required to provide ICE a written report that includes, at a minimum, an Inspection Summary, a Facility Snapshot/Description, Areas of Concern/Significant Observations, and Recommended Rating and Justification. Additionally, the inspectors must submit a completed Significant Incident Summary form that identifies any significant incidents such as assaults, uses of force, deployment of special reaction teams, escapes, grievances, psychiatric/medical referrals, and detainee deaths.

In addition to these inspections, ICE detention facilities are subject to ERO special assessments, audits, reviews, and site visits by the ICE ODO and DHS CRCL, while other unannounced visits and inspections are also periodically conducted by the DHS OIG and the U.S. Government Accountability Office.

DHS OFFICE OF THE INSPECTOR GENERAL REPORTING

ICE continues to work daily with its field offices, the ICE ODO, and DHS CRCL to ensure that facilities comply with ICE detention standards, to take corrective actions when needed, and to address recommendations provided by the DHS OIG. ICE greatly appreciates the work conducted by the DHS OIG regarding the inspection process and carefully evaluates its recommendations for ensuring the welfare of its detained population.

In a June 26, 2018, report entitled, *ICE's Inspection and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,* the DHS OIG made 5 recommendations, with which ICE concurred, and which have been used to implement significant improvements to the inspections process.

In response to OIG's findings, ICE is re-evaluating the existing inspection scope and methodology in the statement of work for annual and biennial contracted inspections to ensure inspection procedures are adequate and appropriately resourced to fully evaluate detention conditions at facilities. Upcoming new contract requirements include, but are not limited to, the extension of the annual facility inspection by an additional day (from 3 to 4 days), an increase in the number of subject-matter experts on inspection teams (to include 2 health experts), and interviews with detainee volunteers (teams must include either a bilingual inspector or access to interpretive services) along with a list of major grievance areas or concerns that arise during these discussions.

ICE has also created a Quality Assurance Team (QAT) consisting of seasoned Federal employees to perform quality assurance reviews of ICE's contract inspectors during each annual inspection. QAT members review contractor performance, interview detainees, review grievances and complaints, evaluate use of force, and review segregation practices, among other things. ICE employees also attend and observe inspections to monitor The Nakamoto Group, Inc. inspection teams on a regular, but random, basis to ensure compliance.

Furthermore, ICE is also developing a follow-up inspection process for select facilities where egregious or numerous deficiencies are identified; updating and enhancing current procedures to ensure verification of all corrective actions for identified deficiencies, including better tracking of all corrective actions by facility, responsible field office, and status of resolution; and developing protocols for ICE ERO field offices to require facilities to implement formal corrective action plans resulting from deficiencies identified from on-site monitors.

In conclusion, ICE has made significant changes to inspection protocols following the release of several relevant OIG reports and continues to reshape and reevaluate the detention inspection and oversight process where necessary, including with regard to its contract inspection provider. ICE also notes that where relevant, it has held contractor-appropriate discussions about necessary improvements and will continue to enforce its detention standards and procedures for the safe, secure, and humane treatment of aliens in ICE custody.

CONCLUSION

ICE understands that immigration enforcement actions, including detention, often have a significant impact on individuals and their families. However, the agency's mission requires it to uphold the Nation's immigration laws as passed by Congress, many of which require the detention of those individuals whose presence is necessary for immigration proceedings or for removal from the United States. ICE is committed to carrying out this process with the highest level of professionalism and welcomes the opportunity to discuss the care provided to its detained population, as well as the oversight mechanisms in place in order to ensure detainee welfare and agency and contractor accountability.

Thank you again for the opportunity to testify regarding this important matter and I look forward to answering any questions you may have.

Ms. TORRES SMALL. I thank all of the witnesses for their testimony. I will remind each Member that he or she will have 5 minutes to question the panel.

I will now recognize myself for questions.

We have been talking a lot about these 600 elements in the scope of work, and this differs, this process for Nakamoto differs from the Office of Detention Oversight, or ODO, which has a much narrower scope of inspection and allows them to more deeply assess the health and safety of detainees.

OIG's recommendations for ICE is to revise the inspection scope and methodology for contracted inspectors within ICE's statement of work.

Ms. Shaw, do you believe that ICE's current statement of work keeps its contractors from fully complying with its oversight responsibilities?

Ms. SHAW. So based on our observations related to that report, we found that it was an incredibly challenging goal that had been set for the inspectors to try to review the full scope of the 39 to 42 applicable standards in a 3-day period with a 4- to 5-person team is a tall order.

Based on, you know, our experienced and highly-trained staff, I think they felt that they, too, would have struggled to try to meet those goals.

So the statement of work, the breadth of the statement of work makes it very difficult to get any sort of a deep dive into some of these issues.

Ms. TORRES SMALL. Should ICE revise its statement of work to ensure quality inspections to assess compliance with detention standards? You don't have to—you can just say yes if that is——

Ms. SHAW. Yes. That is our recommendation.

Ms. TORRES SMALL. Great.

Have you seen any plans to amend the new statement of work that satisfies your recommendations?

Ms. SHAW. That recommendation continues to be open and treated resolved, meaning that we are continuing to work with ICE on their corrective action. We have seen iterations, possible ways that they might revise the scope, but nothing definitive has been decided at this point.

Based on our most recent update, because they are putting out requests for proposals on that contract, I think that will potentially slow down the process slightly, but we would continue to suggest that regardless of who their contractor is, they need to revise that statement of work to ensure that they are getting detailed findings.

Ms. TORRES SMALL. Now, when you say it would slow down the process, you mean the RFP would go out without changing the scope of work and there might be a new contract without changing the scope of work?

Ms. SHAW. So I am speaking based on our understanding from what we have been hearing from ICE, but the latest update that we received was that they were putting out a request for proposal. So they had not provided a new update on the status of their revisions to the statement of work.

Ms. TORRES SMALL. Does that concern you?

Ms. SHAW. I think just based on the little bit that I know about how contracts are done, I think it is important to have a clearly defined statement of work, at least in mind, when you are going through that process.

Ms. TORRES SMALL. Thank you.

Ms. SHAW. But I defer to ICE.

Ms. TORRES SMALL. Thank you.

Mr. Johnson, what is the status of the plans identified by Ms. Shaw?

Mr. JOHNSON. As Ms. Shaw stated, we are in the middle of a recompete, and the plan to increase the—or make the needed improvements in our statement of work have been sort-of drafted in the current competition or in the new competition that is coming, and we expect to do an award within the next 3 months.

Ms. TORRES SMALL. So will you commit to finishing revising the scope of work before finishing the RFP process?

Mr. JOHNSON. Yes. The new requirements will be included in the new contract going forward, correct.

Ms. TORRES SMALL. Ms. Shaw, are you planning any follow-up work to evaluate whether Nakamoto's inspections have been improved?

Ms. SHAW. We currently don't have planned work in that area, but it is the case that as part of our recommendation follow-up process we are consistently obtaining updates from ICE based on how well they are implementing their corrective action plan. So we would expect to get some updates through that process.

We will continue our unannounced inspections program next year and visit facilities, many of which will have been reviewed by Nakamoto, and that will give us another opportunity. As part of our pre-inspection scoping work, we do look at what Nakamoto has found to evaluate whether we are seeing corrections when we are on-site or not.

Ms. TORRES SMALL. Thank you.

In the short time I have left, I just want to bring up the issue of penalties versus waivers. So in 2½ years ICE has issued only 2 financial penalties but offered 65 waivers, including allowing the use of a spray that is 10 times more toxic than pepper spray, strip searches in 9 different facilities that don't comport to ICE standards, and, in my own district, permitting the commingling of detainees with varying criminal histories, including, which as you mentioned, threat levels.

Mr. Johnson, what is the point of standards if ICE simply uses waivers to sanction noncompliance?

Mr. JOHNSON. So I think first it is important to note that the only provisions that ICE has ever issued waivers on are things that are certainly not health——

Ms. TORRES SMALL. Mixed threat levels doesn't affect health and safety?

Mr. JOHNSON. So classification is really important for housing and for recreation.

Ms. TORRES SMALL. I apologize. I am out of time. Thank you.

I now recognize the Ranking Member of the subcommittee, the gentleman from Texas, Mr. Crenshaw, for 5 minutes of questions.

Mr. CRENSHAW. Thank you, Madam Chairwoman.

Do you want to just continue your answer, Mr. Johnson?

Mr. JOHNSON. Sure. Thank you, sir.

So historically, classification is generally sort-of held for housing as well as recreation. Those are the areas where detainees or inmates generally are most vulnerable.

In your specific instance, the only waiver of sort-of a classification requirement had to do with whether an individual who was going from their housing unit or to the medical area needed to be escorted by an officer during as the standards require.

So that is an area that we have sort-of waived in the past because, you know, it sort-of cuts against the whole idea of civil detention to escort Level 3s, and it should be really based on the threat that the particular detainee sort-of poses as opposed to just the fact that he may have had a marital dispute with his wife, and that is why the individual was classified as a Level 3.

So I really think you have to just look at the specific circumstances of the waiver before you can just sort-of conclude that ICE's waiver has somehow made an individual unsafe or vulnerable because we would never grant——

Mr. CRENSHAW. OK. So in an example, it is not necessarily the case that a violent criminal was put in a cell with a nonviolent immigrant.

Mr. JOHNSON. That is correct. Classification—housing would always be——

Mr. CRENSHAW. Is there additional explanation, circumstances, to the other waivers?

Mr. JOHNSON. Sure. There is a number of waivers. I mean, a lot of the waivers that we have granted are for things that were sort-of written in our standards 20 years ago that are no longer sound detention practices.

The most popular waiver that we grant has to do with the barber shop provision, which requires that the barber shop be in a dedicated area of the facility, that the barber shop have——

Mr. CRENSHAW. Well, I know about those. I meant specifically what the Chairwoman had alluded to. Was there additional explanation that would explain those particular waivers? I think she mentioned pepper spray and——

Mr. JOHNSON. Yes. I am not familiar with the pepper spray waiver. I am happy to take a close look at it.

Mr. CRENSHAW. Let's move on to the discussion of scope. So the IG report talks about there is too much scope for the contractors. There is very narrow scope for the ODO. Is the recommendation in

particular to do everything like the ODO, to narrow the scope, or is there some middle ground that was recommended by the IG?

Ms. SHAW. So our recommendation specific to ODO was higher frequency of inspections.

Mr. CRENSHAW. Higher frequency, but maintain the scope that they use?

Ms. SHAW. Correct.

Mr. CRENSHAW. Do you recommend that that same scope be used for Nakamoto as well?

Ms. SHAW. We did not. We left it to ICE to revise the statement of work according to what they felt would allow them to achieve compliance in their standards.

Mr. CRENSHAW. Mr. Johnson, so what is ICE's position on that?

Mr. JOHNSON. I mean, I think our position is that we have 39 or 42 standards, depending on which version of the standards are applicable. We have——

Mr. CRENSHAW. What differentiates between those standards?

Mr. JOHNSON. So the more robust standards, the PBNDS 2011, which are generally applicable at our dedicated facilities or facilities that house only or for the most part close to nearly all ICE detainees, our more robust standards are sort-of tailored to those facilities. We have our lower version of the standards, which are the National Detention Standards, which are generally for our local jails where we have shared populations and in many instances a relatively small ICE population compared to the overall large inmate population.

Mr. CRENSHAW. Is there any benefit to sort-of commingling the contractors with ODO to ensure, I guess, more consistency in inspections?

Mr. JOHNSON. From my perspective, no. I mean, I think, from ICE's, you know, we are getting exactly what we expect out of our inspections. We have to inspect against all of the requirements. We have sort-of developed that checklist to sort-of hot identify what we believe are the most critical elements of each.

Mr. CRENSHAW. You like keeping those separate.

Mr. JOHNSON. Correct.

Mr. CRENSHAW. Now, just getting to the root causes of this, given the vast amount of detainees in custody that peaked this summer to 54,000, to what extent has that put increased pressure on your operations in these facilities?

Mr. JOHNSON. Well, I mean, we had to activate a lot of new facilities. Many facilities had never held ICE detainees previously. So for those it was a huge learning curve for them to sort-of figure out and learn what the inspections required. So, I mean, I am sure for some of those folks, it was a little challenging at times. So it did impact the operations.

Mr. CRENSHAW. Thank you.

Mrs. WATSON COLEMAN [presiding.] Thank you.

Thank you, Mr. Johnson and Ms. Shaw, for your testimony.

Mr. Johnson, how many employees do you have that oversee or work with these facilities that have detainees?

Mr. JOHNSON. I have about 200 or so direct reports, and the folks that actually focus on detention, I would say about half of those, about 100, 120.

Mrs. WATSON COLEMAN. One hundred to what? I am sorry.

Mr. JOHNSON. I said 100 to 120.

Mrs. WATSON COLEMAN. They do what? You are distinguishing them as?

Mr. JOHNSON. Detention operations.

Mrs. WATSON COLEMAN. OK. How many facilities are you responsible for ensuring that the standards of care are appropriate?

Mr. JOHNSON. So today we use about 250 facilities.

Mrs. WATSON COLEMAN. So your 120 inspectors, inspection people, how do they determine which facilities? They do the smaller facilities and Nakamoto does the larger facilities?

Mr. JOHNSON. So Nakamoto inspects all the facilities that we use that house people for over 72 hours. I have detention—on-site detention service managers at our largest facilities, and they cover about 50 facilities and reach about 70 percent of our population.

Mrs. WATSON COLEMAN. I am sorry, did you tell me there are 250 facilities altogether?

Mr. JOHNSON. That is correct.

Mrs. WATSON COLEMAN. Of those, have you had occasion to close any for deficiency in service, unsafe conditions?

Mr. JOHNSON. We have closed several facilities.

Mrs. WATSON COLEMAN. How many is several?

Mr. JOHNSON. Over the last 10 years, I would say——

Mrs. WATSON COLEMAN. Tell me about the last 3 years.

Mr. JOHNSON. Three years? I don't recall off-hand how many we have shut down.

Mrs. WATSON COLEMAN. So Nakamoto's group provides a report of their findings, right?

Mr. JOHNSON. Right.

Mrs. WATSON COLEMAN. Those are recommendations to your Department?

Mr. JOHNSON. That is correct.

Mrs. WATSON COLEMAN. OK. Do you under any circumstances ignore their findings and recommendations?

Mr. JOHNSON. Generally, no.

Mrs. WATSON COLEMAN. Generally no or never no?

Mr. JOHNSON. Generally, no. I mean——

Mrs. WATSON COLEMAN. You have then?

Mr. JOHNSON. I mean, I recall one instance where we disagreed with a particular recommendation, and we went back to them and had a discussion and explained our position.

Mrs. WATSON COLEMAN. So there is a mention in my briefing here that there was an instance where ICE let recommendations that came from Nakamoto to you all pend for an extended period of time, over 100 days. Does that come to your recollection?

Mr. JOHNSON. So vaguely, I do remember a statement that seemed to suggest that there was an inspection that was sort-of sitting in a draft status for an extended period of time.

Mrs. WATSON COLEMAN. What is the amount of time that those recommendations stand waiting for a response from you all? Do you have a requirement in terms of a response time?

Mr. JOHNSON. There is no requirement. I mean, I think folks generally try to get those reports finalized sooner rather than later, but there could have been a technical issue with the report.

Mrs. WATSON COLEMAN. So what is the follow-up on telling a facility that it has X number of violations and that they have to clean them up? What is the process for follow-up?

Mr. JOHNSON. So once the report is finalized, a uniform corrective action plan is generated that is sent to the field office and the facility for any serious life safety issue. They are required to come up with a corrective action plan in short order, I think it is a week, maybe 2 weeks, for any sort-of regular sort-of——

Mrs. WATSON COLEMAN. No, no. My question is when you have these deficiencies brought to your attention and you tell the facility you have X number of days or whatever to correct it, what is your follow-up to ensure that what you tell them to do, they do?

Mr. JOHNSON. So at our DSM staff facilities where we actually have on-site staff, we have a presence there, and we can ensure that the things they said they were going to do were, in fact, done.

Mrs. WATSON COLEMAN. How many facilities have on-site staff?

Mr. JOHNSON. About 50.

Mrs. WATSON COLEMAN. Are they like full-time in that one facility?

Mr. JOHNSON. These are full-time folks that spend the overwhelming majority of the time. Now, they could have another facility close by that they have to provide roving coverage of, but generally they are there the entire time.

Mrs. WATSON COLEMAN. In the last couple of years, have you all used your financial penalties to get a facility to do what you needed them to do to meet the standards?

Mr. JOHNSON. We have.

Mrs. WATSON COLEMAN. So how many?

Mr. JOHNSON. More than 2. I heard earlier that that had only occurred twice. It has at least been 10, 15 that I am aware of, but we could get you an exact number.

Mrs. WATSON COLEMAN. I have asked Mr. Crenshaw if he wanted a second round, and he said that it wasn't necessary, so I am going to indulge myself a minute.

I am not quite sure why we are having all this consternation about inspections of facilities, meeting standards, and whether or not the standards are relevant, whether or not the scope of the standards are doable and make sense, and why we don't have the kind of follow-up that we are supposed to have.

So my question to you, Ms. Shaw, do we need extra people? Or do we need streamlining of operation? Or do we need better commitment?

Ms. SHAW. I think based on our recommendations, the primary issue that we have is really a process one, ensuring that there is adequate follow-up, that there is documentation to support claims by the facilities that they have implemented corrective action. So they need a more robust process for ensuring follow-up.

Mrs. WATSON COLEMAN. Does that mean that you need more staff, sir?

Mr. JOHNSON. I mean, I would like to have more staff at our larger facilities to make sure we have that on-site presence to monitor conditions each day. So certainly the staff would be welcome.

Mrs. WATSON COLEMAN. OK. My last question.

How do you do quality control checking of your contractee, Nakamoto?

Mr. JOHNSON. So what I would say is 10 years ago the Government used to inspect its own facilities, but after a lot of criticism about——

Mrs. WATSON COLEMAN. No. My question is, what do you do to ensure that Nakamoto is doing the job you contracted them to do?

Mr. JOHNSON. So today we have seasoned Federal employees that accompany Nakamoto on every inspection. They have a role in the inspections process, but they will from this point forward be monitoring the inspector to make sure that they are providing the services that we are paying for.

Mrs. WATSON COLEMAN. Thank you, Mr. Johnson.

Thank you, Ms. Shaw and Mr. Johnson, to the witnesses in our first panel. Thank you for being here and taking our questions and giving us your testimony.

Before adjourning, I would ask for unanimous consent to submit statements to the record from the American Civil Liberties Union, the Detention Watch Network, the American Immigration Council, the National Immigration Justice Center, the Government Accountability Project, the Southern Poverty Law Center, the Transgender Law Center, and the Asian American Advancing Justice.

Without objection, so admitted.

[The information follows:]

ARTICLE FROM ACLU.ORG

THE DEPARTMENT OF HOMELAND SECURITY'S OWN WATCHDOG SAYS ICE DETENTION INSPECTIONS ARE MEANINGLESS

By Victoria Lopez, Senior Staff Attorney, ACLU National Prison Project & Madhuri Grewal, Federal Immigration Policy Counsel, ACLU National Political Advocacy Department

July 3, 2018 11:15 PM

In response to its own nightmarish family separation and zero-tolerance policies, the Trump administration is claiming that in order to keep families together, it must jail them. This isn't only untrue—it's expanding a system independent oversight agency.

A new report by the Department of Homeland Security's Office of Inspector General confirms that Immigration and Customs Enforcement jails are profoundly dangerous places with few safeguards to protect the rights of those detained, much less children and families. The inspector general's report details how ICE inspections and monitoring of immigrant detention facilities fail on multiple levels.

Rather than address these abject failures, the Trump administration is damningly taking the opposite tack. It now wants to detain tens of thousands of immigrant children and families in ad hoc family jails, including on military bases or in newly constructed facilities under Department of Homeland Security control.

Over the last week alone, DHS asked the Department of Defense to jail 12,000 immigrant children and parents on military bases and issued a request for information to detain an additional 15,000 people in family jails.

The Trump administration thinks it can get away with swiftly expanding detention by building family jails and contracting with the Bureau of Prisons because the existing patchwork of over 200 immigration detention facilities—including private prisons and county jails—operates with impunity. Oversight and accountability of these failed operations, reports the inspector general, is predictably scant.

Inspections of ICE jails are conducted by a private company, Nakamoto Group, as well as ICE's own Office of Detention Oversight (ODO). Notably, neither entity will investigate all 211 ICE facilities in any given year. Nakamoto inspects an average of 100 facilities each year, and ODO has inspected an average of 28 facilities each year in the last 3 fiscal years. Finally, there is supposed to be a "continuous" monitoring program, which also does not occur at every facility. The bottom line is

that the inspector general found that none of these inspections ensure compliance with detention standards.

The agency's watchdog also highlights that inspections do not occur with enough frequency, do not meaningfully address facility conditions, and are limited to review of a narrow set of standards. Even worse, according to the report, when there are clear violations, ICE fails to "systematically hold facilities accountable" and "some deficiencies remain unaddressed for years."

Some of the documented violations that were ignored for years are shocking, including strip searches with no reasonable suspicion and repeated failures by the facilities to notify ICE about sexual assaults, both in violation of detention standards and legal obligations. Furthermore, the report notes inspections are so incomplete that they are ineffective at providing the necessary level of oversight. One ICE official even suggested to the inspector general that the Nakamoto inspections are "useless."

In one case, Nakamoto inspectors were required to conduct private and confidential interviews with detained immigrants. They failed to do so. Instead, they simply conducted brief group conversations, in English, with no translators present, and asked only very basic questions about food and recreation. In another case, 2 immigrants were held in "administrative segregation" or solitary confinement simply because there was no other space in which to detain them. The Nakamoto inspector didn't even bother looking into whether policies on isolation were followed.

Even more troubling, some inspectors actually lied.

In one instance, Nakamoto reported that immigrants in detention "understood how to obtain assistance from ICE officers . . . [and had] positive comments regarding access to library services." Yet the inspector general's investigators did not witness a single Nakamoto inspector asking about the law library, and they even heard immigrants telling inspectors they didn't know the identity of ICE officers, let alone how to contact them.

These inspections are a pantomime of Federal responsibility at best. ICE has no real oversight and certainly no accountability. And now, ICE wants to expand its massive network to jail even more people, including thousands of children and families.

Our Nation now boasts, shamefully, the largest immigration detention system in the world. The number of people impacted by the immigration detention system has dramatically increased over the past few decades despite the fact that there are clear alternatives to jailing immigrants.

Today there are on average over 40,000 people locked up every day by immigration authorities, costing taxpayers over $2 billion per year. The treatment of immigrants in detention is nothing less than a human rights crisis, and one that needs immediate action.

The OIG's report is damning, but it is not the first of its kind. It is the latest condemnation after years of reporting that has made it clear that the system of monitoring and inspections is woefully inadequate and fails to address even the most serious issues, including deaths.

In the whirlwind of announcements about the administration's zero tolerance and family separation policies, CBP's statement clarified the Trump administration's intentions: "We're suspending prosecutions of adults who are members of family units until ICE can accelerate resource capability to allow us to maintain custody."

If the Trump administration succeeds in expanding the failing detention system it will accomplish 2 things: Hurt immigrant families and line the pockets of private prison companies, like CoreCivic (formerly CCA) and GEO Group. Already, the nation's two largest family jails, located in Dilley and Karnes City, Texas, are operated by these prison profiteers.

The jailing of immigrants is a cruel and harmful practice. We cannot allow this administration to lock up more immigrants in a system that is already so broken. We must demand Congress reduce the number of detention beds, cut funding for Trump's massive deportation force, and reject all funding and proposals for any new plans to jail immigrants and families.

It's up to us to demand how our taxpayer dollars are being spent, and we must collectively say: Not one more cent.

STATEMENT OF DETENTION WATCH NETWORK

THURSDAY, SEPTEMBER 26, 2019

Detention Watch Network is a national membership organization building power through collective advocacy, community organizing, and strategic communications to abolish immigration detention in the United States.

The Department of Homeland Security (DHS) operates a sprawling network of more than 200 long-term (more than 72-hour) immigration jails across the country that are managed and overseen by Immigration and Customs Enforcement (ICE). As of September 14, 2019, ICE is detaining 51,814 individuals after reaching a historic high of over 55,000 people in detention in August 2019.[1] This rapidly expanding and wholly unaccountable system arbitrarily detains tens of thousands of people every day in cruel and punitive conditions. However, due to a combined lack of transparency and sham inspections system, ICE can operate detention centers without fear of having to answer for the inhumane treatment of the people in its custody.

I. INHUMANE CONDITIONS

ICE capitalizes on its swelling resources with the explicit intent to grow the system at a rapid rate rather than invest in improving conditions or caring for those in its custody. Since 2003, 195 people have died in ICE detention; and 8 people have died in ICE custody in fiscal year 2019 alone.[2] Studies conducted by independent medical professionals confirm that approximately half of these cases were attributable to medical negligence on behalf of the agency.[3] Abuse and neglect have proven endemic to the massive ICE detention system.[4] The DHS OIG has released reports decrying "egregious" food quality and safety issues, hygiene issues so severe that they cause health risks for individuals in detention, and limited basic clothing and hygiene supplies.[5]

This rampant abuse and neglect impact all individuals detained in ICE jails, but disproportionately impacts vulnerable populations. Autopsy reports from the death of trans asylum seeker Roxana Hernandez Rodriguez found that she died due to lack of medical treatment but also exhibited "deep bruising" indicative of physical abuse that she likely endured while detained in the Cibola County Correctional Center in New Mexico.[6] Roxana's experience is not an anomaly, but rather symptomatic of the callousness of an agency working on behalf of an administration dedicated to cruel anti-immigrant policies.

II. PERVERSE FINANCIAL INCENTIVES AND DUBIOUS CONTRACTING

In its current form, the system is largely operated by private prison companies and local and county jails. As of 2017, approximately 71 percent of people in immigration detention were held in privately-operated jails, and 29 percent were held in jails where ICE is contracting with a local or county government, through an Intergovernmental Service Agreement.[7] In both cases, these entities are motivated by profit rather than upholding human dignity.

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[1] ICE posts current detention data on its website at *https://www.ice.gov/detention-management#tab2.*

[2] Detention Watch Network, Another death in ICE custody after ICE grabs $271 million from FEMA and other DHS agencies, September 13, 2019, *https://www.detentionwatchnetwork.org/pressroom/releases/2019/another-death-ice-custody-after-ice-grabs-271-million-fema-other-dhs.*

[3] Human Rights Watch et al., Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigrant Detention, (June 2018), *https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration.*

[4] Alice Speri, The Intercept, Detained then Violated; 1,224 Complaints Reveal a Staggering Pattern of Sexual Abuse in Immigration Detention, (April 2018), *https://theintercept.com/2018/04/11/immigration-detention-sexual-abuse-ice-dhs/.*

[5] Department of Homeland Security Office of the Inspector General, Concerns About ICE Detainee Treatment and Care at Four Detention Facilities OIG–19–47, June 3, 2019, p. 4, *https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf.*

[6] Scott Bixby, Betsy Woodruff, Trans Woman Was Beaten Before Death, Autopsy Finds, The Daily Beast, November 26, 2018, *https://www.thedailybeast.com/trans-woman-roxsana-hemandez-rodriguez-beaten-in-ice-custody-before-death-pathologist-finds?source=TDB&via=FB-__Page&fbclid=IwAR14MDowg4-edLlHzaIzXo1tLkHIo4rlefMhLE5F5tIIPXi0bw3xmaxmE3c.*

[7] Tara Tidwell Cullen, National Immigrant Justice Center, "ICE Released Its Most Comprehensive Immigration Detention Data Yet. It's Alarming," (March 2018), *https://immigrantjustice.org/staff/blog/ice-released-its-most-comprehensive-immigration-detention-data-yet.*

Private prison companies are incentivized to cut corners like cutting medical staffing and denying care, putting migrant lives at risk for a greater payout to shareholders.[8] Despite this risk, the agency's reliance on private prisons continues to grow. ICE relies on the agility of private prison companies to move quickly—since just February of this year, the agency has entered into 8 new contracts with detention centers in Louisiana and Mississippi alone, all operated by private prison companies.[9] Local and county jails have the same perverse incentives. The Department of Homeland Security's Office of the Inspector General (OIG) found that conditions in county jails that contract with ICE to augment municipal revenue are just as harsh, if not worse, than in private prisons.[10]

ICE also regularly engages in dubious contracting practices to massively expand the detention system. In July 2018, ICE modified the existing Intergovernmental Service Agreement with the city of Eloy, Arizona and private prison company CoreCivic to hold 1,000 additional adults at the La Palma Conectional Center.[11] ICE used the city of Eloy as a "middleman" to broker this agreement between CoreCivic and La Palma, repeating a technique the agency previously used to establish the Dilley Family Residential Center and which the Department of Homeland Security's Office of Inspector General deemed both improper and unnecessary.[12] In the same month of 2018, ICE also entered into a contract with the Management and Training Corporation (MTC) to re-open 1,000 beds at the former Willacy County Correctional Center, in Raymondville, Texas.[13] This facility had previously been shuttered twice, the last time due to a rebellion by those held there amid accounts of poor medical care, sexual abuse, and oppressive conditions.[14] ICE renamed the facility to the El Valle Detention Center, but it is unclear what, if any, changes were made to prevent systemic abuse from plaguing the facility once again.[15]

III. SHAM INSPECTIONS AND TOTAL LACK OF ACCOUNTABILITY

As the ICE detention system continues to be plagued by grossly poor conditions, mounting deaths, and unaccountable abuses, the agency has failed to invest in robust inspections or meaningful accountability. Recent investigations into deaths in ICE detention have found that in nearly half, violations of medical standards or medical neglect were contributing, or even causal factors.[16] [17] [18] Yet, in all but one case, these same facilities passed an inspection immediately before and immediately after the death occurred. The Department of Homeland Security's Inspector General has found that ICE's inspections process is entirely inadequate leaving deficiencies

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[8] Carl Takei, Michael Tan, Joanne Lin, American Civil Liberties Union, "Shutting Down the Profiteers: Why and How the Department of Homeland Security Should Stop Using Private Prisons," (September 2016), *https://www.aclu.org/sites/default/files/field__document/white__paper__9-30-16__released__for__web-v1-opt.pdf*.

[9] Noah Lanard, "Congress told ICE to Detain Fewer People. Instead it Keeps Adding Private Prisons," Mother Jones, August 22, 2019: *https://www.motherjones.com/politics/2019/08/congress-ice-louisiana-mississippi-private-prisons/*.

[10] DHS Office of the Inspector General, *Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey,* February 13, 2019, *https://www.oversight.gov/sites/default/files/oig-reports/OIG-19-20-Feb19.pdf*.

[11] Globe Newswire, *CoreCivic Enters Into New Agreement With Federal Government to Utilize the La Palma Correctional Center,* July 24, 2018, *https://globenewswire.com/news-release/2018/07/24/1541538/0/en/CoreCivic-Enters-Into-New-Agreement-With-Federal-Government-to-Utilize-the-La-Palma-Correctional-Center.html*.

[12] DHS Office of Inspector General, *Immigration and Customs Enforcement Did Not Follow Federal Procurement Guidelines When Contracting or Detention Services,* February 21, 2018, *https://www.oig.dhs.gov/sites/default/files/assets/2018-02/OIG-18-53-Feb18.pdf*.

[13] Management Training Corporation, *MTC Signs Contract with ICE to Operate Detention Facility in Raymondville,* July 18, 2018, *https://www.mtctrains.com/wp-content/uploads/2018/07/MTC-TO-OPERATE-FACILITY-IN-RAYMONDVILLE.pdf*.

[14] Seth Freed Wessler, *The True Story of a Texas Prison Riot,* The Nation, June 23, 2015, *https://www.thenation.com/article/the-true-story-of-a-texas-prison-riot/*.

[15] Jeremy Raff, *ICE Is a Godsend for One Small Town in Texas,* The Atlantic, July 11, 2018, *https://www.theatlantic.com/politics/archive/2018/07/ice-prison-trump-immigration-crackdown/564539/*.

[16] Human Rights Watch, *Code Red: The Fatal Consequences of Substandard Medical Care in Detention,* June 20, 2018, *https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration*.

[17] American Civil Liberties Union, Detention Watch Network, National Immigrant Justice Center, *Fatal Neglect: How ICE Ignores Deaths In Detention,* February 2016, *https://www.detentionwatchnetwork.org/sites/default/files/reports/Fatal%20Neglect%20ACLU-DWN-NIJC.pdf*.

[18] Human Rights Watch, *Systemic Indifference: Dangerous & Substandard Medical Care in US Immigration Detention,* May 8, 2017, *https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care-us-immigration-detention*.

unaddressed for years, despite numerous inspections of individual facilities revealing deficiencies severe enough to threaten the health and safety of detained people.[19] [20] [21]

The entities that conduct inspections are contracted or directly employed by ICE, resulting in a system that incentivizes positive reports. This includes private companies like the Nakamoto Group, whose inspections have been described as "breez[ing] by standards" and "very, very, very difficult to fail" by ICE staff.[22] It also includes oversight bodies within the agency itself, like the Office of Detention Oversight and Enforcement and Removal Operation's Custody Management office, that only conduct inspections about once every 3 years, which the DHS OIG has deemed insufficiently frequent to meaningfully address concerns. They also provide facilities with advance notice of these inspections, allowing staff to "temporarily modify practices to pass an inspection." Even when deficiencies are found in inspections, ICE routinely issues waivers to provide exemptions rather than penalizing contractors for failing to meet the relevant detention standards.[23]

In June 2018, DHS OIG released a report documenting the massive failings of the inspections process, yet no changes have been enacted in response. The current inspections process is broken—it is an inexcusable pretense for oversight that paves a path for detention center abuse and worsening conditions, while contractors profit off of the human suffering and ICE evades accountability.

IV. GROWTH OF THE SYSTEM BY MANIPULATION OF APPROPRIATIONS

The immigration detention system has expanded by over 60 percent in the last 2 years, from an average of 34,000 people in detention per day in 2016 to a current population of nearly 52,000 people as of September 14, 2019.[24] Much of this growth has been facilitated by purposeful financial mismanagement by the agency in an effort to rapidly expand immigration detention, evade Congressional oversight, and avoid accountability for detention abuses. Since 2015, ICE has perfected a scheme to expand detention beyond its appropriation and has ignored Congressional direction to live within its appropriated means and improve its "lack of fiscal discipline and cavalier management of funding for detention operations."[25]

Truly, ICE's detention expansion is not an issue of aimless mismanagement or lack of fiscal discipline, but rather a calculated and practiced scheme to bypass Congressional power. Since 2015, ICE has taken advantage of series of continuing resolutions to expand detention by using either a lump sum bonus at the start of a continuing resolution, known as an anomaly, or an advance of funding granted by the Office of Management and Budget, known as an exception apportionment. Congress then bases its negotiations for a final spending bill upon this elevated detention level. During the course of the fiscal year, ICE will subsequently overspend its already bloated appropriated budget for detention and enforcement again, typically by notifying Congress of their intent to transfer and reprogram funds from other parts of DHS.

ICE is on track to use this scheme once more as we enter fiscal year 2020. Throughout a series of continuing resolutions and a partial Government shutdown

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[19] DHS Office of the Inspector General, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,* June 26, 2018, *https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf.*

[20] DHS Office of the Inspector General, *Concerns about ICE Detainee Treatment and Care at Detention Facilities,* December 11, 2017, *https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf.*

[21] DHS Office of the Inspector General, *Management Alert—Issues Requiring Action and the Adelanto Processing Center in Adelanto, California,* September 27, 2018.

[22] DHS Office of Inspector General, OIG–18–67: *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,* (June 2018), p. 7–12, *https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf.*

[23] DHS Office of the Inspector General, *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards,* January 29, 2019, *https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf.*

[24] For the most recent Average Daily Population Data, ICE typically updates its Detention Management page every 2 weeks at: *https://www.ice.gov/detention-management#tab2.*

[25] See House Report, Division F (Homeland Security), Consolidated Appropriations Act of 2017, 131 Stat. 135, Public Law No. 115–31, May 4, 2017, *http://docs.house.gov/bills-thisweek/20170501/DIVISION%20F%20HOMELAND%20SOM%20OCR%20FY17.pdf.*

[26] Julia Paisley and Heidi Przybyla, *Why the Trump admin wants more detention space for migrants and Democrats want a limit,* NBC News, February, 11, 2019, *https://www.nbcnews.com/politics/immigration/why-ice-wants-more-detention-space-migrants-democrats-want-cap-n970071.*

[27] Dara Lind, *Congress's deal on immigration detention, explained,* Vox, February 12, 2019, *https://www.vox.com/2019/2/12/18220323/immigration-detention-beds-congress-cap.*

from October through February of last year, ICE used an exception apportionment to expand detention by approximately 8,000 people per day above its appropriated average daily population of 40,500.[26] Then in mid-February, Congress signed the fiscal year 2019 supplemental appropriations act which appropriated a historic high average daily population of 45,274.[27] Congress made clear that the elevated average daily population in the fiscal year 2019 supplemental appropriations package was to course correct for ICE's overspending and instructed the agency to "glide down" to 40,500 by the end of the fiscal year. Yet, ICE expanded to a high of over 55,000 people detained per day by August, precisely by using its transfer and reprogramming authority to cover for the additional 16,000 beds above its appropriated number.[28]

Instead of putting accountability measures in place that would prohibit ICE from continuing to abuse its fiscal authorities by overspending and transferring money, Congress has bailed ICE out every year, permitting the agency to operate outside their legal dominion and expand detention without restraint.

V. SOLUTIONS

As the Oversight, Management, and Accountability Subcommittee of the House Committee on Homeland Security considers the above testimony, Detention Watch Network sincerely urges committee Members to consider the reports of abuse, neglect, mismanagement, and callous cruelty not as anomalies, but as basic tenets of the immigration detention system. The alarming death toll in ICE detention underscores that the immigration enforcement system is plagued by egregiously poor conditions, a lack of accountability, and a culture of violence and secrecy. As such, it is not a system that can be reformed through additional funding or minor changes to policy. It is a system that needs to be dismantled as the United States reimagines our approach to migration and works to build a society that is centered on dignity, freedom, and justice. Right now, Detention Watch Network strongly encourages the committee to use its authority to engage in robust oversight of this Government agency's facility operations, contracting practices, accountability mechanisms, and funding implementation. We also encourage Members of Congress to respond to the years of ICE abuses by significantly cutting the agency's funding and by endorsing the Dignity for Detained Immigrants Act, H.R. 2415, that would serve as an important step to provide vital accountability for the health and safety of those in ICE custody.

STATEMENT OF THE AMERICAN IMMIGRATION COUNCIL

SEPTEMBER 26, 2019

The American Immigration Council ("Council") is a non-profit organization that has worked to increase public understanding of immigration law and policy—and the role of immigration in American society—for over 30 years. We write to thank the subcommittee for scheduling this hearing to discuss ICE immigration detention facilities and their impact on immigrants, their families, and communities across the United States.

Immigration detention in the United States is rife with problems that limit due process and negatively impact the ability of immigrants to effectively defend themselves in court. In recent years, the Council has submitted numerous complaints to the Department of Homeland Security's Office of Civil Rights and Civil Liberties documenting wide-spread abuse in ICE detention. Today, we write to share our knowledge about these problems and inform the subcommittee of these systemic human rights and due process violations. We hope that our perspective provides insight context for this important hearing.

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[26] Julia Paisley and Heidi Przybyla, *Why the Trump admin wants more detention space for migrants and Democrats want a limit,* NBC News, February, 11, 2019, *https://www.nbcnews.com/politics/immigration/why-ice-wants-more-detention-space-migrants-democrats-want-cap-n970071.*

[27] Dara Lind, *Congress's deal on immigration detention, explained,* Vox, February 12, 2019, *https://www.vox.com/2019/2/12/18220323/immigration-detention-beds-congress-cap.*

[28] Julia Ainsley and Frank Thorp V, "Trump admin pulling millions from FEMA disaster relief to send to southern border," NBC News, August 27, 2019, *https://www.nbcnews.com/politics/immigration/trump-admin-pulling-millions-fema-disaster-relief-send-southern-border-n1046691.*

SYSTEMIC FAILURES: INADEQUATE MEDICAL AND MENTAL HEALTH CARE TREATMENT FOR PEOPLE DETAINED IN ICE FACILITIES

Far too frequently, immigrants in ICE detention experience civil and human rights violations, including inadequate medical care, sexual and physical abuse, exploitative labor practices, and even death.

The placement of ICE detention centers in rural areas—including facilities used to detain children and families—creates significant barriers to obtaining needed medical care.[1] Moreover, even detention centers that are located in urban areas are often understaffed and inadequately prepared to meet the needs of the detained populations.[2] The systemic understaffing of medical units in ICE detention centers has serious consequences for the people detained in them.

For example, in June 2019, the Council identified a 71-year-old pre-diabetic man suffering from Parkinson's disease, a traumatic brain injury, chronic kidney disease, heart disease, and dementia who was detained by ICE in Aurora, Colorado ("Aurora"). The level of care in this contract facility was so deficient that this man was forced to rely on other detainees for help with day-to-day activities, such as showering. He was also denied critical medication because—according to the nurse—the facility did not have sufficient medicines in stock.[3] His condition deteriorated considerably while he was detained in Aurora. He told family members that he feared he would die in detention. He ultimately lost the ability to walk.[4]

Another person—a 28-year-old man detained in Aurora for 5 months in 2019—suffered from serious physical and emotional effects relating to prior sexual trauma. He reported that, while he was detained in Aurora, he experienced severe pain and bleeding stemming from his prior experience. This man and his advocates reported difficulty in obtaining medical treatment for his condition as well as his medical records. His condition went untreated for the duration of his detention.[5] He described his experience in Aurora as follows:

"Being detained there was terrible. The guards don't treat people well. They even say that they will not get us medical help unless we're dying. Not until we are dead will they help us."[6]

Further, another man detained in Aurora from August 2018 until June 2019 suffered from the effects of a traumatic brain injury, a seizure disorder, depression, anxiety, bipolar disorder, and post-traumatic stress disorder (PTSD). He experienced at least 2 seizures while in custody in Aurora. He had a history of at least 2 suicide attempts prior to being detained by ICE—both of which occurred while he was held in segregation at other facilities in the past. He also attempted suicide during his detention in Aurora. At the end of April, this man suffered a mental health crisis prompted by his frustration with his inadequate medical care. He injured his hand and yet did not receive medical attention for 2 days; he had to elevate his request with a GEO lieutenant in order to gain access to a medical provider. However, once examined, the nurse mocked him, causing his mental stability to spiral. Based on threats of self-harm, he was placed on suicide watch at the Aurora facility.[7]

Similar issues are also prevalent in the family detention context.[8] In 2015, the Council filed a complaint regarding inadequate medical treatment at the South Texas Family Residential Treatment Center in Dilley, Texas, where women were required to wait for up to 14 hours in the sun to receive medical care. For example, a woman with 2 broken fingers and a child who was vomiting blood were both instructed to "drink water" and were denied further care; more than 250 children were improperly administered adult doses of the Hepatitis A vaccine; intravenous fluids were administered through a bent needle; a 5-year-old was denied prescrip-

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[1] Letter from American Immigration Council, American Immigration Lawyers Association, and Catholic Legal Immigration Network, Inc. to Cameron Quinn and John V. Kelly (February 28, 2019), *https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_urges_immediate_release_of_infants_from_immigration_detention.pdf.*

[2] Letter from American Immigration Council and American Immigration Lawyers Association to Assistant Director Stewart D. Smith, Acting Inspector General Jennifer Costello, Officer Cameron Quinn, and Acting Director Mark Morgan, 5–6 (June 11, 2019), *https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_supplement_failure_to_provide_adequate_medical_and_mental_health_care.pdf.*

[3] Id.

[4] Id.

[5] Id. at 8–9.

[6] Id.

[7] Id. at 3–4.

[8] American Immigration Council, "Deplorable Medical Treatment at Family Detention Centers" (Washington, DC: 2015), *https://www.americanimmigrationcouncil.org/news/deplorable-medical-treatment-family detention-centers* (last visited Sept. 23, 2019).

tion medication; and a woman with breast cancer was repeatedly denied care.[9] One woman described her experience with medical staff at the South Texas Family Residential Center in these words:

"Simply, they don't care. What is more important for them is control. These are delicate situations when someone is sick and vulnerable. They just care about control."[10]

Four years after this complaint, the Council continues to document on-going medical problems at the South Texas Family Residential Center. After an alarming increase in the number of infants held in detention, we raised the alarm about their treatment and urged their immediate release.[11]

Immigration detention facilities have also faced allegations of physical and sexual abuse of people in their custody.[12] In fiscal year 2015, 729 reports of abuse by ICE personnel or the staff at detention facilities were reported through ICE's Enforcement and Removal Operations' Detention Reporting and Information Line.[13] In Aurora, the Council documented physical and sexual harassment, including an instance when contract staff tackled and restrained a detainee to remove his shoes and socks before placing him in solitary confinement. The Council has also documented the confinement of a transgender woman in men's housing, where she was denied critical medical attention and subjected to extensive verbal and sexual harassment.[14] The woman said that:

"People at Aurora Facility—both male detainees and guards—sometimes think it is their right to harass and grope me."[15]

For many, the failure to provide adequate medical care or protection from abuse has dire consequences. ICE has acknowledged at least 185 deaths of immigrants in detention between October 2003 and July 2018.[16] A whistleblower email obtained by the press indicates that at least some of these deaths were preventable.[17] Just this year, 8 people have died in ICE custody.[18]

SYSTEMIC FAILURES: DUE PROCESS VIOLATIONS

The over-detention of people across the country in jail-like settings undermines due process and prevents thousands of people from having their fair day in court.

Immigration detention is strictly civil in nature, which means that it is supposed to be "nonpunitive and merely preventative."[19] However, many aspects of immigration detention make it indistinguishable from criminal incarceration.[20] For example, detainees' liberty is highly restricted by regimented daily scheduling: There is constant surveillance, limited visitation hours and phone calls, and required Government-issued uniforms and identification wristbands.[21] Additionally, immigration detainees can be disciplined, subjected to limited contact with outsiders, and ultimately held in segregation.[22]

Working with experienced and competent counsel significantly impacts the likelihood of success in immigration removal proceedings, and despite the fact that immigrants are subject to criminal-like detention, they are not provided Government-appointed counsel.[23] Immigrants in removal proceedings only have legal representa-

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[9] Id.
[10] Id.
[11] AIC, supra note 1.
[12] Ian Peacock and Emily Ryo, *The Landscape of Immigrant Detention in the United States* (Washington, DC: American Immigration Council, 2018), 5, *https://americanimmigrationcouncil.org/research/landscape-immigration-detention-united-states.*
[13] Id. at 25–26.
[14] AIC, supra note 2 at 6–7.
[15] Id. at 7.
[16] Peacock, supra note 12 at 5.
[17] Ken Klippenstein, "ICE Detainee Deaths Were Preventable: Document," TYT, June 3, 2019, *https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h.*
[18] See, e.g. U.S. Immigration and Customs Enforcement, "ICE detainee from Mexico passes away at Illinois hospital," June 12, 2019, *https://www.ice.gov/news/releases/ice-detainee-mexico-passes-away-illinois-hospital* (last visited September 23, 2019).
[19] Peacock, supra note 12 at 8.
[20] Id.
[21] Id.
[22] Id.
[23] Id.

tion when they are able to obtain counsel at their own expense.[24] In the family detention context, immigrants who are represented by attorneys are 14 times more likely to win their cases in court.[25] While nearly 40 percent of immigrants Nationally are represented by counsel, less than 20 percent of immigrants in ICE detention are represented by attorneys.[26] Moreover, ICE detention facilities present several unique and significant barriers that prevent immigrants from obtaining attorneys.[27]

As an example, contact with outsiders can be limited or unnecessarily expensive for immigration detainees held in privately-run detention facilities in which officials are permitted to control and manipulate the price of phone calls, including calls to legal counsel.[28] These prices are often too high for detainees to afford.[29] Immigration detention facilities are often located in rural, remote locations of the United States where it is difficult to find competent and experienced legal counsel.[30] Additionally, ICE regularly transfers immigration detainees between facilities, sometimes in different States. The Council has found that more than half of all detained immigrants are subject to such transfers.[31]

Because transfers can cross State and circuit-court jurisdictional lines, it can be difficult for detainees to find legal counsel who can represent them throughout the entirety of their cases.[32]

SYSTEMIC FAILURES: IMMIGRATION DETENTION IS EXCEPTIONALLY EXPENSIVE

Privately-run immigration detention centers cost the Government exorbitant amounts of money each year. The average cost of detaining someone in ICE custody is approximately $130 per day, although that cost varies depending on prices set by private prison companies.[33] Despite this high cost, the Federal Government has become more and more reliant on immigration detention. At the end of 2018, the President's budget request provided for 52,000 beds in immigrant detention centers.[34] And yet, detention is typically not necessary to ensure that immigrants and families appear in court. Our research shows that from January 2008—June 2019, less than 20 percent of all non-detained immigrants in removal proceedings failed to appear in court.[35] Of those non-detained immigrants who were represented by counsel, 97 percent showed up in court.[36]

In contrast, the Executive Office for Immigration Review's Legal Orientation Program, which provides help to detainees seeking legal counsel, saved the Government nearly 18 million dollars.[37] Similarly, releasing individuals on parole, under Orders of Supervision (electronic monitoring, periodic check-ins with ICE officers, or travel restrictions), or on their own recognizance after they have signed paperwork committing to attend scheduled immigration court hearings, are viable alternatives to detention.[38]

In light of the foregoing facts, we urge the committee to demand greater accountability from those tasked with enforcing our immigration laws, and to work to foster

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[24] Ingrid Eagly and Steven Shafer, *Access to Counsel in Immigration Court* (Washington, DC: American Immigration Council, 2016), 1, *https://www.americanimmigrationcouncil.org/research/access-counsel-immigration-court.*

[25] TRAC, *Representation makes fourteenfold difference in outcome: immigration court "women with children" cases,* 2015, *http://trac.syr.edu/immigration/reports/396/* (last visited September 23, 2019).

[26] Id. at 5.

[27] Id. at 1.

[28] PennState Law Center for Immigrants' Rights Clinic, *Imprisoned Justice: Inside Two Georgia Immigrant Detention Centers,* 2017, 43, *https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned__Justice__Report-1.pdf.*

[29] Id.

[30] Peacock, supra note 12 at 15–16, 21.

[31] Id. at 18.

[32] Id. at 19.

[33] Southern Poverty Law Center, National Immigration Project of the National Lawyers Guild, and Adelante Alabama Worker Center, *Shadow Prisons: Immigrant Detention in the South,* 2016, 10, *https://perma.cc/2GMD-M9RD.*

[34] Peacock, supra note 12 at 7.

[35] American Immigration Council, *Immigrants and Families Appear in Court: Setting the Record Straight* (Washington, DC: 2019), 2, *https://www.americanimmigrationcouncil.org/sites/default/files/research/immigrants__and__families__appear__in__court__setting__the__record__straight.pdf.*

[36] Id.

[37] Cost Savings Analysis—The EOIR Legal Orientation Program, 3 (2012), *https://www.justice.gov/sites/default/files/eoir/legacy/2013/03/14/LOP__Cost__Savings__Analysis__-4-04-12.pdf.*

[38] American Immigration Council, *Seeking Release From Immigrant Detention* (Washington, DC: 2013), 2, *https://www.americanimmigrationcouncil.org/sites/default/files/research/seeking__release__from__immigration__detention.pdf.*

a system with greater respect for due process and the needs of vulnerable populations across the United States.

We thank you for the opportunity to submit this statement, and for the subcommittee's efforts to engage in a thoughtful conversation about the impact of ICE detention on immigrants throughout the United States.

STATEMENT OF THE NATIONAL IMMIGRANT JUSTICE CENTER

SEPTEMBER 26, 2019

Nearly 500,000 people have experienced incarceration in Immigration and Customs Enforcement (ICE)'s jails and prisons this fiscal year.[1] Taxpayers are footing a $3.2 billion annual bill for immigration detention,[2] but the greater cost is paid by the generations of immigrants and their loved ones who bear the scars of an intentionally opaque and abusive system. A system that is, maybe most tragically, unnecessary.

This statement begins by placing the recent dramatic expansion of the immigration detention system in historical context. A slightly wider frame helps us remember that the United States did not always rely on incarceration for the management of migration processes, and its commitment to doing so now is driven by politics and nativism, not rational decision making. This statement also provides an overview of the layers of corruption, abuse, and impunity that are the hallmarks of ICE's detention operations. The National Immigrant Justice Center (NIJC) calls on Members of Congress to pursue visionary and transformative change to the United States' approach to immigration policy—including an end to immigration detention and the development of truly community-based alternative programming—while ensuring that immediate changes are made to remedy these on-going rights violations.

NIJC is headquartered in Chicago and dedicated to ensuring human rights protections and access to justice for immigrants, refugees, and asylum seekers. NIJC's team works day in and day out to provide meaningful legal services to hundreds of immigrants jailed by ICE throughout the Midwest and nationally, but the task is daunting. As the immigration detention system grows, the abuses and due process violations that are endemic persist and become even more deeply rooted.

THE HISTORY OF AMERICA'S FAILED EXPERIMENT WITH THE MASS INCARCERATION OF IMMIGRANTS

The immigration detention system as we know it today—a sprawling network consisting largely of contracted prisons and county jails operating under the guise of "administrative detention"—constitutes a relatively new experiment in American history.[3] It can be easy to forget this perspective because of the Trump administration's insistence that there is an ever-expanding "need" for immigration detention capacity.[4] Yet only decades ago, the use of detention for the purpose of migration management was an anomaly in United States law and policy, not the norm.

The first institutional detention of immigrants in the United States began in the late 1800's on Ellis Island in New York and Angel Island in the San Francisco Bay, where most who were detained were held briefly for medical checks before being deported or allowed to continue into the community.[5] When Ellis Island closed in 1954, the Immigration and Naturalization Service (INS) formally announced it would be abandoning the policy of immigration detention and instead releasing the vast majority of arriving immigrants into the United States on conditional parole,

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[1] As of September 14, 2019, ICE had detained 497,415 people in fiscal year 2019, with 51,814 people in custody on that date. ICE maintains detention data on its website at *https://www.ice.gov/detention-management#tab2,* as required by section 226 of H.J. Res. 31, Consolidated Appropriations Act of 2019, Feb. 15, 2019, *https://www.congress.gov/bill/116th-congress/house-joint-resolution/31/text.*

[2] See Conference Report to accompany H.J. Res. 31, Making Further Continuing Appropriations for the Department of Homeland Security for Fiscal Year 2019, and for Other Purposes, Feb. 13, 2019, *https://www.congress.gov/congressional-report/116th-congress/house-report/9/1?overview=closed.*

[3] Ana Raquel Minian, *The New York Times,* "America didn't always lock up immigrants," Dec. 1, 2018, *https://www.nytimes.com/2018/12/01/opinion/sunday/border-detention-tear-gas-migrants.html.*

[4] For discussion, see Caitlin Dickerson, *The New York Times,* "ICE Faces Migrant Detention Crunch as Border Chaos Spills Into Interior of the Country," Apr. 22, 2019, *https://www.nytimes.com/2019/04/22/us/immigration-detention.html.*

[5] Arthur C. Helton, Center for Migration Studies of New York, Inc., "The Imprisonment of Refugees in the United States," *In Defense of the Alien,* Vol. 9 (1986), pp. 130–137, *https://www.jstor.org/stable/23140908?seq=1#metadata__info__tab__contents.*

bonds, or supervision.[6] Then-Attorney General Herbert Brownell, Jr. described this announcement as a "step forward toward humane administration of the immigration laws."[7] The Supreme Court opined on the progressive nature of the change as well, stating: "Physical detention of aliens is now the exception, not the rule . . . Certainly this policy reflects humane qualities of an enlightened civilization."[8]

This presumption of liberty for immigrants remained in place until the 1980's, when the concept of immigration detention as we know it today began to emerge and politics got in the way of the progress Brownell had trumpeted. The flight of thousands of Haitian refugees from the violence and repression of the Duvalier regime prompted a reversal, one adopted by President Ronald Reagan's INS explicitly for the purpose of deterring Haitians from attempting flight.[9] The formalization of a policy of detention for immigration processing was met with litigation and alarm; those opposing the change included the United Nations High Commissioner for Refugees, who noted that the policy violated the United Nations Protocol relating to the Status of Refugees, to which the United States is party.[10]

Over the course of the 1990's, this retrogressive policy change became entrenched. The same policies and political rhetoric that resulted in the mass incarceration of communities of color in American jails and prisons fueled the expansion of the immigration detention system into for-profit prisons and county jails.[11] Scholar César Cuauhtémoc García Hernández describes that, "[f]ollowing the model of the policy reforms shaping criminal law and procedure in the late 1970's and 1980's—best illustrated by the 'broken windows theory' of criminal policing—the regulation of migrants and migration took a punitive bent. Security became the prism through which migration was examined, and policing became the key response of choice.[12]

From 1994 to 2000, the system nearly tripled—jumping from a detained population of 6,785 to 19,458.[13] In 2004, journalist Mark Dow published a book exposing the depths of the secrets and abuses occurring within what he referred to as the "American gulag"—"a particular prison system operated by the INS or, since early 2003, by the BICE [Bureau of Immigration and Customs Enforcement, as it was known]—with an astonishing lack of accountability, not only to outside criticism, but to the rest of the Government as well."[14]

Dow warned that the shifting of immigration enforcement functions from INS to ICE, an enforcement-only agency within the newborn Department of Homeland Security (DHS), would likely pull the "secretive immigration prison world . . . even further from public scrutiny."[15] A former INS District Chief of Detention and Removals reinforced these concerns in interviews with Dow, noting that the Federal immigration detention system was quickly becoming a "mini-BOP" but lacking entirely in the infrastructure or expertise to safely detain individuals in such numbers.[16] Under the aegis of ICE and over the course of administrations of both political parties, the system ballooned. By 2016, ICE was jailing an average of 34,376 people daily.[17]

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[6] Id. at p. 131.

[7] Id.

[8] *Leng May Ma* v. *Barber,* 357 U.S. 185, 190 (1958).

[9] Forced by Court order to comply with rulemaking requirements, the Immigration and Naturalization Service promulgated a regulation in the *Federal Register* in 1982, stating: "This interim rule, published pursuant to an order of the District Court for the Southern District of Florida, sets forth the Service's policy regarding the detention and parole of aliens who seek to enter the United States illegally. The administration has determined that a large number of Haitian nationals and others are likely to attempt to enter the United States illegally unless there is in place a detention and parole regulation meeting the approval of the District Court." 47 Fed. Reg. 30,044 (1982).

[10] Helton, supra n. v, at p. 134.

[11] For a chart mapping the growth of immigration detention on the growth of the Federal prison system, see National Immigrant Justice Center, *A Better Way: Community-Based Programming as an Alternative to Immigrant Incarceration (April 2019), at p. 2, https://www.immigrantjustice.org/sites/default/files/uploaded-files/no-content-type/2019-04/A-Better-Way-report-April2019-FINAL-full.pdf.*

[12] César Cuauhtémoc García Hernández, Boston University Law Review Vol. 97:245, *Abolishing Immigration Prisons,* 2017, *http://www.bu.edu/bulawreview/files/2017/03/GARCIA-HERNANDEZ.pdf.*

[13] See Congressional Research Service, Immigration-Related Detention: Current Legislative Issues, Apr. 28, 2004, *https://trac.syr.edu/immigration/library/P2.pdf.*

[14] Mark Dow, *American Gulag: Inside U.S. Immigration Prisons* (University of California Press, 2004), at p. 11.

[15] Id.

[16] Id. at p. 9.

[17] Source data for the chart can be found at: Congressional Research Service, Immigration-Related Detention: Current Legislative Issues, Apr. 28, 2004, *https://trac.syr.edu/immigration/*

MASSIVE EXPANSION UNDER THE TRUMP ADMINISTRATION

Over the course of only 2½ years, this administration has grown the already massive immigration detention infrastructure it inherited by 50 percent.[18] This growth has been achieved in direct violation of Congressional intent. For 2 years running, Congressional appropriators have explicitly instructed ICE to reduce its detained population,[19] and both years ICE has responded with tremendous growth, even during the 2018–2019 Government shut-down.[20] As fiscal year 2019 concludes, ICE is jailing 11,000 more immigrants on a daily basis than their appropriated budget allows.[21] This executive end-run around Congressional intent has been achieved largely through the persistent transfer of funds away from disaster relief and other domestic priorities to compensate for ICE's over-spending on detention.[22]

Much of this growth is driven by the for-profit prison industry, which has spent more than $25 million lobbying lawmakers and Federal agencies over the past 10 years, including $3.8 million just in 2018.[23] A recent analysis of Government contract data by Bloomberg News found CoreCivic Inc. and GEO Group—the two largest private prison companies operating immigration jails—to have received boosts of $85 million and $121 million respectively over the past 4 fiscal years as Government contract spending for immigration enforcement and detention has skyrocketed.[24] As of 2017, approximately 70 percent of people in immigration detention were held in privately-operated jails.[25]

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library/P2.pdf (for the years 1994–2000); Congressional Research Service, Immigration-Related Detention: Current Legislative Issues, Jan. 12, 2012, *https://fas.org/irp/crs/RL32369.pdf* (for the years 2001–2012); Immigration and Customs Enforcement, Draft, Fiscal Year 2014 ICE Enforcement and Removal Operations Report, *https://www. prisonlegalnews.org/media/publications/Fiscal%20Year%202014%20ICE%20Enforcement%20and%20Removal%20Operations%20-Report%20(Draft)%2C%20ICE.pdf* (for the years 2013–2014); U.S. Department of Justice, Report and Recommendations Concerning the Use of Restrictive Housing, Jan. 2016, *https://www.justice.gov/archives/dag/file/815551/download* (for 2015); Geneva Sands, ABC News, "Immigration-related arrests by ICE increase under President Trump," Apr. 17, 2017, *https://abcnews.go.com/US/immigration-related-arrests-ice-increase-president-trump/story?id=4684-7044* (for 2016); Fiscal Year 2019 ICE Congressional Budget Justification, *https://www.dhs.gov/sites/default/files/publications/U.S.%20Immigration%20and%20Customs%20-Enforcement.pdf* (for 2017); Spencer Ackerman, Daily Beast, "ICE is imprisoning a record 44,000 people," Nov. 12, 2018, *https://www.thedailybeast.com/ice-is-imprisoning-a-record-44000-people* (for 2018); and current data posted regularly on ICE's website at *https://www.ice.gov/detention-management#tab2.*

[18] See id.

[19] See, e.g., U.S. House of Representatives, Committee on Appropriations—Democrats, Fiscal Year 2018 Omnibus Appropriations Act: Summary of Appropriations Provisions at p. 12, *https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/wysiwyg__uploaded/Summary%20of%20FY2018%20Omnibus__0.pdf* (outlining the fiscal year 2019 bill's provisions funding "an average daily population in detention of 40,354, which will require ICE to reduce the number of detention beds in use between now and the end of fiscal year 2018"); U.S. House of Representatives, Committee on Appropriations, Consolidated Appropriations Act; Division-by-Division Summary, *https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/documents/Summary%20of%20Conference%20Report.pdf* (outlining the fiscal year 2019 spending bill's provisions establishing "Congress's intent to reduce the daily population in ICE detention to approximately 40,520 by the end of the fiscal year, down from a current count of approximately 49,060.").

[20] Hamed Aleaziz, BuzzFeed, "ICE Might Be Violating Federal Law by Keeping Immigrants Detained During the Shutdown," Jan. 9, 2019, *https://www.buzzfeednews.com/article/hamedaleaziz/shutdown-ice-detention-may-violate-Federal-law.*

[21] See *FY19 Appropriations Act Summary,* supra n. xix, requiring a draw-down to a population of 40,520, contrasted with the current daily population of 51,814 posted on ICE's website at *https://www.ice.gov/detention-management#tab2.*

[22] Julia Ainsley and Frank Thorp V, NBC News, "Trump admin pulling millions from FEMA disaster relief to send to southern border," August 27, 2019, *https://www.nbcnews.com/politics/immigration/trump-admin-pulling-millions-fema-disaster-relief-send-southern-border-n1046691;* See DHS *Fiscal Year 2018 Transfer and Reprogramming Notification to Congress,* available at *https://www.documentcloud.com/documents/4878224-CHC-REO-DHS-FY-2018-Transfer-and-Reprogramming.html#document/p30.*

[23] Alan Zibel, Public Citizen, *Detained for Profit: Spending Surges Under U.S. Immigration Crackdown* (Sept. 18, 2019), *https://www.citizen.org/article/detained-for-profit-spending-surges-under-u-s-immigration-crackdown/*, at p. 10.

[24] Michaela Ross, Madi Alexander, and Paul Murphy, *Bloomberg News,* "Immigration Spending Surges as White House Calls for More Funds," Jan. 25, 2019, *https://about.bgov.com/news/immigration-spending-surges/*.

[25] Tara Tidwell Cullen, National Immigrant Justice Center, "ICE Released Its Most Comprehensive Immigration Detention Data Yet. It's Alarming," Mar. 2018, *https://immigrantjustice.org/staff/blog/ice-released-its-most-comprehensive-immigration-detention-data-yet.*

The administration's commitment to expanding the incarceration of immigrants was signaled from nearly Day 1. The White House's proposed budget for fiscal year 2018 sought $2.7 billion to ramp up detention capacity to 51,379, a number it has now surpassed with 51,814 behind bars.[26] It is important to ask: Why were these efforts so important to the nascent administration? With 2½ years behind us, we now know that the administration has carefully designed its immigration policies to inflict maximum cruelty on immigrants in an effort to deter asylum seekers and cause fear among immigrant communities.[27] We also know that the administration saw the decades-old experiment with the incarceration of immigrants as one of its most powerful tools toward those goals.

A SYSTEM DESIGNED FOR CRUELTY: CORRUPTION, ABUSES, AND IMPUNITY

It should stand as a sharp warning to Members of Congress that the administration sees the immigration detention system as a critical component of its efforts to make the American immigration system so unbearable for immigrants as to deter them from coming in the first place. But it is also not surprising. As noted above, today's immigration detention system is a larger and more sprawling outgrowth of the system the Reagan administration put in place with the stated purpose of deterring Haitian migrants from fleeing to the United States.[28] From the start, the system was built to isolate immigrants during their case proceedings, far from legal counsel, out of the public eye and without sufficient mechanisms for redress or accountability for abuses. Immigrants in custody are facing civil proceedings and therefore many of the Constitutional protections afforded in the criminal legal system to do not apply, creating a dangerous legal space for immigrants in civil custody that is punitive by every measure of the word.

As early as 1986, the late famed refugee advocate Arthur Helton noted:

"The new detention policy is an initiative designed to mistreat all equally . . . [Immigrants] are incarcerated in facilities owned and operated or contracted for by the INS . . . The detainees, most of whom do not speak English, are isolated from family and friends . . . The physical conditions of confinement vary depending on the facility, but are generally similar to prison conditions. There is little or no social or educational programming available . . . Overcrowding is a recurrent problem . . . The policy of long-term detention devastates many of those who seek asylum in the United States. Prolonged imprisonment affects detainees' psychological condition and ability to present their cases. As it has in the past, frustration and despair suffered during protracted asylum proceedings triggers suicide attempts and mass hunger strikes."[29]

Belton's description of the immigration detention system as it existed in 1986 could literally be pulled from the pages of any of the many reports on the state of immigration detention today. The system is set up for impunity. This section explores a few key component parts of the detention system, demonstrating how layers of corruption breed abuses which are, by design, without accountability.

Corruption in contracting

ICE currently utilizes 222 facilities for the short-term and long-term detention of immigrants during their immigration proceedings, including dozens of private prisons, county jails, and 5 ICE-owned processing centers.[30] This vast network is held together by a patchwork of contracts that ICE does not make public, leaving organizations like NIJC to resort to protracted litigation and advocacy efforts to expose underlying corruption and profiteering.[31]

There are no formal or enforceable regulations providing the minimal standards of care for those detained by ICE. Instead, ICE generally incorporates into its contracts with private prison companies and county jails 1 of 3 sets of standards the

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[26] Department of Homeland Security, Fiscal Year 2018 Budget in Brief, p. 4, *https://www.dhs.gov/sites/default/files/publications/DHS%20FY18%2OBIB%20Final.pdf.*

[27] Priscilla Alvarez, CNN, "What the 2017 draft memo reveals about the administration's family separations policy," Jan. 18, 2019, *https://www.cnn.com/2019/01/18/politics/draft-memo-significance/index.html.*

[28] See n. ix, supra.

[29] Id.

[30] For a detailed discussion of the types of facilities and demographic break down jailed at each, see DHS Office of Inspector General, *OJG–19–18: ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards* (Jan. 2019), *https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf,* at p. 3.

[31] NIJC's transparency work is documented on our website at *https://immigrantjustice.org/issues/transparencyandhumanrights.*

agency itself has developed, primarily based on correctional standards despite the civil nature of immigration proceedings.[32] Only about 60 percent of detained immigrants are held in ICE jails that were last inspected under the most recently updated set of guidelines, known as the Performance-Based National Detention Standards of 2011 (PBNDS 2011), and some immigration jails are not contractually governed by any standards at all.[33] Congressionally-imposed reporting obligations require ICE to notify appropriators if it enters into new contracts or extends contracts without requiring PBNDS 2011 compliance, but ICE appears to see this process as a rubber stamp, providing Congress with cursory notifications that merely note that compliance with higher standards would be more costly.[34]

In early 2019, DHS's Inspector General issued a report finding that ICE's contracting tools are inadequate to hold detention contractors accountable for failing to meet standards.[35] The report revealed a particularly alarming practice in which ICE lets contractors get away with violating contracted standards by granting waivers. The Inspector General found the process to be essentially a sham designed to promote loopholes: "we found," the report states, "that ICE has no formal policies and procedures to govern the waiver process and has allowed ERO officials without clear authority to grant waivers.[36] In response to new reporting requirements included in the fiscal year 2019 DHS spending bill, ICE subsequently posted on its website a master spreadsheet documenting the 181 waivers currently operational in 2019, many of which implicate issues central to the health and safety of immigrants in detention.[37]

A waiver provided to the Worcester County Jail in Maryland, for example, permits the jail to utilize a far more lenient standard regarding the use of strip searches than otherwise provided by contracted standards, with no justification other than the jail's "right" to engage in strip searches when it deems reasonable.[38] The waiver was granted in June 2016 and remains operational today. The excerpt of the waiver pasted here notes ICE's acceptance of the proposition that, "Staff should consider every inmate as a potential carrier of contraband." In the context of a civil detention setting where those in custody have not been charged with nor are they suspected of committing any criminal offense, such a presumption of criminality is jarring.

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[32] Dora Schriro, DHS, Immigration and Customs Enforcement, *Immigration Detention Overview and Recommendations* (Oct. 2009), *https://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf.*

[33] See Tidwell Cullen, supra n. xxv.

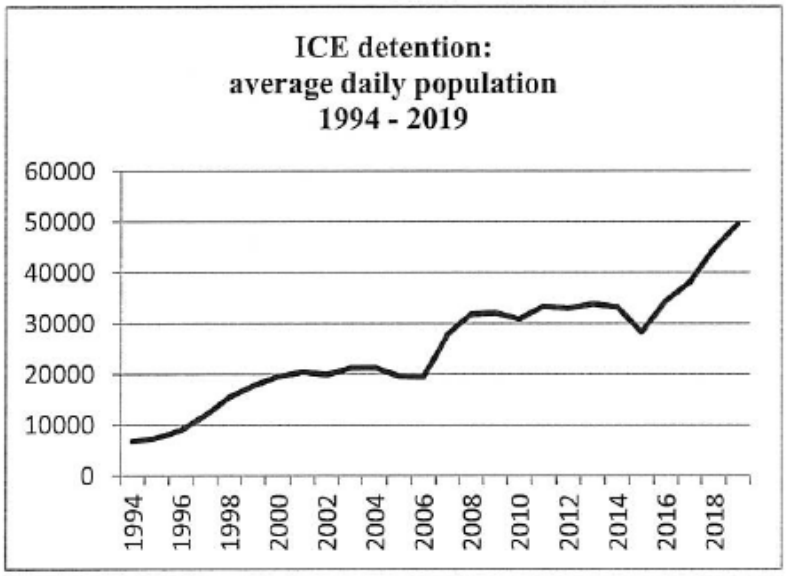
[34] See, e.g., DHS, *ICE Notification of Non-Performance-Based National Detention Standards 2011 Detention Contract (Webb County),* Fiscal Year 2018 Report to Congress, April 2, 2018, *https://www.dhs.gov/sites/default/files/publications/ICE%20%20Notification%20of%20NON-PBNDS%202011%20Detention%20Contract%20%20Webb%20County.pdf.*

[35] Department of Homeland Security, Office of Inspector General, *OIG–19–18: ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards* (Jan. 29, 2019), *https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf.*

[36] Id. at p. 9.

[37] The spreadsheet is entitled "Inspection Waivers Master File (XLSX)" and is downloadable from the ICE website at *https://www.ice.gov/facility-inspections.*

[38] Memorandum for Tae D. Johnson, Assistant Director, Custody Management, U.S. Immigration and Customs Enforcement, Re: Waiver for Strip Searches—Worcester County Jail, undated, available via download at *https://www.ice.gov/facility-inspections.*



Sham inspections

ICE's corrupt contract practices are protected in large part by a layered system of inspections designed to allow deficiencies to go uncorrected and abuses unresolved. Since 2009, a provision in the DHS spending bill has precluded ICE from continuing to contract with a facility that fails two consecutive inspections.[39] This provision has done little more than incentivize ICE to ensure that its inspections are meaningless. In 2015, NIJC and Detention Watch Network released a report analyzing 5 years of ICE inspections for more than 100 facilities, finding the inspections woefully inadequate in uncovering deficiencies and designed to give facilities cover to get passing ratings at all costs.[40]

Last year, in June 2018, DHS's Inspector General issued a report affirming most of our organizations' findings.[41] Specifically, the Inspector General found significant concerns regarding the procedures used by Nakamoto—a private company that contracts with ICE to perform regular inspections of many jails—and found ICE's own inspections insufficiently frequent to meaningfully address concerns. ICE staff told the Inspector General's investigators that Nakamoto inspectors "breeze by the standards," and do not "have enough time to see if the [facility] is actually implementing the policies."[42] One ICE employee went so far as to refer to Nakamoto inspections as being "very, very, very difficult to fail."[43]

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[39] See, e.g., H.J. Res. 31, supra n. 1, at sec. 210 ("None of the funds provided under the heading 'U.S. Immigration and Customs Enforcement—Operations and Support' may be used to continue any contract for the provision of detention services if the two most recent overall performance evaluations received by the contracted facility are less than 'adequate' or the equivalent median score in any subsequent performance evaluation system.").

[40] Detention Watch Network and National Immigrant Justice Center, *Lives in Peril: How Ineffective Inspections Make ICE Complicit in Immigration Detention Abuse (2015), https://immigrantjustice.org/sites/default/files/content-type/research-item/documents/2017-03/THR-Inspections-FOIA-Report-October-2015-FINAL.pdf.*

[41] DHS Office of Inspector General, *OIG–18–67: ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (June 2018), *https://www.oig.dhs.gov/sites/default/files/assets/2018-06/0IG-18-67-Jun18.pdf.*

[42] Id. at p. 4.

[43] Id. at p. 7 n.12.

Abuses committed with impunity: Deaths, inadequate medical care, and the systemic use of solitary confinement

The corruption in contracting and inspections throughout the ICE detention system allows abuses to persist with little recourse for those banned, and near complete impunity for those responsible.

There are frequent deaths in ICE custody, deaths that ICE's own reviews reveal to be attributable to medical negligence in approximately half of all cases.[44] Independent medical experts' analyses of ICE's death reviews have identified consistent elements of substandard care that contribute to deaths in ICE custody, including unreasonable delays in obtaining care, poor practitioner and nursing care, and botched emergency response.[45] Despite these findings, ICE has failed to investigate or remedy the unsafe conditions putting human lives in jeopardy. In the very same facilities where multiple deaths have occurred, individuals in detention and their advocates continue to report egregious lapses in medical care and unconscionable delays in treatment.[46]

ICE's use of solitary confinement is another area in which consistent reporting and even Government whistleblowing has raised awareness of abuses to DHS brass, to little effect. A 2012 investigation into the uses and harms of solitary confinement in ICE custody released by NIJC and Physicians for Human Rights[47] was followed by a 2013 *New York Times* expose on ICE's routine use of solitary confinement.[48] Dr. Terry Kupers, a psychiatrist and expert in the use of solitary confinement who was interviewed for the article, stated, "ICE is clearly using excessive force, since these are civil detentions . . . And that makes this a human rights abuse." In a nod to the exposure of these abuses, ICE issued a directive on the use of solitaiy confinement in 2013, nominally limiting the use of solitary and requiring regular reporting on its use.[49]

The directive has proven worth little more than the paper on which it is written. In 2014, a DHS employee began a 5-year-long effort to "raise the alarm" about ICE's abusive use of solitary confinement, making appeals from her position at the Office for Civil Rights and Civil Liberties through several Government watchdogs including the Office of Special Counsel, the DHS OIG, and ultimately the Senate Judiciary and House Oversight and Government Reform committees, as a whistleblower.[50] Her efforts bore little fruit. Records recently released by the Project on Government Oversight reveal 6,559 placements of immigrants in solitary confinement from January 2016 to May 2018.[51] About 40 percent of these placements involved individuals

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[44] See Human Rights Watch et al., *Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigrant Detention* (June 2018), *https://www.hrw.om/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration* (examining ICE's own reviews of 15 deaths that occurred in custody from December 2015 and April 2017, and finding substandard medical care to have contributed or led to 8 of the 15; see similar findings in Human Rights Watch et al., *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention* (May 2017), *https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care-us-immigration-detention.*

[45] Id.

[46] See, e.g., ACLU of Colorado, *Cashing in on Cruelty: Stories of death, abuse and neglect at the GEO immigration detention facility in Aurora* (Sept. 2019), *https://aclu-co.com/wp-content/uploads/2019/09/ACLU_CO_Cashing_In_On_Cruelty_9-17-19.pdf,* at pp. 13–14; Southern Poverty Law Center, "SPLC, allies sue ICE for ignoring medical, mental health and disability needs of detained immigrants," Aug. 19, 2019, *https://www.splcenter.org/news/2019/08/19/splc-allies-sue-ice-ignoring-medical-mental-health-and-disability-needs-detained-immigrants.*

[47] National Immigrant Justice Center and Physicians for Human Rights, *Invisible in Isolation: the Use of Segregation and Solitary Confinement in Immigration Detention* (Sept. 2012), *https://immigrantjustice.org/sites/immigrantjustice.org/files/Invisible%20in%20IsolationThe%20Use%20of%20Segregation%20and%20Solitary%20Confinement%20in%20Immigration%20Detention.September%202012_7.pdf.*

[48] Ian Urbina and Catherine Rentz, *The New York Times,* "Immigrants held in solitary cells, often for weeks," Mar. 23, 2013, *https://www.nytimes.com/2013/03/24/us/immigrants-held-in-solitary-cells-often-for-weeks.html.*

[49] U.S. Immigration and Customs Enforcement Policy Memo 11065.1: Review of the Use of Segregation for ICE Detainees, Sept. 4, 2013, *https://immigrantjustice.org/sites/default/ files/Segregation%2520Directive%2520%2528Sept%25202013%2529.pdf.*

[50] Maryam Saleh and Spencer Woodman, The Intercept, "A Homeland Security whistleblower goes public about ICE abuse of solitary confinement," May 21, 2019, *https://theintercept.com/2019/05/21/ice-solitary-confinement-whistleblower/.*

[51] Project On Government Oversight, *Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months* (Aug. 2019), *https://www.pogo.com/investigation/2019/08/isolated-ice-confines-some-detainees-with-mental-illness-in-solitary-for-months/.*

with mental illness, and more than 4,000 of those records show individuals suffering in solitary for more than 15 days. One person was held for more than 2 years.[52]

The United Nations Special Rapporteur on torture, Juan Méndez, has called on States to ban the use of solitary confinement as a form of punishment, noting scientific evidence showing that solitary confinement can lead to lasting mental damage after only a few days.[53]

Tragically, this persistent exposure of the abusive conditions in the detention system has yet to make a difference for the individuals who continue to suffer in ICE detention centers each day. NIJC client Kelly, a transgender asylum seeker who has been detained by ICE since late 2017, spoke with NBC News about her experiences in solitary confinement months earlier: "The only thing they told me was that it was because of the way I looked . . . They claimed it was for security reasons . . . I told them from day one that I didn't want to be locked up almost 24 hours a day, alone in a cell, without medical attention. Every time I closed my eyes, when I was trying to sleep, I began to have nightmares, horrible memories, things that I didn't want to remember . . . It's still happening to me."[54]

Right to counsel rendered meaningless

The systemic lack of accountability for abuses committed in ICE custody is compounded by the isolated and remote location of ICE jails and prisons. An NPR analysis recently found that more than half of immigrants detained by ICE are in remote rural prisons.[55] This is not an accident: The administration is well aware that immigrants jailed remotely, far from their loved ones and less likely to find representation, are more likely to lose their cases regardless of the strength of their claim to relief.[56]

Section 1362 of chapter 8 of the U.S. Code provides that immigrants facing removal proceedings have the right to an attorney; however, because there is no system of appointed counsel in immigration court, this right is only meaningful for those who can afford an attorney or are able to access free representation. It is a common saying among immigration attorneys that the two biggest factors determining whether a person will win or lose in immigration court are: (1) If the person is detained, and (2) if the person has a lawyer. In 2016, a study came out showing that only 14 percent of immigrants in detention were able to find a lawyer, and that among immigrants in detention, those with counsel were twice as likely as unrepresented immigrants to successfully defend against their deportation.[57]

The Trump administration's rapid expansion of the detention system appears intentionally designed to worsen the access to counsel crisis. ICE has clustered much of its expansion in the southeast United States, including a recent push to open 3 new detention centers that can hold about 4,000 individuals in Mississippi and Louisiana.[58] In addition to significant concerns about the conditions immigrants will face in these privately-run prisons (including one prison with a history of deaths following poor medical treatment), advocates and immigration attorneys have called ICE on its transparent gambit to jail immigrants in locations where the right to counsel is meaningless. The executive director of one Louisiana legal aid organization told Mother Jones that even immigrants who could afford lawyers would be unlikely to find one if detained in Louisiana: "ICE is saying they want to get to 15,000 [detainees] by the end of the summer in Louisiana . . . There's an intentional, purposeful approach behind this of putting people where they can't access counsel."[59]

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[52] Id.

[53] United Nations News, "Solitary confinement should be banned in most cases, U.N. expert says," Nov. 18, 2011, *https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says.*

[54] Tara Tidwell Cullen, National Immigrant Justice Center, "ICE's use of solitary confinement has gotten worse," May 21, 2019, *https://immigrantjustice.org/staff/blog/ices-use-solitary-confinement-has-gotten-worse.*

[55] Yuki Noguchi, NPR, "Unequal outcomes: Most ICE detainees held in rural areas where deportations risks soar," Aug. 15, 2019, *https://www.npr.org/2019/08/15/748764322/unequal-outcomes-most-ice-detainees-held-in-rural-areas-where-deportation-risks.*

[56] Id.

[57] Ingrid Eagly and Steven Shafer, American Immigration Council, *Access to Counsel in Immigration Court* (Sept. 2016), *https://www.americanimmigrationcouncil.org/research/access-counsel-immigration-court.*

[58] Noah Lanard, Mother Jones, "ICE just quietly opened three new detention centers, flouting Congressional limits," July 9, 2019, *https://www.motherjones.com/politics/2019/07/ice-just-quietly-opened-three-new-detention-centers-flouting-congress-limits/.*

[59] Id.

Vulnerable populations in heightened danger

Under the Trump administration, little if any discretion is utilized by ICE officers in determining who to detain. The administration's application of the full force of a punitive and harmful detention system on all immigrants regardless of vulnerabilities has left many exposed to inordinate harm.

ICE reports that approximately 65 percent of its currently detained population was transferred to ICE custody from the border or airport, largely an asylum-seeking population.[60] Additionally, nearly 9,000 of those in custody have already been determined by DHS to have a credible fear of persecution or torture if returned to their countries of origin.[61] For survivors of torture and trauma, the experience of ICE detention can lead to quickly deteriorating mental health and a re-living of the harms recently fled. The Center for Victims of Torture and the Torture Abolition Survivor Support Coalition have found that, "Detention is a daunting experience for anyone but particularly egregious for survivors of torture. For survivors, given the long-term impacts of torture and trauma, the fact of being detained at all is often retraumatizing. Further, particular elements inherent in the detention experience—including a profound sense of powerlessness and loss of control—may recapitulate the torture experience. Beyond this, the indefinite nature of immigration detention is a blanket over it all, contributing to severe, chronic emotional distress.[62]

LGBTQ individuals in detention similarly face heightened risk of violence and harm. Data shared by ICE with Rep. Kathleen Rice in 2017 demonstrated LGBTQ people in ICE custody to be 97 times more likely to be sexually victimized than non-LGBTQ people.[63] LGBTQ people in detention regularly report a wide array of abusive and dangerous conditions, including routine sexual harassment and abuse from guards and other detainees, the delay or denial of hormone therapy, and the constant use of solitary confinement for so-called "protection."[64]

Despite public outrage, the administration has also doubled down on its commitment to the use of family detention, moving to abrogate the *Flores* Settlement Agreement in favor of regulations providing for the expansion and indefinite use of detention for families.[65] Medical professionals, child welfare professionals, and Government whistleblowers have all decried the use of detention for asylum-seeking families, which causes inevitable and potentially irreversible trauma to children.[66]

TOWARD A BETTER WAY

The United States' now-40-year-old experiment with the primary reliance on jails and prisons for migration control has failed by any measure. Arthur Helton's 1986 warning that the emerging immigration detention system was an "initiative designed to mistreat all equally" echoes in the testimony of today's witnesses, more than 30 years later.

NIJC urges Members of Congress to begin doing the hard work of laying a foundation to end the use of immigration detention, to stop this system that unnecessarily deprives immigrants of their liberty and disrupts their rights to access to counsel, family unity, and wellness. There is a better way, through the adoption of community-based and community-supported programming centered around case management that supports immigrants through their case proceedings and provides

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[60] This data is maintained by ICE at *https://www.ice.gov/detention-management#tab2.*

[61] Id.

[62] Center for Victims of Torture et al., *Tortured and Detained: Survivor Stories of U.S. Immigration Detention* (Nov. 2013), *https://www.cvt.org/sites/default/files/Report__Tortured-AndDetained__Nov2013.pdf.*.

[63] Sharita Gruberg, Center for American Progress, "ICE's rejection of its own rules is placing LGBT immigrants at severe risk of sexual abuse," May 30, 2018, *https://www.americanprogress.org/issues/lgbt/news/2018/05/30/451294/ices-rejection-rules-placing-lgbt-immigrants-severe-risk-sexual-abuse/*.

[64] Robert Moore, *Washington Post,* "Gay and transgender detainees allege abuse at ICE facility in New Mexico," Mar. 25, 2019, *https://www.washingtonpost.com/immigration/gay-transgender-detainees-allege-abuse-at-ice-facility-in-new-mexico/2019/03/25/e33ad6b6-4f10-11e9-a3f7-78b7525a8d5f__story.html.*

[65] See Michael D. Shear and Zolan Kanno-Young, *The New York Times,* "Migrant Families Would Face Indefinite Detention Under New Trump Rule," Aug. 21, 2019, *https://www.nytimes.com/2019/08/21/us/politics/flores-migrant-family-detention.html.*

[66] See, e.g., Miriam Jordan, *The New York Times,* "Whistle-Blowers Say Detaining Migrant Families 'Poses High Risk of Harm,'" July 18, 2018, *https://www.nytimes.com/2018/07/18/us/migrant-children-family-detention-doctors.html?;* Julie M. Linton, Marsha Griffin, Alan J. Shapiro, American Academy of Pediatrics, *Policy Statement: Detention of Immigrant Children* (May 2017), *https://pediatrics.aappublications.org/content/139/5/e20170483?utm__source=MagMail-&utm__medium=email&utm__term=dmiller%40aap.org&utm__content=All-Member-072618-&utm__campaign=A%20Message%20from%20the%20AAP%20President%20on%20Family%20Separation%20and%20Detention.*

them the resources that allow them to flourish, rather than setting them up to fail. Working toward this alternative vision will bring the United States in line with our international legal and moral obligations, be far less costly, and make great headway toward establishing a migration processing system that actually works.[67]

While working toward this long-term goal, NIJC also urges Members of Congress to take immediate steps to mitigate the harmful impact of the ICE detention system, including:

- Engage in one or more unannounced visits to an ICE detention center.[68]
- For Members with an ICE facility in their State or district, actively engage with that facility: Visit regularly, engage in oversight steps, intervene when conditions are deficient, and support local legal service providers and visitation groups in maintaining access.
- Invest in non-profit community-based alternative-to-detention programs. Cut funding for ICE's detention and enforcement account, and support restrictions in DHS's authority to transfer and reprogram funds into that account.
- Support changes necessary to move the immigration detention facilities inspections regime out of ICE and into an independent body such as the DHS Office of Inspector General.
- Support H.R. 2415, the Dignity for Detained Immigrants Act, which remedies many of the most harmful aspects of the detention system, including:
  - Ending mandatory, or no-bond, detention;
  - Ensuring a presumption of liberty rather than a presumption of detention for all immigrants; and
  - Ending the use of private prisons and county jails for immigration detention.

The United States immigration detention takes so much from so many. On our watch, our Government is incarcerating hundreds of thousands of immigrants each year, depriving individuals of access to counsel, tearing families apart and destabilizing communities, and it is not necessary and it is not sound policy. Urgent action is needed, today.

STATEMENT OF DANA L. GOLD, ESQ., GOVERNMENT ACCOUNTABILITY PROJECT

SEPTEMBER 26, 2019

Dear Committee Members: Thank you for the opportunity to submit written comments in support of your hearing, "Oversight of ICE Detention Facilities: Is DHS Doing Enough?"

I serve as senior counsel for Government Accountability Project, a national nonprofit whistleblower protection and advocacy organization founded in 1977. As Congress and the Nation have been reminded over the past week with news about the intelligence community whistleblower who used prescribed channels to raise the alarm about serious and urgent issues related to abuses of authority of the highest order, whistleblowers—ethical civil servants who discover information about wrongdoing and choose to disclose those concerns—are one of the best mechanisms to facilitate oversight, promote legal compliance and accountability, and prevent or mitigate serious harm.

My organization currently represents 3 DHS whistleblowers, Drs. Scott Allen and Pamela McPherson, and attorney Ellen Gallagher, all of whom work or worked for DHS's Office of Civil Rights and Civil Liberties (CRCL) at the time of their initial disclosures. All 3 raised concerns about systemic problems in ICE detention facilities: Drs. Allen and McPherson, CRCL's medical and mental health subject-matter experts, raised concerns about the imminent risk of harm posed to children in detention at Family Residential Centers; Ms. Gallagher, as a senior policy advisor in CRCL's immigration section, blew the whistle with extensive documentation on ICE's wide-spread use of solitary confinement on mentally ill and medically vulnerable adult civil detainees.

All 3 began raising concerns under the Obama administration internally to CRCL leadership; they also brought their concerns to the DHS Office of Inspector General (OIG), to Congress, and finally to the press in increasingly desperate efforts to address the harms—life-threatening physical and psychological damage to migrant detainees—that they initially raised internally to DHS.

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[67] See *A Better Way,* supra n. xi.

[68] NIJC and Detention Watch Network have prepared a step-by-step Toolkit for Members of Congress interested in visiting an ICE facility, available at *https://www.immigrantjustice.org/research-items/toolkit-immigration-detention-oversight-and-accountability.*

Despite the fact that these civil servants—DHS's own experts—have communicated their specific and verified concerns with increasing escalation, the detention practices they have warned as being harmful to migrant detainees have not only continued, but have increased in the surge of detention under the Trump administration's "zero-tolerance" immigration policy. As such, we remain gravely concerned that the oversight mechanisms within DHS are so limited in investigative scope, capacity, legitimacy, and authority that, rather than serve as checks on abuses and preventers of harm, their ineffectualness enables the very abuses and harms they are meant to check.

On June 27, 2019, we wrote a letter to this and other relevant Congresssional committee chairs detailing our concerns regarding DHS's failures to address serious concerns raised by its own whistleblowers on matters of life and death, and we are grateful that this committee is now conducting a hearing into this matter.

Below I have outlined both the nature of our whistleblower clients' disclosures and the processes they used to seek redress for their concerns that detention facilities pose the risk of harm to children and vulnerable adult immigrant detainees. Over the past several months, their disclosures have continued to be validated, yet remain unaddressed. Taken together, they paint a picture of DHS oversight weaknesses that demand Congressional intervention to remedy.

A. IMMIGRATION EXPERT AND ATTORNEY ELLEN GALLAGHER'S DISCLOSURES OF ICE'S WIDE-SPREAD USE OF SOLITARY CONFINEMENT ON MENTALLY ILL AND MEDICALLY VULNERABLE ADULT DETAINEES

Attorney Ellen Gallagher, when working as a senior policy advisor within the immigration section of DHS's Office of Civil Rights and Civil Liberties, discovered in reading hundreds of ICE segregation reports that ICE was regularly putting mentally ill and medically vulnerable adult migrant civil detainees in solitary confinement across dozens of ICE facilities in violation of statutory mandates and Federal detention standards, practices that qualify as torture under United Nations standards. Often segregation was used for reasons directly related to their mental illness.

These practices revealed that detainees—notably in civil detention which is by definition not punitive—were deprived of proper medical care and attention, even when suicidal; many were shackled, strip-searched, silenced, and brutalized; others missed immigration court dates that otherwise might have enabled them to seek bond, legal protection, and counsel.

Examples she discovered and disclosed were, often on the face of the segregation reports and in their notes, egregious and troubling. One detainee was diagnosed with schizoaffective disorder with hallucinations and suicidal ideation, yet spent months in and out of solitary confinement before being sentenced to 390 more days for throwing his feces at a security guard. Another was sentenced to 45 days in "24-hour lockdown" because guards during a search of his cell found a single anti-anxiety pill, hidden in a book he was reading. Detainees on "suicide watch" were routinely placed in isolation without information as to the length of time they would remain there, whether or how frequently they would be monitored, or the medical treatment they would receive. Reports from a regional jail showed mentally ill immigration detainees naked in deplorable conditions and denied reentry to the general population until they agreed to maintain "proper hygiene." Other detainees were sentenced to periods from 15 to 45 days in disciplinary segregation for offenses including "insolence," "spitting," "possession of a cellphone," "failure to follow an order," "attempted horseplay" and "attempted fighting."

Ms. Gallagher began raising concerns in 2014 about ICE's practices internally to CRCL management, which repeatedly chose not to investigate the individual cases she raised that evidenced serious violations of detention standards. She then raised concerns to DHS's Office of Inspector General (OIG), and also filed a whistleblower disclosure with the Office of Special Counsel (OSC). The OSC deferred to the OIG, which failed to investigate the full scope of Ms. Gallagher's disclosures. Despite 2 separate requests for reconsideration to the OSC to independently review the disclosures and supporting evidence, the OSC instead deferred to the OIG's own incomplete investigation. During this period as well, Ms. Gallagher's disclosures to Congress did not generate meaningful action.

In May 2019, Ms. Gallagher finally decided to go on the record after years of raising her concerns through every avenue within the Government had failed to result

in any meaningful investigation to address the wide-spread use of solitary confinement in immigration detention.[1]

On June 3, 2019, the Department of Homeland Security Office of Inspector General (DHS OIG) issued a report, *Concern about ICE Detainee Treatment and Care at Four Detention Facilities,* that failed to address the systemic abuses and violations across ICE facilities reported by Ms. Gallagher, instead focusing on wrongdoing at only the 4 adult detention facilities it visited. The OIG report found, among other violations, that 3 out of 4 sites visited used improper segregation practices which both violated ICE policy standards and infringed upon detainee rights. The findings included premature placement into solitary confinement, use of restraints at all times when detainees were outside their cells, strip searches upon entering isolation, and inadequate time outside cells. While this report's conclusions substantively confirmed Ms. Gallagher's disclosures, made over a period of almost 5 years and documenting hundreds of examples of ICE's inappropriate use of solitary confinement, the report's recommendations were limited only to reforms at the 4 facilities visited by the OIG.

Despite the limited scope of the OIG's investigation and findings, Ellen Gallagher's warnings regarding ICE's use of solitary confinement were recently validated and expanded upon by the Project on Government Oversight (POGO), which last month released a report, *ISOLATED: ICE Confines Some Detainees with Mental Illness in Solitary for Months,* demonstrating that approximately 40 percent of detainees placed in solitary confinement between January 2016 and May 2018 have mental illness, with more than 4,000 of the 6,559 records reviewed showing detainees being confined for more than 15 days. Through analyzing the results of a Freedom of Information Act request, POGO was able to confirm and describe ICE's continued and increased inappropriate use of solitary confinement across dozens of its facilities.

DHS's failure to address ICE's wide-spread use of solitary confinement on mentally ill and medically vulnerable detainees reveals the utter ineffectiveness of its oversight mechanisms.

CRCL failed to even investigate Ms. Gallagher's disclosures, despite its statutory mandate to "oversee compliance with Constitutional, statutory, regulatory, policy, and other requirements relating to the civil rights and civil liberties of individuals affected by the programs and activities of the Department" and to "investigate complaints and information indicating possible abuses of civil rights or civil liberties, unless the Inspector General of the Department detainees that any such complaint or information should be investigated by the Inspector General."[2]

Likewise, the OIG has failed to conduct investigations to address systemic, inappropriate use of solitary confinement occurring across the ICE adult detention system in the face of clear, overwhelming evidence.

Worse, the OIG's limited investigative scope—be it because of limited resources, expertise, capacity, or mandate—has preempted other mechanisms for accountability, including the OSC whistleblower disclosure process. This process requires the agency head to investigate and respond to a whistleblowers' valid disclosures and issue a report regarding steps they will take to address the problem. The whistleblower then has the opportunity to comment on the report and provide further evidence, with the OSC finally deciding whether the agency's report is adequate or not, and submitting the entire package to the President, Congressional leaderships, and appropriate Congressional committees.

If the OIG, deliberately or inadvertently, preempts OSC's investigations by failing to fully address a whistleblower's disclosures, and the OSC defers to the OIG, the upshot is that Congress is deprived of one of its most valuable mechanisms to fulfill its own mandate of overseeing the Executive branch.

B. DRS. SCOTT ALLEN'S AND PAMELA MCPHERSON'S DISCLOSURES OF IMMINENT HARM TO CHILDREN IN DHS FAMILY RESIDENTIAL CENTERS

Our clients Drs. Allen and McPherson serve respectively as the medical and mental health subject-matter experts in detention for the Department of Homeland Security's Office of Civil Rights and Civil Liberties (CRCL). In the course of investigating 4 of the Family Residential Centers for CRCL between 2014–2017—Artesia in New Mexico, Karnes and Dilley in Texas, and Berks in Pennsylvania—Drs. Allen

[1] See "A Homeland Security Whistleblower Goes Public About ICE Abuse of Solitary Confinement," The Intercept (May 21, 2019), and "Thousands of Immigrants Suffer in Solitary Confinement in U.S. Detention Centers," NBC News (May 21, 2019). These press accounts also document Ms. Gallagher's efforts to disclose evidence of ICE's inappropriate use of solitary confinement in adult detention.

[2] See 6 U.S.C. § 345(a), Establishment of Officer for Civil Rights and Civil Liberties.

and McPherson consistently raised concerns in their reports to CRCL as well as in extensive oral briefings about both the harms posed to children in detention generally as well as specific and systemic problems related to practices and policies at the family detention centers that endangered children. Indeed, their findings resulted in shutting down Artesia as too rife with problems to protect children at that facility.

When the Trump administration began expanding family detention as part of its "zero-tolerance" immigration policy, the doctors became gravely concerned that the issues that compromised care, and which had not yet been resolved, would be further exacerbated with the increased populations. This predictably put children at imminent risk of harm. In June 2018, Drs. Allen and McPherson exercised their rights as whistleblowers by communicating these concerns to CRCL management, to the DHS OIG, and to Congress.[3]

In addition to their overarching warnings that detention, for any amount of time, harms children, their specific concerns about systemic weaknesses at detention facilities included the lack of qualified medical and mental-health professionals; a lack of language translators making diagnoses exceedingly difficult; inadequate and dangerous facilities posed by the retrofitted prisons used to house families with small children; failure to provide trauma-informed care; lack of training of custodial staff to care for at-risk children; inadequate detention standards; and confusing lines of authority and weak coordination between different agencies, program partners, and Government departments that can cause dangerous communication breakdowns and accountability failures that put children at risk.

CRCL refused to investigate the doctors' concerns, claiming that the Inspector General had jurisdiction over their complaint.

However, the OIG never acknowledged receipt of let alone conducted an investigation into Drs. Allen and McPherson's disclosures, first submitted on June 25, 2018, despite the doctors' explicit warnings that a hastily-deployed expansion of family detention unnecessarily places children at imminent threat of risk of significant mental health and medical harm. Only after we wrote our letter to Congress in June 2019 decrying DHS oversight failures, and the then-Acting OIG faced questions in a July 12, 2019 House Committee an Oversight and Reform hearing about the OIG's failure to respond to the doctors' OIG complaint, were we approached by the OIG to discuss our clients' concerns.

Notably, CRCL has not conducted on-site investigations of family detention centers since September 2017, despite being aware of the systemic problems that put children in detention at risk of physical and psychological harm and despite receiving numerous complaints from or on behalf of detainees which would justify investigation.[4]

Not only did the doctors receive no indication from DHS oversight mechanisms that their concerns were being addressed, their warnings about harms to children in detention, echoed by more than 14 medical professional associations, including the American Medical Association, the American Academy of Pediatrics, the American College of Physicians, and the American Psychiatric Association,[5] were willfully ignored, as DHS in September 2018 proposed rulemaking to replace the *Flores* settlement agreement, having the intended effect of allowing for prolonged and indefinite detention of children. Drs. Allen and McPherson, in written comments to DHS and ICE, expressed their opposition to practices that would prolong detention of children, particularly while the systemic issues they had identified that pose imminent harm remained unaddressed.

With all oversight mechanisms failing to end detention of children, the doctors escalated their concerns to the press by going on the record with *60 Minutes, N.P.R.,* and *The Washington Post,* writing in December 2018 after the death of 7-year-old

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[3] See, e.g., July 17, 2018 *Letter to Senate Whistleblower Caucus Chairs* from Drs. Scott Allen and Pamela McPherson.

[4] See March 19, 2019 Letter to Congress from Drs. Allen and McPherson, *https://jayapal.house.gov/wp-content/uploads/2019/03/031919-whistleblowers-letter-to-Congress-w-cover-letter-fact-sheet-re-children-in-detention pdf.*

[5] See Letter to House Judiciary Committee, House Energy and Commerce Committee, House Homeland Security Committee, and House Appropriations Committee (July 24, 2018) (letter viewable at *https://www.acponline.org/acp_policy/letters/letter_house_oversight_request_on_child_detention_centers_2018.pdf);* Letter to Senate Judiciary Committee, Senate HELP Committee, Senate HSGAC Committee, and Senate Appropriations Committee (July 24, 2018) (letter viewable at *https://www.psychiatry.org/newsroom/news-releases/apa-joins-health-care-community-in-calling-on-congress-to-hold-hearings-on-treatment-of-children-separated-from-parents-at-border);* American College of Physicians, *Internists Call for Congressional Oversight of Family Detention* (July 20, 2018), *https://www.acponline.org/acp-newsroom/internists-call-for-congressional-oversight-of-family-detention.*

Jakelin Caal Maquin in CBP custody, "We warned DHS that a migrant child could die in custody. Now one has."

Rather than minimize detention as its own ICE Advisory Panel recommended in 2016,[6] DHS decided instead to prolong detention indefinitely in its recent final rule replacing the *Flores* Settlement Agreement standards, reflecting not only a disregard of its own medical and mental health subject-matter experts within its own oversight entities, but the willful endangerment of migrant children in order to deter migration at the Southern Border. When its own scientific experts, supplied by the overwhelming consensus of the medical professional community, warn that detention causes harm to children and DHS seeks to expand and prolong detention, DHS "oversight" of ICE detention may as well be meaningless.

C. NEW CONCERNS ABOUT DHS OVERSIGHT FAILURES OF ICE DETENTION FACILITIES

DHS announced just days ago that it intends to resume detaining migrant families at the Karnes County Residential Center, one of the detention facilities about which Drs. Allen and McPherson identified concerns about the ability to prevent harm to children. Given that CRCL has not conducted any on-site investigations of DHS family detention centers since September 2017, it belies credulity to think Karnes will have remedied the myriad problems identified by Drs. Allen and McPherson that existed even before a surge in family detention.

As for addressing ICE's wide-spread use of solitary confinement on mentally ill and medically vulnerable detainees, despite multiple letters from Congress to ICE demanding investigations into their use of solitary confinement, it is unclear what DHS oversight mechanisms are doing to address these practices that are finally being publicly exposed and decried.

The DHS OIG, in talking with me and my colleague Irvin McCullough on August 5, 2019 in response to our letter condemning their failure to investigate the most serious of whistleblowers' concerns—practices that pose harm to civil detainees and innocent children—tried to explain some of what hamstrings their ability to conduct effective oversight. Diana Shaw, Assistant Inspector General for Special Reviews & Evaluations, noted problems that included limited resources, a lack of their own subject-matter experts, the difficulty of conducting systemic investigations, limitations on their ability to conduct unannounced facility visits, a perceived limitation that they may only make recommendations relating to the facilities they actually observe, and unfunded mandates that result from the source of Congressional appropriations differing from multiple Congressional requests to conduct investigations.

These barriers to oversight should be fully investigated and remedied by Congress. When whistleblowers' concerns of the highest magnitude are ignored, as was in the case of Drs. Allen and McPherson, or only very partially addressed, as was the case with Ms. Gallagher's disclosures, one of the most valuable mechanisms for DHS accountability and oversight—the ability to meaningful respond to, investigate, and address whistleblowers' significant concerns—is broken.

There is a dire need for legitimate oversight that captures the full extent of ICE's and DHS's violations; accountability regarding the scope and recommendations of OIG's investigations; and explanations for CRCL's and the OIG's (and in Ms. Gallagher's case, the OSC's) failure to conduct oversight in response to these whistleblowers' disclosures. Whistleblowers' concerns should not only be acknowledged—they should be fully investigated, by both the administration and the Congress, to identify and correct abuses affecting millions of detainees and their families across the country.

Whistleblowers are the early warning systems to prevent problems and address abuses. These whistleblowers gave DHS the opportunity to prevent harm to children and adult migrants in the civil detention system; the fact that this committee is now holding a hearing questioning the effectiveness of DHS oversight practices reveals that the Executive branch oversight functions, including how they respond to their own whistleblowers and their disclosures, are inadequate on their own without Congressional intervention or amplified scrutiny by the press and civil society.

I do want to acknowledge that leadership at both the DHS OIG, where Ms. Gallagher currently works as a senior advisor, and at CRCL, for which Drs. Allen and McPherson continue to serve as contracted subject-matter experts, have not taken any retaliatory action to date against any of our clients. That DHS leadership in these oversight functions recognizes the rights of employees and contractors to raise concerns about such serious abuses reflects a respect and appreciation for whistleblowers as part of the overall oversight function at the agency. But lack of reprisal

[6] Report of the ICE Advisory Committee on Family Residential Centers (October 7, 2016), *https://www.ice.gov/sites/default/files/documents/Report/2016/acfrc-report-final-102016.pdf.*

is not the same as responding in a meaningful way to the substance of serious disclosures. Congress should thoroughly investigate and remedy real and perceived barriers that have resulted in failed oversight by DHS of on-going practices that continue to endanger migrant detainees at ICE detention facilities.

Thank you for the opportunity to contribute written testimony in support of this hearing. I, along with my clients, stand ready to support this committee's efforts in any way we can.

LETTER FROM MISCELLANEOUS ORGANIZATIONS

August 29, 2019.

The Honorable JOSEPH V. CUFFARI,
Inspector General, Office of Inspector General/Mail Stop 0305, U.S. Department of Homeland Security, 245 Murray Lane SW, Washington, DC 20528–0305.

Sent via USPS and email to: dhs-oig.officepublicaffairs@oig.dhs.gov
Re: Request for Investigation of Abusive Treatment of Detainees at Bossier and Pine Prairie Detention Centers

DEAR ACTING INSPECTOR GENERAL CUFFARI: We write to request that the Office of Inspector General immediately investigate two incidents that occurred at Bossier Medium Security Facility ("Bossier") in Plain Dealing, Louisiana, and at Pine Prairie ICE Processing Center ("Pine Prairie"), in Pine Prairie, Louisiana. Based on our interviews of eyewitnesses and victims, and consistent with the National news reports, we believe that Immigration and Customs Enforcement ("ICE") and its contractors at these two immigration detention centers responded to detained immigrants peacefully protesting their indefinite and inhumane detention conditions with unlawful force, and improperly interfered with protected speech. We request that you conduct a thorough investigation of these troubling incidents and publicly release the results as quickly as possible.

On August 2, 2019, ICE and its contractors beat and pepper-sprayed more than thirty (30) peaceful hunger strikers at Bossier.[1] Victims reported that ICE and its contractors pushed the hunger strikers up against a wall and kicked one in the chest. Witnesses reported having seen the hunger strikers bleeding as they were hauled away. At least one person required hospitalization. ICE and its contractors forced more than 20 of the hunger strikers into solitary confinement following the attack, cut off phone communication between them and the outside world, and according to reports from attorneys representing some of the hunger strikers, denied them access to legal visitation.[2]

On August 3, 2019, ICE and its private prison contractors at Pine Prairie shot tear gas canisters and rubber bullets at approximately 115 hunger strikers sitting in protest in the recreation yard. Some hunger strikers were also beaten.[3] We have attached photos of injuries caused by these attacks published by news outlets. Witnesses report seeing private prison guards covered in the blood of the protesters. At least 1 protestor required CPR resuscitation after the gas attack. Despite the extensive evidence of injuries caused by the attack, ICE acknowledges only that it used pepper spray to disperse a crowd. After the attack, our clients informed us that ICE locked some of the hunger strikers into solitary confinement and punitively denied them communication with their family, friends, and attorneys. They transferred another group of peaceful protestors to Adams County Conectional Center, a detention facility with a recent history of unlawful repression of peaceful protests.[4] At Pine Prairie, ICE and its contractors subsequently locked detained individuals into solitary confinement, after people spoke about the incident to loved ones on their Pine Prairie-issued tablets.

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[1] *Dozens of ICE Detainees Were Pepper-Sprayed by Guards for Protesting at a Louisiana Jail,* Mother Jones, August 2, 2019, *https://www.motherjones.com/politics/2019/08/immigrant-detention-ice-bossier-louisiana-pepper-spray/*.

[2] *Deputies at La. jail pepper spray, strike ICE detainees,* Washington Blade, August 3, 2019, *https://www.washingtonblade.com/2019/08/03/deputies-at-la-jail-pepper-spray-strike-ice-detainees/*.

[3] *More Than 100 Immigrants Were Pepper-Sprayed At An ICE Facility,* Buzzfeed News, August 6, 2019, *https://www.buzzfeednews.com/article/hamedaleaziz/ice-immigrants-pepper-sprayed-louisiana-pine-prairie*.

[4] *Warren Demands Answers From ICE About Its New Detention Centers in the South,* Mother Jones, July 12, 2019, *https://www.motherjones.com/politics/2019/07/warren-demands-answers-from-ice-following-mother-jones-report-on-detention-centers/*.

Neither incident required the application of the use of force. Even if some intervention were to be deemed necessary, the relationship between the need and the amount of force used clearly exceeded lawful authority.

These abuses are part of ICE's disturbing practice of punishing detained protestors for exercising their right to protest with severe retaliation and excessive force.[5] These practices violate the First and Fifth Amendment rights of these immigrants, who were lawfully and peacefully protesting an ICE detention system in which at least 25 people have died since 2016.[6] ICE's conduct also violates its own policies and standards regarding use of force.[7]

All immigration detainees, including those who are being held pursuant to civil immigration law, and who have no prior criminal history, are entitled to rely on the protections of the due process clauses in the Fifth and Fourteenth Amendments, and they have rights under the First Amendment.

The Constitution provides protections to immigrant detainees regardless of whether they are being held on criminal or civil grounds with regard to conditions that constitute "punishment."[8] Civil detainees are also guaranteed certain liberty interests such as reasonably safe conditions of confinement, freedom from unreasonable bodily restraint, and the right to food, clothing, medical care, and shelter.[9] Likewise ICE's own detention standards prohibit use of force "to punish a detainee" and "using force against a detainee offering no resistance."[10] The standards authorize use of weapons only when detained individuals are "armed and/or barricaded . . . cannot be approached without danger to self or others; and . . . a delay in controlling the situation would seriously endanger the detainee or others, or would result in a major disturbance or serious property damage."[11] ICE's Use of Force Policy states that chemical agents may be used only to "temporarily incapacitate an assailant. They may be used in situations where empty-hand techniques are not sufficient to control disorderly or violent subjects."[12] It is clear from the reports that we have received that ICE and its contractors used unlawful force against these peaceful hunger strikers.

Further, the First Amendment prohibits ICE from abridging freedom of speech.[13] By prohibiting outside communication by protestors and those who reported those the attacks and forcing them into solitary confinement, ICE appears to be violating their First Amendment rights. Likewise, ICE detention standards require that even those in solitary confinement "be permitted to place calls to attorneys, other legal representatives, courts, government offices . . . and embassies or consulates phones."[14] No ICE disciplinary standard authorizes solitary confinement for those who report abuses in detention.[15]

Please investigate why ICE and its contractors used unlawful force, weapons, and chemical agents at these facilities though none of the protestors was disorderly, dangerous, or violent, and to what extent ICE and its contractors violated ICE's own standards and the First Amendment in these incidents. It is critical that the public obtains a full accounting of the specific circumstances surrounding these attacks; that you determine how and why ICE continues to beat and gas peaceful protesters; and that you assess whether ICE or any other administration officials bear any responsibility for the circumstances leading to these abuses.

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[5] *BREAKING: As Hunger Strikes Erupt Nationwide In ICE Detention, Immigrants Subjected To Retaliation and Excessive Force,* Freedom for Immigrants, August 6, 2019, *https://www.freedomforimmigrants.org/news/2019/8/6/multiple-hunger-strikes-erupt-in-ice-jails-and-prisons-nationwide*.

[6] *The Trump Administration Has Let 24 People Die in ICE Custody,* Vice News, June 10, 2019. *https://news.vice.com/en_us/article/3k3jd3/the-trump-administration-has-let-24-people-die-in-ice-custody; Mexican man dies in ICE custody in Georgia,* NBC News, July 25, 2019, *https://www.nbcnews.com/news/latino/mexican-man-dies-ice-custody-georgia-n1034651*.

[7] See notes 10–12, supra.

[8] *Bell* v. *Wolfish,* 441 U.S. 520, 535 (1979); See e.g. *Lynch* v. *Cannatella,* 810 F.2d 1363, 1375 (5th Cir. 1987) ("[W]hatever due process rights excludable [noncitizens] may be denied by virtue of their status, they are entitled under the Due Process Clauses of the Fifth and Fourteenth Amendments to be free of gross physical abuse at the hands of State or Federal officials.")

[9] *Youngberg* v. *Romeo,* 457 U.S. 307, 315–316 (1982).

[10] PBNDS 2.15(V)(E)(2) and 2.15(V)(E).

[11] PBNDS 2.15(V)(E)(5).

[12] Interim ICE Use of Force Policy, ICE, July 7, 2004, *https://www.dhs.gov/sites/default/files/publications/ice-use-of-force-policy.pdf*.

[13] See *Stefanoff* v. *Hays Cnty.,* 154 F.3d 523, 527 (5th Cir. 1998) (Finding that "a hunger strike may be protected by the First Amendment if it was intended to convey a particularized message."); *Hart* v. *Hairston,* 343 F.3d 762, 764 (5th Cir. 2003)) (Finding that the First Amendment prohibits retaliation for speaking out about conditions of confinement).

[14] 2011 ICE Performance-Based Detention Standards ("PBNDS"), Chapter 2.12, Section V, Subsection BB, *https://www.ice.gov/doclib/detention-standards/2011/2-12.pdf*.

[15] PBNDS Appendix 3.1.A.

All of the victims of the violence perpetrated by ICE and its contractors at Bossier and Pine Prairie are detained immigrants. ICE and its contractors used unlawful physical violence against them. Congress enacted the Inspector General Act of 1978 to "ensure integrity and efficiency in government" and according to your website, your mission is "[t]o provide independent oversight and promote excellence, integrity, and accountability within DHS." In the name of integrity and accountability, we urge you to investigate the above-detailed incidents of violence against detained immigrants at Bossier and Pine Prairie.

Thank you for your attention to this matter.

Sincerely,

ACLU OF LOUISIANA
AL OTRO LADO
AMERICANS FOR IMMIGRANT JUSTICE
ASIAN AMERICANS ADVANCING JUSTICE—ATLANTA
DETENTION WATCH NETWORK
FREEDOM FOR IMMIGRANTS
INNOVATION LAW LAB
ISLA
JUST DETENTION INTERNATIONAL
KENTUCKY COALITION FOR IMMIGRANT AND REFUGEE
NEW ORLEANS WORKERS CENTER FOR RACIAL JUSTICE
PROJECT ISHMAEL—FIRST GRACE COMMUNITY ALLIANCE
PROJECT SOUTH
RAICES
SOUTHERN POVERTY LAW CENTER
TAOS IMMIGRANT ALLIES
TENNESSEE IMMIGRANT AND REFUGEE RIGHTS
UNITARIAN UNIVERSALIST SERVICE COMMITTEE.

LETTER FROM MISCELLANEOUS ORGANIZATIONS

September 25, 2019.

Dr. STEWART D. SMITH,
Assistant Director for ICE Health Services Corps., Enforcement and Removal Operations, Immigration and Customs Enforcement, Department of Homeland Security, Washington, DC 20528.

Mr. MATTHEW ALBENCE,
Acting Director, U.S. Immigration and Customs Enforcement, Department of Homeland Security, Washington, DC 20528.

Mr. MARK A. MORGAN,
Acting Commissioner, U.S. Customs and Border Protection, Department of Homeland Security, Washington, DC 20528.

Ms. CAMERON QUINN,
Officer for Civil Rights and Civil Liberties, Office for Civil Rights and Civil Liberties, Department of Homeland Security, Washington, DC 20528.

Mr. JOSEPH V. CUFFARI,
Inspector General, Office of Inspector General, Department of Homeland Security, Washington, DC 20528.

RE: Failure to provide adequate medical and mental health care to LGBTQ people and people living with HIV in immigration detention facilities

DEAR DR. SMITH, MR. ALBENCE, MR. MORGAN, MS. QUINN, AND MR. CUFFARI: We, the undersigned organizations, file this complaint on behalf of current and formerly detained lesbian, gay, bisexual, transgender, and queer individuals and people living with HIV (LGBTQ, PLWHIV) in immigration detention facilities. This complaint details recent accounts of Immigration and Customs Enforcement's (ICE) and Customs and Border Protection's (CBP) provision of egregiously inadequate medical and mental health care, jeopardizing the health, safety, and lives of individuals in Federal custody while they exercise their legal right to pursue their immigration claims and seek protection in the United States. ICE and CBP's continued failure to provide such basic care is in clear violation of the U.S. Constitution, statutory law, and ap-

plicable detention standards.[1] This failure has led to the deaths of multiple LGBTQ, PLWHIV migrants, and continues to cause inseparable harm.

In light of the substantial evidence of ICE's inability to safely house and adequately care for LGBTQ, PLWHIV individuals in its custody, we call for ICE to exercise its parole authority and release all LGBTQ, PLWHIV individuals on their own recognizance. We also urge the Office of Inspector General (OIG) to work with the Office for Civil Rights and Civil Liberties (CRCL) to immediately conduct a systemic investigation into the provision of medical and mental health care to LGBTQ, PLWHIV individuals in ICE and CBP custody. We call on ICE to comply with the OIG's January 29, 2019 recommendation and use its contracting tools to hold accountable those detention facilities that fail to meet the applicable standards of care by ending their contracts and imposing financial penalties. Finally, we call on DHS to strengthen its oversight of all facilities to identify and promptly remedy abuses and medical neglect within these centers.

THE ABUSE OF LGBTQ, PLWHIV INDIVIDUALS IN DHS CUSTODY IS WELL-DOCUMENTED

The wide-spread abuse and mistreatment of LGBTQ, PLWHIV individuals in ICE custody is well-documented. The Department of Homeland Security (DHS) has already received countless reports of LGBTQ, PLWHIV individuals' experiences with verbal, sexual, and physical violence, medical negligence, inhumane housing conditions, and overuse of solitary confinement in both public and private detention centers.[2] Rather than being confined to a few detention centers, these reports are widespread and consistent, demonstrating the systemic inability of DHS to meet even basic standards of care for LGBTQ, PLWHIV migrants.

For example, just 2 months prior to Johana Medina's death, a complaint was sent to DHS detailing the rampant discrimination and violence inflicted on LGBTQ individuals at Otero County Processing Center, the detention center where Johana Medina died as a result of the substandard care she received in DHS custody.[3] Even after this complaint was received and after Johana Medina's death, ICE continues to deny transgender women and gay and bisexual men at Otero basic health care and provides misinformation on how to access hormone therapy. In fact, an investigative report published in 2018 demonstrated that DHS has received more than 200 complaints of abuse and mistreatment from individuals housed at Otero County Processing Center, and yet, Otero continues to operate today and DHS has failed to take adequate actions to improve conditions at the facility.[4]

Another complaint filed by the American Immigration Council (Council) and the American Immigration Lawyers Association (AILA) in 2018 detailed the lack of access to basic medical care and mental health care at the Denver Contract Detention Facility in Aurora, Colorado.[5] DHS failed to meaningfully address the concerns

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[1] The United States is additionally obligated under international law to provide adequate health care for detained immigrants. Namely, the United States is a signatory to the International Covenant on Economic, Social, and Cultural Rights, which guarantees everyone a right to physical and mental health. United Nations General Assembly, International Covenant on Economic, Social and Cultural Rights, Art. 12, December 16, 1966, *https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx.*

[2] See National Immigrant Justice Center, Submission of Civil Rights Complaints Regarding Mistreatment and Abuse of Sexual Minorities in DHS Custody, available at *http://www.immigrantjustice.org/sites/immigrantjustice.org/files/OCRCL%20Global%20Complaint%20Letter%20April%202011%20FINAL%20REDACTED.pdf;* Sharita Groberg, "Dignity Denied: LGBT Immigrants in U.S. Immigration Detention," (Center for American Progress 2013) available at *https://www.americanprogress.org/wp-content/uploads/2013/11/ImmigrationEnforcement.pdf;* Human Rights Watch, "Do You See How Much I'm Suffering Here? Abuse Against Transgender Women in US Immigration Detention," (Human Rights Watch 2016) available at *https://www.hrw.org/sites/default/files/report__pdf/us0316__web.pdf;* Letter from Rep. Kathleen Rice to DHS Secretary Kirstjen Nielsen (May 30, 2018) (available at *https://kathleenrice.house.gov/uploadedfiles/2018.05.30__lgbt__immigrants__in__ice__detention__letter__to__sec__nielsen.pdf).*

[3] ACLU New Mexico, Santa Fe Dreamers Project, and Las Americas: Immigrant Advocacy Center; Detention Conditions Impacting the Safety and Well-Being of LGBTQ Immigrants in the Otero County Processing Center, *https://www.aclu-nm.org/sites/default/files/field__documents/advance__copy__of__3.25.2019__las__americas__santa__fe__dreamers__project-__aclu-nm__letter__to__dhs__re__otero.pdf.*

[4] Craig, Nathan, and Margaret Brown Vega. "'Why Doesn't Anyone Investigate This Place?': Complaints Made by Migrants Detained at the Otero County Processing Center, Chaparral, NM Compared to Department of Homeland Security Inspections and Reports." El Paso, TX: Detained Migrant Solidarity Committee (DMSC) and Freedom for Immigrants (FFI), 2018.

[5] Failure to Provide Adequate Medical and Mental Health Care to Individuals Detained in the Denver Contract Detention Facility, *https://www.americanimmigrationcouncil.org/sites/default/files/general__litigation/complaint__demands__investigation__into__inadequate__medical-__and__mental__health__care__condition__in__immigration__detention__center.pdf.*

raised in the complaint, and 1 year later, in June 2019, the Council and AILA supplemented the complaint with additional evidence of inadequate medical and mental health care.[6] Specifically, the complaint includes the case of a transgender woman who reported she was denied access to hormone treatment, and was subjected to serious sexual and verbal harassment by facility guards and other detained individuals.

On July 9, 2019, 29 transgender women and non-binary individuals held at Cibola County Conectional Center in New Mexico called for an investigation into poor medical services—including HIV care—and mistreatment at the facility.[7] In April, 2019, 7 organizations, including the American Civil Liberties Union, investigated Cibola and reported that the center had inadequate medical and mental health care, abuses related to solitary confinement, discrimination and verbal abuse, and inappropriate meals, among other issues.[8]

The OIG's own investigation of 5 ICE facilities, including Santa Ana City Jail where the previous transgender housing pod was located and Otero County Processing Center, "identified problems that undermine the protection of detainees' rights, their humane treatment, and the provision of a safe and healthy environment" and "potentially unsafe and unhealthy detention conditions."[9] In an earlier inspection of the Essex County Correctional Facility, the OIG noted the "serious issues" it identified "not only constitute violations of ICE detention standards but also represent significant threats to detainee health and safety."[10]

Rather than take effective action to address the numerous complaints of abuse and mistreatment of LGBTQ, PLWHIV individuals in detention, DHS has focused on subjecting an increasing number of people to these horrific conditions. The number of individuals in immigration detention is at a historical high and keeps rising, despite the fact that many of these individuals are eligible for release. By the Department's own count, 300 individuals who identify as transgender have been in the custody and supposed care of ICE since October 2018 alone. This is the highest number of transgender migrants in the care of the U.S. Government ever recorded. At the same time, DHS has failed to take measures to ensure the basic health and safety of this population. It is unjustifiable for the U.S. Government to subject an increasing number of individuals, including those qualified as vulnerable populations such as LGBTQ, PLWHIV individuals, to these dangerous conditions.

DHS HAS CONSISTENTLY DEMONSTRATED IT IS INCAPABLE OF PROVIDING ADEQUATE HIV CARE

The stories included in this complaint shed light on the effects of growing roadblocks in access to basic health care as well as life-saving HIV care in detention due to chronic, systemic medical neglect and lack of oversight in detention. While ICE has adopted 3 sets of detention standards, including PBNDS 2011, it does not require contractors to adopt any recent standards when it enters into new contracts or contract extensions. The result is a "patchwork system in which facilities are subject to differing standards and some are subject to no standards at all",[11] and people are outright denied access to care, delayed in receiving medical attention, and are left in conditions that exacerbate their physical and mental health ailments.

The risks that accompany substandard HIV care are serious, and they arise from the inconsistent or delayed access to treatment. This is why 2011 PBNDS standards have aimed—without success—to secure uninterrupted access to HIV/AIDS medication for people in detention.

The U.S. Government recognizes that poor adherence to HIV treatment is associated with less effective viral suppression. The U.S. Department of Health and Human Services underscores that strict adherence to antiretroviral therapy is key to sustained HIV suppression, reduced risk of drug resistance, and survival, as well

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[6] SUPPLEMENT—Failure To Provide Adequate Medical and Mental Health Care to Individuals Detained in the Denver Contract Detention Facility, *https://www.americanimmigrationcouncil.org/sites/default/files/general__litigation/complaint__supplement__failure__to__provide__adequate__medical__and__mental__health__care.pdf.*

[7] Laura Gomez, "Migrants held in ICE's only transgender unit plead for help, investigation in letter," *AZ Mirror,* July 9, 2019 *https://www.azmirror.com/2019/07/09/migrants-held-in-ices-only-transgender-unit-plea-for-help-investigation-in-letter/*.

[8] Detention Conditions Impacting the Safety and Well-Being of Immigrants in the Cibola County Correctional Center in Milan, New Mexico. April, 2019 *https://www.aclu-nm.org/sites/default/files/field__documents/2019__04__15__nm__stakeholders__letter__to__crcl__re__cibola__county__correctional__center.pdf.*

[9] OIG–18–32.

[10] OIG–19–20.

[11] *https://immigrantjustice.org/research-items/toolkit-immigration-detention-oversight-and-accountability*.

as decreased risk of HIV transmission.[12] An unsuppressed viral load may risk the immediate health of HIV positive individuals and it will also risk creating treatment resistance. If patients fail to respond to their given drug regimen, they are moved to second-line drugs, which may be more expensive or difficult to manage.[13] [14]

Evidence has shown that individuals with HIV who keep adherence to HIV medicine as prescribed can stay virally suppressed and thus have effectively no risk of transmission. In fact, the Centers for Disease Control and Prevention's (CDC) HIV Treatment as Prevention Technical Fact Sheet reports a 96 percent reduction in HIV transmission risk among heterosexual mixed-status couples where the HIV-positive partner started antiretroviral therapy (ART) immediately versus those delaying ART initiation.[15] Far too many people in detention are outright denied access to HIV-related care or experience significant delays. This delay of treatment is cruel, counterintuitive to ending HIV transmission, and causes irreparable harm.

REPORTS OF DEFICIENT MEDICAL AND MENTAL HEALTH CARE FOR LGBTQ, PLWHIV INDIVIDUALS

Below are multiple accounts of medical negligence and mistreatment of LGBTQ, PLWHIV individuals in detention centers across the country. This by no means represents all of the stories of abuse and mistreatment, but rather provides a glance at the systemic harms and inadequate care provided to LGBTQ, PLWHIV individuals under the care of DHS and CBP. There are many stories not included here for fear of reprisal.

DETENTION CENTERS MANAGED BY CORECIVIC

Cibola County Correctional Center—Milan, New Mexico

A. is a transgender woman from El Salvador who has been detained in Cibola County Detention Center for almost 20 months. A.'s medical records indicate she suffered from advanced syphilis and, according to a pro bono medical evaluation, her medical records indicate that her condition has progressed to neurosyphilis, increasingly affecting her cognitive abilities. Despite this evidence and her counsel's advocacy, ICE has continuously failed to provide her penicillin, a well-known and easily accessible medication. ICE has also repeatedly refused to release A. from detention so she can get the medical treatment she requires.

Otay Mesa Detention Center—San Diego, California

G. is a 34-year-old HIV-positive Salvadoran trans woman and activist who worked to advance trans rights in Latin America and the Caribbean prior to applying for asylum and was detained in male housing for more than 6 months in Otay Mesa in 2017. During this time, her HIV medication was withheld. Additionally, she was misdiagnosed with tuberculosis. Rather than treating her HIV, she was over-medicated in attempts to treat tuberculosis she did not have.

Otay Mesa Detention Center—San Diego, California

Y.E. is a transgender woman from Mexico. She was brutally raped, tortured, beaten, and kept hostage by the cartels for months because she dressed as a woman. Again and again she was gang-raped. The rapes caused tears in her anus and rectum. The rapes also resulted in her contracting HIV. After she presented herself at the border, lawfully asking for asylum, she was placed in a detention center and was taken off medication for HIV for a significant amount of time. In addition to requesting treatment for HIV, she repeatedly asked for help with the tears in her anus/rectum. The medical staff at the detention center refused to address it because the tearing did not happen at the facility and because they believed it to be too invasive. Because no treatment was given, she caught an infection that resulted in

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[12] U.S. Department of Health and Human Services, "Guidelines for the use of antiretroviral agents in HIV-Infected adults and adolescents". Revised July 2019. *https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/*.

[13] Kenneth L. Schaecher, Addressing Adherence Challenges Associated With Antiretroviral Therapy: Focus on Noninfectious Diarr, The Importance of Treatment Adherence in HIV, September 29, 2013. *https://www.ajmc.com/journals/supplement/2013/a472_sep13_hiv/a472_sep_13_schaecher_s231*.

[14] Jane Mwangi, CDC Kenya (Centers for Disease Control and Prevention), Our Research in Kenya: Finding Ways to Improve HIV Treatment Access and Outcomes, *https://blogs.cdc.gov/global/2012/07/26/our-research-in-kenya-finding-ways-to-improve-hiv-treatment-access-and-outcomes/*.

[15] Centers for Disease Control and Prevention CDC, Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV. HIV Treatment as Prevention Technical Fact Sheet. *https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf*.

anal bleeding. She was held in custody for months before finally being released on parole.

Otay Mesa Detention Center—San Diego, California

S.A.G.C. is an HIV-positive transgender woman who has been repeatedly abused and raped because of anti-transgender bias in her home country of El Salvador. The severity of the abuse in her country was such that during the credible fear interview both the asylum officer and the translator needed a moment because of the horrors she described. Although her health was deteriorating in detention and she felt harassed for being a transgender woman in an all-male pod, she was kept in custody until she was granted a $2,500 bond—even though she had letters of support from her sponsor and the community that would be accepting her. That bond amount was prohibitive to S.A.G.C. and it was only after a bond fund paid for her release that she was able to get out of detention.

Otay Mesa Detention Center—San Diego, California

B.C.H. is an asylee from El Salvador. He fled El Salvador after his life was threatened by gangs on account of his sexual orientation and political opinion. B.C.H. entered Otay Mesa Detention Center in May 2018 weighing 220 pounds. When he was released in September 2018, he weighed only 190 pounds.

B.C.H. required serious psychological support due to his traumatic history of sexual abuse and assault. While at Otay Mesa, he mentioned to Al Otro Lado that he was seeing a psychologist, but at one point, despite the threat of imminent death should he return to El Salvador, he was certain he wanted to stop fighting his case and return to El Salvador due to the conditions at Otay Mesa. We are unsure what, if any, psychological treatment he was receiving, and his unaddressed trauma combined with his extreme weight loss raised serious red flags regarding the adequacy of medical care at the facility. Despite his severe weight loss and mental trauma, his parole bond was set at $10,000, an amount impossible for him to pay.

Otay Mesa Detention Center—San Diego, California

S.Y.M.M. is a 47-year-old gay man from Honduras. He is blind in one eye and suffers from a myriad of health conditions, including hypertension and the growth of a cyst on his head. S.Y.M.M.'s ICE Medical Records indicate that the pain in his head resulting from the cyst on his scalp worsened significantly while detained. Additionally, at one point, one of his teeth became severely infected, and he was never treated for that ailment. S.Y.M.M.'s parole request was denied, and he was only able to leave the facility when Al Otro Lado submitted a new request. Even so, his bond was set at a prohibitively high $5,000. He was only released when a community organized to pay his bond.

Otay Mesa Detention Center—San Diego, California

R.E.P.L. is a transgender woman from Guatemala who was sexually abused by her father and her uncles. When she tried to escape the constant sexual abuse of the men in her family, local police tracked her down, assaulted her, and returned her to them. When she finally escaped her family, R.E.P.L. was taken in by a woman who was affiliated with the 18th Street Gang. This woman forced her under duress to be a sex worker, and R.E.P.L. was held captivate for 2 years. Police gang-raped R.E.P.L. when she tried to escape that woman's house and she had no choice but to flee Guatemala to seek protection in the United States. En route to the United States, R.E.P.L. was again violently gang-raped while in Mexico and believes she contracted HIV. R.E.P.L. requested asylum in January of 2019 and was subsequently detained at Otay Mesa Detention Center. She expressed her concern to staff at the facility that she was HIV positive, making countless requests in writing for an HIV test. Al Otro Lado staff reached out on numerous occasions to R.E.P.L.'s deportation officer to ensure she received the necessary testing but never received a response. While R.E.P.L. was detained at Otay, there was an outbreak of several infectious diseases, including mumps and chicken pox. Therefore, it was critical for her to know whether she had HIV or not, as her immune system may have been severely compromised. The lack of any initiative by the facility to ensure she was tested for HIV put her health at serious, life-threatening risk. Despite her traumatic past and serious health concerns, the immigration judge refused to grant her release on her own recognizance and set a bond in the amount of $1,500. She was only released after a community organized to pay her bond.

Cibola County Correctional Center—Milan, New Mexico

C.L. is a transgender woman from Peru who was in detained for nearly 5 years. She was transferred from Santa Ana Jail in California to Cibola County Correctional Center when Cibola first opened its transgender unit. While in Cibola, she

repeatedly requested medical care for Hepatitis C, which she'd been denied at Santa Ana, and continued to be denied treatment after the transfer. She was in need of urgent medical care several times while in detention, and recalls once being in the hospital for 2 weeks. She was shackled by her ankles and her wrists and two guards were posted outside her door. She wondered why they would do this when she was in no condition to escape.

Otay Mesa Detention Center—San Diego, California

Y is a transgender HIV-positive woman from Mexico. Upon her arrival at the border, Y was detained in San Ysidrio, where immigration officials confiscated her HIV medicine and kept her in a freezing room for 9 days. Y asked 3 times for her HIV medication back and was denied each time. Y was later transferred to Otay Mesa Detention Center, where she was once again denied her life-saving medication for an entire month. Furthermore, the Otay Mesa medical staff refused to provide adequate treatment for the injuries Y suffered during a brutal sexual assault in Mexico. In Otay Mesa, Y was housed with the male population and was harassed by 2 detained men and an ICE official. When she tried to make complaints about the harassment to the facility manager, the manager dismissed her by referring to her complaint as "gossip."

Otay Mesa Detention Center—San Diego, California and Hudson County Correctional Facility—Kearny, New Jersey

E is a gay man from Honduras. Upon arrival to the United States, E was detained at the Otero County Processing Center and, later, at the Hudson County Correctional Facility. E faced continuous harassment in both detention facilities from guards and other detained individuals because of his sexual orientation. In Hudson, the officers and other individuals in detention constantly referred to E as "gay" instead of his name or other appropriate forms of address. E also had serious dental problems while he was in Hudson. However, the medical staff refused to provide E with the necessary medical treatment, in contradiction to the applicable Performance-Based National Detention Standards.

Otay Mesa Detention Center—San Diego, California

P is a 38-year-old Honduran citizen and transgender woman living with HIV. She entered without inspection at the Southern Border in California on February 2, 2019, and was detained at Otay Mesa for about 6 months. In Honduras, local police stopped P because she was dressed in women's clothes and then they raped her. P's employer in Honduras continuously harassed and threatened her until 1 day they hired people to beat her up in front of several witnesses who came forward. While she was detained at Otay Mesa, her HIV medication was delayed and she never received hormone therapy. As a result, her mental and physical health deteriorated.

DETENTION CENTERS MANAGED BY GEO GROUP, INC.

Adelanto Detention Center—Adelanto, California

J. is a transgender man from El Salvador who has been detained in Adelanto Detention Center for about 9 months. Before being detained, J. had been receiving gender-affirming hormone therapy for many years. Since he has been detained, however, J. has not received gender-affirming hormone treatment despite numerous requests. J.'s mental and physical health have significantly deteriorated as a result.

Adelanto Detention Center—Adelanto, California

J. is a gay man, a national of Mexico, and a Franco-Gonzalez class member, who was deemed—by an immigration judge—as non-competent to represent himself during his removal proceedings due to his mental health. J. was diagnosed with the following mental health disorders: Major neurocognitive disorder due to multiple etiologies with behavioral disturbance; amphetamine-type substance use disorder, severe, in a controlled environment; major depressive disorder, recurrent, severe with psychotic symptoms; unspecified neurodevelopmental disorder (history of a learning disability). Due to signs of his deteriorating health, in January 2018 his legal representative requested HIV testing for J. Despite being court-ordered, the HIV test was not performed for more than 7 months. J.'s medical records indicate that in August 2018 he received a positive HIV diagnosis, and that GEO medical staff began antiretroviral treatment, over 8 months after his legal representative first requested it.

Adelanto Detention Center—Adelanto, California

I.S.I. identifies as LGBTQ and has a diagnosis of bipolar disorder. She has been in ICE custody since September 2018. Despite complications with her mental health,

she was found competent by an immigration judge and denied a free appointed immigration attorney. Since then, she has attempted to die by suicide at least 4 times. Her attorney at the Los Angeles LGBT Center was unable to locate her client for over 2 weeks during one of these periods. She is not safe in ICE Custody and does not feel safe. She reports that the medical care she is receiving is not helping her.

South Texas Detention Facility—Pearsall, Texas

A. is an HIV+ transgender woman asylum seeker who has been detained at the South Texas Detention Center ("STDC") since December 2014. A. has suffered from severe medical problems and improper treatment since her arrival at STDC. She has lost more than 25 pounds (and is now severely underweight at 89 pounds) since the start of detention, and has been suffering from insomnia, nausea, and loss of appetite because of the side effects of her medication, and possible incompatibility of her hormone therapy and antiretroviral drugs administered by the detention center. She only gets 3 hours of sleep each night, or sometimes none at all. Because of the symptoms from her medication, she struggles to consume and retain food, and relies on vitamins purchased with her own funds from the commissary to obtain nutrition and sustenance.

Although A. receives nutritional shakes to supplement her meals, she continues to experience nausea, and the underlying problems of her medication possibly interfering with each other, or mis-prescribed medication has yet to be sufficiently addressed.

In June and July, 2019, she experienced two incidents where she fainted and lost consciousness for hours. In the first incident, other individuals in detention asked the guards for medical help, but either because of a delay in dispatch or response, medical services providers did not reach A. until hours later. In the second incident, which occurred in the late morning, she was taken to an outside facility, where she was told that her lungs were swollen and that she had a sinus infection, and merely given acetaminophen and returned to the facility in the afternoon. Unfortunately, even though A. has raised these issues with the facility and with ICE, her medical issues have not been comprehensively addressed, and she continues to rapidly lose weight as a result of her nausea and lack of sleep, and her health continues to deteriorate. She expresses a fear of dying at STDC.

Aurora Detention Facility—Aurora, Colorado

L.M. is a transgender woman who was detained for 6 months in Aurora, where she was detained with men and was harassed on a regular basis. Soon after her arrival, she reported to detention center staff that she needed to continue the hormone treatment she had been receiving. Staff responded that she would be put on a list to see a doctor. However, L.M. did not receive a doctor's appointment for over 2 months. At the appointment, the medical provider told her they would need to consult her medical records to find her hormone prescription, and if they could not find it, would need to refer her to a specialist. She did not receive any updates for another 2 months, at which point she received an appointment with a specialist, which was then canceled. L.M. finally received the appointment and her prescription the day before her release but never received the hormones.

Due to the abrupt end to her treatment, L.M. experienced nausea, difficulty sleeping, lack of appetite, mood changes, and depression during the 6 months she was detained. Due to the harassment she faced for being a transwoman detained with men, she reported these incidents to the detention center guards but their only response was to put her in solitary confinement, claiming it was for her own safety. She was put in solitary confinement several times for up to a month at a time, a practice that can rise to the level of inhuman and degrading treatment and even torture.

DETENTION FACILITIES MANAGED BY LASALLE CORRECTIONS

Irwin County Detention Center—Ocilla, Georgia

S. is a bisexual woman from Jamaica who is HIV-positive and has been residing in the United States since she was 4 years old. She was abandoned and became homeless when she was around 10 years old and was sexually exploited throughout her teenage years. Given her prostitution-related charges, she has been forced to remain in ICE custody throughout the pendency of her proceedings. Since being detained, she has frequently gone days without her HIV medication. She has to write a letter to the warden every month to receive her HIV medicine and if she does not write the letter, she does not receive her refill. Occasionally, she receives the wrong brand of HIV medication. The head of medical at the facility has also made it difficult for S. to receive blood work, leaving S. unable to monitor her levels. In addition, a nurse disclosed S.'s HIV status to the guards.

Irwin County Detention Center—Ocilla, Georgia

C., an east Asian trans man, has been held in immigration detention for almost 2 years. For the first 19 months, he was held in solitary confinement solely because he is a transgender man. While in solitary, his health suffered due to inadequate medical care, including not receiving his blood pressure medicine, being given the wrong treatment for a severe illness which led to weeks of extreme stomach pain, and being fed food that made his diabetes worse. At one, point while he was getting a hormone shot, the person giving it to him was so incompetent that the syringe broke while inside his leg. Further, C. has also been identified and confirmed to be a victim of trafficking by Federal law enforcement. In fact, Federal law enforcement confirmed that his convictions were tied to human trafficking but still, ICE refuses to release him because of his convictions. C. was recently transferred out of Irwin Detention Center, but is still being held in immigration detention, despite ICE's awareness of his victim status.

DETENTION CENTERS MANAGED BY ICE

Krome Service Processing Center—Miami, Florida

D. is a gay, HIV-positive man from Russia. He had already applied for asylum, when he was unjustly detained in a Florida detention facility in 2017, while returning from a trip to the U.S. Virgin Islands. He went multiple days without access to anti-retroviral medication and developed an opportunistic infection. Because he has a compromised immune system, this was life-threatening. When he asked to see a doctor, D. was forced to spend multiple days in a freezing waiting room. ICE refused to release him until the Associated Press ran a story about his mistreatment.

DHS IS VIOLATING LEGAL STANDARDS BY REFUSING MEDICAL TREATMENT AND DELAYING CARE

The inhumane and punitive conditions described above are in direct contravention of established law and norms. It is the responsibility of DHS to hold the detention facilities under its purview to the legal requirements and to appropriately penalize them when they continuously harm migrants in their care.

Constitutional Protections

The Fifth Amendment Due Process Clause of the U.S. Constitution protects substantive rights of "all persons" present in the United States, including detained immigrants.[16] As such, people in detention are entitled to, at a bare minimum, adequate medical care, as well as adequate food, shelter, clothing, and reasonable safety.[17]

Immigration detention is civil, not criminal, in nature.[18] Unlike criminal detention, civil detention cannot be punitive and any restriction on a person's liberty must be rationally related to a legitimate governmental goal.[19] In the context of criminal detention, the Eighth Amendment clearly prohibits "deliberate indifference" on the part of the detention staff to a detained individual's "serious medical need[s]."[20] Courts have held that people in civil detention are entitled to a standard of care greater than—or at the very least, equal to—the standard of care afforded to people in criminal detention.[21] Indeed, the Ninth Circuit has held that, unlike people in criminal detention, civilly confined individuals need not prove "deliberate indifference" to demonstrate a violation of their Constitutional rights.[22]

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[16] *Zadvydas* v. *Davis,* 533 U.S. 678, 693 (2001).

[17] See *Youngberg* v. *Romeo,* 457 U.S. 307, 315–16, 324 (1982) (finding civil detainee entitled to adequate food, shelter, clothing, medical care, and reasonable safety under the Fourteenth Amendment).

[18] Zadvydas, 533 U.S. at 690 (acknowledging that immigration detention is civil).

[19] *Bell* v. *Wolfish,* 441 U.S. 520, 535–539 (1979).

[20] *Estelle* v. *Gamble,* 429 U.S. 97, 104 (1976) ("prison official's deliberate indifference to an inmate's serious medical needs is a violation of the Eighth Amendment's prohibition against cruel and unusual punishment").

[21] *Jones* v. *Blanas,* 393 F.3d 918, 931–34 (9th Circ. 2004), cert denied, 546 U.S. 820 (2005) (a civilly detained person is entitled to "'more considerate treatment' than his criminally detained counterparts . . . Therefore, when a [civil] detainee is confined in conditions identical to, similar to, or more restrictive than those in which criminal counterparts are held, we presume that the detainee is being subjected to 'punishment.'" (internal citations omitted)); see also *Youngberg* v. *Romero,* 457 U.S. 307, 321–32 (1982) ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.").

[22] Jones 393 F.3d at 934; see also *Hydrick* v. *Hunter,* 500 F.3d 978, 994 (9th Cir. 2007) ("[T]he Eighth Amendment provides too *little* protection for those whom the State cannot punish." (emphasis in original, citations omitted)).

The accounts of abuse and neglect detailed above describe profoundly deficient physical and mental health care, including the denial of life-saving HIV medication. As such, ICE and CBP have violated the higher Eighth Amendment standard, showing deliberate indifference to serious medical needs and failing to provide critical care. These failures on the Government's part, which have caused detained immigrants to endure debilitating pain, suffer serious injury, and have placed them in mortal danger, amount to Constitutionally-prohibited punishment. It is clear that LGBTQ, PLWHIV immigrants cannot be housed safely in detention and therefore should be released.

Statutory Law

Various Federal and State statutes also protect detained immigrants. For instance, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 provide protections from discrimination and mandate access to adequate and reasonable accommodations for LGBTQ, PLWHIV immigrants with physical and mental disabilities who are detained by ICE and CBP.[23] Likewise, the Prison Rape Elimination Act imposes National standards for the prevention, reduction, and punishment of prison rape, including standards for the provision of physical and mental health services to individuals who have been the victim of sexual abuse.[24] The stories above illustrate that not only are detention centers failing to provide even the most basic care to LGBTQ, PLWHIV after experiencing sexual violence, they are placing people in inhumane segregation leading to a further deterioration of physical and mental health. This has forced many LGBTQ, PLWHIV individuals to abandon viable claims for asylum and return to the violent conditions from which they fled in the first place. This is the very outcome asylum protections were created to prevent.

Detention Standards

In addition to these legal obligations, ICE and CBP must comply with their own set of standards, which are designed to protect detained immigrants. Notably, as currently applied, these standards have failed to translate into adequate physical and mental health care for LGBTQ, PLWHIV individuals due to inconsistent application, insufficient oversight and lack of accountability. In other words, ICE and CBP are failing to comply with their own standards.

The most comprehensive of these standards, the 2011 Performance-Based National Detention Standards (2011 PBNDS), updated in 2016, set forth extensive medical care requirements for ICE. For instance, the 2011 PBNDS require appropriate physical, dental, and mental health care as well as pharmaceutical services, 24-hour access to emergency care, and timely responses to medical complaints for all detained people.[25] They also require language services for individuals with limited English proficiency during any physical or mental health appointment, treatment, or consultation.[26] The stories above illustrate that far too many LGBTQ, PLWHIV individuals are flat-out denied access to care or are left waiting for months on end for treatment.

For PLWHIV, the facility has more specific requirements. For example, it must provide medical care consistent with National recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, the CDC, and the Infectious Diseases Society of America, and must provide access to all medications for the treatment of HIV currently approved by the FDA.[27] Moreover, adequate supplies of such medications must be kept on hand to ensure newly-detained individuals are able to continue with their treatments without interruption.[28] Detained immigrants are entitled to request an HIV test at any time.[29] Clearly, this is not happening.

The 2011 PBNDS also mandate that special consideration be given to people at risk of sexual assault, including individuals who have self-identified as members of

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[23] Americans With Disabilities Act of 1990, Pub. L. No. 101–336, 104 Stat. 327 (1990), *http://library.clerk.house.gov/reference-files/PPL_101_336_AmericansWithDisabilities.pdf.;* Rehabilitation Act of 1973, Pub. L. No. 93–112, 87 Stat. 355 (1973), *https://www.gpo.gov/fdsys/pkg/STATUTE-87/pdf/STATUTE-87-Pg355.pdf.*

[24] 6 C.F.R. §§ 115.81–115.83 (2014).

[25] U.S. Immigration and Customs Enforcement, Performance-Based National Detention Standards 2011, 257–81 (2016), *https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf.*

[26] Id. at 264.

[27] Id at 263.

[28] Id.

[29] Id. at 263.

the LGBTQ community.[30] With specific regard to transgender individuals, the 2011 PBNDS require that those individuals who were receiving hormone therapy when taken into ICE custody, maintain continued access to such therapy.[31] The guidelines further demand that detained transgender people have access to "mental health care, and other transgender-related health care and medication based on medical need."[32] Once again, this complaint and others demonstrate that DHS is failing to meet these standards and transgender people are experiencing immense suffering as a result.

The other two National ICE standards—the National Detention Standards (NDS), issued in 2000 and the 2008 PBNDS—while less comprehensive than the 2011 PBNDS, also provide guidelines to ensure the health and safety of detained immigrants. These guidelines include provisions that establish access to health services,[33] mental health screenings and treatment plans,[34] and suicide prevention protocols.[35] These standards also require detention facilities to provide medical treatment to PLWHIV.[36]

In addition to these generalized detention standards, ICE also issued a memorandum concerning the care of detained transgender immigrants in 2015. The memorandum sets forth guidance to ensure the safety of transgender immigrants in ICE's custody. More specifically, the memorandum includes contract modifications for facilities to ensure access to adequate health care, including access to hormone therapy. The memorandum also states that during initial processing or risk classification assessment of an individual, the detention facility staff should inquire about a person's gender identity[37] and make an individualized placement determination to ensure person's safety, including whether detention is warranted. Where feasible and appropriate, ICE should house transgender immigrants in facilities that are equipped to care for transgender people.[38] ICE also has a directive on Gender Dysphoria and Transgender Detainees which applies to all IHSC personnel and requires an IHSC medical provider to complete a physical examination for transgender individuals within 2 business days of intake and that a behavioral health provider must also perform a mental health evaluation for transgender patients within the same time frame.[39] Furthermore, IHSC "must initiate and/or continue hormone therapy for [gender dysphoria] detainees as clinically indicated and in accordance with the IHSC Clinical Guidelines for the Treatment of GD."

Similarly, CBP has a set of standards to provide for the health and safety of individuals in its custody. These standards require CBP officials to inspect detained people for "any signs of injury, illness, or physical or mental health concerns . . . ,"[40] and in cases of emergency, CBP officials must immediately call medical services.[41] The standards also note that individuals known to be on life-sustaining or life-saving medical treatment, LGBTQ people, and individuals with mental or physical dis-

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[30] Id. at 135.
[31] Id. at 273.
[32] Id. at 274.
[33] U.S. Immigration and Customs Enforcement, Detention Operations Manual: Medical Care (2000), *https://www.ice.gov/doclib/dro/detention-standards/pdf/medical.pdf.;* U.S. Immigration and Customs Enforcement, Performance-Based National Detention Standards: Medical Care, 1 (2008), *https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.*
[34] U.S. Immigration and Customs Enforcement, Detention Operations Manual: Medical Care, 3 (2000), *https://www.ice.gov/doclib/clro/detention-standards/pdf/medical.pdf.;* U.S. Immigration and Customs Enforcement, Performance-Based National Detention Standards: Medical Care, 13–14 (2008), *https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.*
[35] U.S. Immigration and Customs Enforcement, Detention Operations Manual: Suicide Prevention and Intervention (2000), *https://www.ice.gov/doclib/dro/detention-standards/pdf/suiciprev.pdf.;* U.S. Immigration and Customs Enforcement, Performance-Based National Detention Standards: Suicide Prevention and Intervention, 1–2 (2008), *https://www.ice.gov/doclib/dro/detention-standards/pdf/suicide_prevention_and_intervention.pdf.*
[36] U.S. Immigration and Customs Enforcement, Detention Operations Manual: Medical Care, 7 (2000), *https://www.ice.gov/doclib/dro/detention-standards/pdf/medical.pdf.;* U.S. Immigration and Customs Enforcement, Performance-Based National Detention Standards: Medical Care, 7–8 (2008), *https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.*
[37] U.S. Dep't. of Homeland Security, Further Guidance Regarding the Care of Transgender Detainees, 2 (June 19, 2015) *https://www.ice.gov/sites/default/files/documents/Document/2015/TransgenderCareMemorandum.pdf.*
[38] Id.
[39] JHSC Directive: 03–25 effective March 15, 2017.
[40] U.S. Customs and Border Protection, *National Standards on Transport, Escort, Detention, and Search,* 14 (Oct. 2015), *https://www.cbp.gov/sites/default/files/assets/documents/2017-Sep/CBP%20TEDS%20Policy%20Oct2015.pdf.*
[41] Id. at 17.

abilities may require additional care and oversight.[42] Additionally the standards require that during transportation of a detained person, CBP officials must be on alibi for signs of medical symptoms, and provide or seek medical care in a timely manner.[43]

While the strength of protections accorded by different detention standards varies, even the weakest standards set minimum requirements for the health and safety of detained people. Unfortunately, however, as the experiences of LGBTQ, PLWHIV individuals detailed in this letter demonstrate, ICE and CBP routinely fail to comply with the most basic requirements.

DHS CANNOT SAFELY HOUSE LGBTQ, PLWHIV INDIVIDUALS AND MUST FIX THE BROKEN OVERSIGHT SYSTEM THAT ALLOWS THESE OFFENSES TO CONTINUE WITH NO ACCOUNTABILITY

ICE and CBP blatantly disregard the health of LGBTQ, PLWHIV individuals and repeatedly fail to not only meet legally required standards of care but even their own detention standards. The countless reports of outright denial of medical treatment and the continuous maltreatment clearly demonstrate that DHS cannot house LGBTQ, PLWHIV individuals safely. Furthermore, there is no reason to keep LGBTQ, PLWHIV people in detention in the first place.

Further, DHS is failing to meet their responsibility of oversight. DHS's own reports demonstrate that contracted agencies who are responsible for investigations do not take their responsibilities seriously. What's more, even when medical neglect and mistreatment is substantiated, DHS rarely uses its authority to implement penalties and address the conditions that led to the harm in the first place. For example, in a report looking at 2018 and 2019 inspection reviews of ICE detention facilities, the OIG concluded that ICE's monitoring systems do not ensure adequate oversight or systematic improvements in detention conditions, with some deficiencies remaining unaddressed for years.[44] Further, the OIG found that ICE did not adequately hold detention facility contractors accountable for their lack of compliance with performance standards because they failed to use contracting tools to hold them accountable.[45]

With this in mind, we demand that:

- First and foremost, ICE release all LGBTQ, PLWHIV people that are currently detained on their own recognizance.
- ICE comply with the OIG's January 29, 2019, recommendation and use its contracting tools to hold accountable those detention facilities that fail to meet these standards for care by imposing financial penalties and canceling contracts for facilities that consistently fail to meet the standards.
- The DHS OIG work with the CRCL to immediately conduct a systemic investigation into the provision of medical and mental health care to LGBTQ, PLWHIV individuals in ICE custody.
- DHS must strengthen its oversight of facilities and improve its audits of facilities, ensure timely cooperation of components with OIG and CRCL investigations, increase its use of unannounced inspections, and improve grievance procedures and take meaningful measures to end retaliation against individuals in custody who exercise their right to file a grievance.
- DHS must ensure that all people in detention are aware of their legal rights through developing and disseminating information that details the medical care that they are entitled to.
- Ensure that people are not held in CBP longer than the minimal amount of time it takes for processing, no longer than 24 hours.
- Ensure that CBP provide all persons in custody with timely medical screenings by a licensed health professional and require an EMT or other certified health professional to be on-duty and available to give medical attention at all times in CBP processing and holding stations. Ensure that the health professionals are competent on transgender and HIV-related health care.
- Create a thorough, independent, and regular investigation process and standards to ensure that CBP is meeting designated standards and to document inci-

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[42] Id. at 19.

[43] Id. at 6.

[44] Office of Inspector General (OIG), ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements, *https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf*.

[45] OIG, ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards, *https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf*.

dents of neglect and abuse. Develop specific policies that detail penalties for CBP facilities with documented cases of abuse and medical neglect.

CONCLUSION

We were deeply saddened and angered to learn of the death of Johana Medina Leon, who died on June 1, 2019 after spending 7 weeks in ICE custody. Her death came almost a year to the day of the death of Roxsana Hernandez, another transgender woman who should not have been detained and who died while in ICE custody. Both of these women experienced medical neglect and the stories in this complaint demonstrate that, tragically, the circumstances around their deaths are not outliers but in fact the norm for the treatment of transgender, as well as lesbian, gay, bisexual, and people living with HIV in ICE and CBP custody. The well-documented mistreatment of LGBTQ, PLWHIV individuals demonstrates that ICE and CBP are unable to adequately care for LGBTQ, PLWHIV people, or really any individuals, in their care.

Despite the frequent and on-going complaints made to DHS, poor oversight and lack of accountability allows these conditions to continue. Neither DHS nor the detention centers that the Department is responsible for overseeing are above the law and should receive appropriate consequences for these egregious offenses.

If you have any questions about the above information, please contact Ash Stephens at Ash@transgenderlawcenter.org or Sharita Gruberg at sgruberg@americanprogress.org.

Sincerely,

TRANSGENDER LAW CENTER,
BLACK LGBT MIGRANT PROJECT,
FAMILIA TRANS QUEER LIBERATION MOVEMENT,
AL OTRO LADO,
LAS AMERICAS IMMIGRANT ADVOCACY CENTER,
CENTER FOR AMERICAN PROGRESS,
LOS ANGELES LGBT CENTER,
FREEDOM FOR IMMIGRANTS,
SANTA FE DREAMERS PROJECT,
SOUTHERN POVERTY LAW CENTER,
IMMIGRATION EQUALITY,
CENTER FOR VICTIMS OF TORTURE,
NATIONAL IMMIGRANT JUSTICE CENTER,
NATIONAL CENTER FOR TRANSGENDER EQUALITY.

STATEMENT OF ASIAN AMERICANS ADVANCING JUSTICE—AAJC

SEPTEMBER 26, 2019

AAJC submits this testimony for the record for the public hearing entitled, "Oversight of ICE Detention Facilities: Is DHS Doing Enough?" held on September 26, 2019 by the Subcommittee on Oversight, Management & Accountability in Washington, DC. Asian Americans Advancing Justice—AAJC ("Advancing Justice—AAJC") is a National non-profit organization founded in 1991 dedicated to advancing civil and human rights for Asian Americans. Advancing Justice—AAJC is the leading national advocate for immigration policy on behalf of the Asian American community, and in this capacity, we work to reunite and keep immigrant families together. We appreciate this opportunity to submit a written statement for today's hearing and thank the committee members for holding this bearing to examine the Trump administration's problematic use and expansion of ICE detention centers.

Immigrant detention should be a last resort, not the norm; however, the Department of Homeland Security continues to increase the number of detained immigrants despite there being adequate, cheaper, and more humane alternatives. The U.S. Government should do everything in its power to keep families together and only take away people's liberty when there is a compelling need to do so. The current immigration detention system only serves to separate families and violate the rights of vulnerable populations including children. Detention centers are not safe and provide inadequate medical care leading to human rights abuses. We urge Congress to not let these human rights abuses continue, and to stop the expansion and use of detention centers to criminalize immigrant communities.

I. GOVERNMENT'S INHUMANE USE OF DETENTION CENTERS AGAINST ASIAN IMMIGRANTS

The Government has a long history of criminalizing and detaining Asian immigrants. One of the worst examples of detention was the incarceration of 120,000 Americans of Japanese ancestry during World War II.[1] Based simply on their ancestry, Japanese Americans were guilty based on race and ancestry. Children were not spared this association of guilt based on ancestry. Fathers, mothers, and children were rounded up and forced to leave their homes and move into detention centers.[2] George Takei likened the Japanese American internment and the modern-day detention centers to concentration camps.[3] He compared the family separation experienced by Japanese-Americans with what many immigrant families face today in detention centers.[4] This legacy of criminalizing and holding in custody immigrant communities continues to this day, and repeats the horrors of the internment of Japanese Americans in detention centers.

Detaining and separating families has a real human price that people continue to pay today. Just this past March, the United States reached a historic high of 50,059 detained immigrants.[5] Asian immigrants make up a significant portion of this population of detained immigrants. Despite only making up a small percentage of the total population, there were as many as 4,881 Asian immigrants who were detained as of June 2018.[6] Many of them were asylum seekers and refugees who were seeking protection in the United States under our refugee and asylum laws. The majority of Asian immigrants detained were from India, China, Bangladesh, Nepal, Iraq, Vietnam, and Pakistan.[7]

Thousands of South Asian immigrants are harmed by immigrant detentions, with Indian nationals in particular, having the highest number of detainees of all Asian immigrants.[8] Just from October 2014 to April 2018, over 17,000 South Asians were arrested by Border Patrol.[9] In June 2018, over 3,000 South Asian migrants were detained.[10] Many South Asian immigrants are simply seeking asylum in the United States and fleeing persecution in their home countries. Instead of finding safety and protection, many South Asian asylum seekers are instead arrested and imprisoned in detention centers.

Our current detention system impacts not only asylum seekers, but all immigrants including long-time members of our communities, lawful permanent residents (LPRs), and even family members of U.S. citizens. As such, there are many

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[1] See Exec. Order 9066, 7 Fed. Reg. 1407 (Feb. 19, 1942) (authorizing the internment of Americans of Japanese ancestry); see also *Korematsu* v. *United States,* 323 U.S. 214 (1944) (upholding the internment under strict scrutiny review).

[2] Id.

[3] *Concentration Camp Survivor George Takei Talks Family Separation At U.S. Border,* Huffpost (July 10, 2019), *https://www.huffpost.com/entry/concentration-camps-border-george-takei-family-separation__n__5d2533ale4b0cfb595fd8e65?guccounter=1&guce__referrer=aHR0cHM6Ly93d3cuZ29vZ2x1LmNvbS8&guce__referrer__sig=AQAAACBreMqk0eT4UKSrEyj1Ldh-Mw3gE__pMwlQ8sZZ3X30XH8q46mcjWUu3__5tU1XAcFlj6i__zFv__ZwNFXVEADBZz4JBH63-uLu7vW0KJEdxesCIbxLRnbTK2tFLbs34TDFJgQBuslspXR8DH0pvYJqfHGs0TqUfGExuyO-06eMus8x7v* (last visited September 25, 2019).

[4] Id.

[5] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside The Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 63 (2019) (citing Emily Kassie, "How Trump Inherited His Expanding Detention System," *The Marshall Project* (February 12, 2019); Spencer Ackerman, "ICE Is Detaining 50,000 People, an All-Time High," *Daily Beast* (March 9, 2019)), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-compressed.pdf.*

[6] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside The Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 63 (2019) (citing TRAC, "Immigration and Customs Enforcement Detainees."), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-compressed.pdf.*

[7] Id.

[8] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside The Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 63 (2019) (citing Parvini, "Growing Number of California Detainees"; PTI, "2,382 Indians Languishing in U.S. Jails for Illegally Crossing Border," Economic Times of India (November 12, 2018)), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-compressed.pdf.*

[9] South Asian Migrants in Detention 1 (2019) (citing TRAC, "CBP Arrests"), available at *http://saalt.org/wp-content/uploads/2019/08/South-Asian-Migrants-in-Detention-Fact-sheet.pdf.*

[10] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside the Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 63 (2019) (citing Transactional Records Access Clearinghouse, "Immigration and Customs Enforcement Detainees," Syracuse University), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-compressed.pdf.*

Asian immigrants who are subject to unfair and unnecessarily harsh mandatory detention and automatic deportation laws that were passed in 1996. Within the Asian American community, Southeast Asian immigrants have been notably targeted. There are 17,000 Southeast Asian lawful permanent residents living with a final order of removal.[11] Thousands of Southeast Asian immigrants are harmed by the detention system. Despite coming here as refugees, many long-term members of communities now must leave the only country that is home to them. In June 2018, about 43 percent of Vietnamese Americans detained lived in the United States for over 2 decades.[12] The percentage of Lao and Cambodian Americans detained who lived here for over 20 years is even higher at 86 percent and 75 percent, respectively.[13] Southeast Asian households who have a family member that is detained face family separation and the continued hardship of not knowing whether their families will be able to reunite or be separated indefinitely.[14] Detention and family separation traumatizes and harms families and communities.

The human impact of current immigration policies and the detention system on the Southeast Asian immigrant community and on families is tremendous. Thear Sam was detained in the fall of 2018 leaving behind his family, all of whom are U.S. citizens.[15] As a result of his detention, his family experienced both emotional and financial hardship.[16] Since Thear was the main provider for his family, his detention meant that his high school daughter could no longer go to her after-school activities.[17] His mother, who is a breast cancer survivor, developed depression and had difficulty eating and sleeping following her son's arrest.[18] The impact of his arrest ripples out to whole communities.[19] Diane Ford from Long Beach, California described the effect of his detention: "Thear is a well-known and well-loved member of the Long Beach community. Those closest to him have been traumatized by the abrupt nature of his arrest, and ICE's refusal to be transparent has only made things worse."[20] Thear is not alone. There are hundreds of Southeast Asian refugees and families torn apart as loved members of communities are taken away to be deported.[21]

II. TROUBLING USE OF THE DETENTION CENTERS

A. Detention Centers are Inadequate and Unsafe

Detention centers provide inadequate medical care, and are not safe for detainees. In many instances, they are even life-threatening for immigrants. From 2003 until January 2018, about 188 detainees died in ICE detention facilities.[22] The death rates have only worsened under the Trump administration. In fiscal year 2017,

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[11] *SEARAC Denounces Scheduled Deportation over 50 Cambodian Americans,* SEARAC (July 1, 2019), *https://www.searac.org/immigration/searac-denounces-scheduled-deportation-of-over-50-cambodian-americans/* (last visited September 25, 2019).

[12] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside the Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 64 (2019) (citing TRAC, "ICE Detainees"), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-compressed.pdf.*

[13] Id.

[14] National Asian Pacific American Women's Forum & Southeast Asia Resource Action Center, "Dreams Detained in Her Words: The Effects of Detention and Deportation on Southeast Asian American Women and Families," *https://www.searac.org/wp-content/uploads/2018/09/dreams__detained__in__her__words__report-2.pdf.*

[15] Hannah Woerner, Katrina Dizon-Mariateague, and Nancy Nguyen, "Families Torn Apart: Trump's Quiet Attacks on the Southeast Asian Immigrant Community," Medium (Apr. 5, 2018).

[16] Id.

[17] Id.

[18] Id.

[19] Id.

[20] Id.

[21] Id.

[22] Id. (citing Human Rights et al., *Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention* (June 2018); Lisa Riordan Seville, Hannah Rappleye, and Andrew W. Lehren, "22 Immigrants Died in ICE Detention Centers During the Past Two Years," *NBC News* (January 6, 2019); Erin Durkin, "The Immigrants Who Have Died in U.S. Custody in 2018," *The Guardian* (December 29, 2018); Scott Bixby, "Immigrant Miscarriages in ICE Detention Have Nearly Doubled under Trump," *Daily Beast* (March 1, 2019); Spencer Woodman, "Private Prison Continues to Send ICE Detainees to Solitary Confinement for Refusing Voluntary Labor," *The Intercept* (January 11, 2018); Ryan Devereaux and Spencer Woodman, "Immigrant Detainee Accuses ICE Contractor CoreCivic of Locking Him in Solitary over $8," *Intercept* (April I 9, 2018)), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-compressed.pdf.*

more immigrants had died in detention than in any year since 2009.[23] A leading cause of death for detainees is inadequate medical care.[24]

Children are even more vulnerable to the deplorable conditions that exist in detention centers. In 2018, 3 children, all under 9 years old, died in a detention center due to inadequate medical care.[25] Pregnant women who need special care, have suffered miscarriages during their detainment.[26] In 2018, at least 18 women suffered miscarriages.[27] The number of miscarriages have doubled under the first 2 years of the Trump administration.[28]

There have been reports of children being subjected to inhumane conditions at detention centers.[29] They have been forced to sleep on cement floors and lack adequate health care or hygiene.[30] The Associate Press reported that 250 infants, children, and teenagers were housed in a Texas migrant detention facility in Clint, Texas.[31] There, the children lacked food, water, and adult supervision.[32] Warren Binford, a law professor at Willamette University in Oregon, described the conditions as: "Basically, what we saw are dirty children who are malnourished, who are being severely neglected. They are being kept in inhumane conditions. They are essentially being warehoused, as many as 300 children in a cell, with almost no adult supervision."[33] We must stop using detention centers which harm children and other vulnerable populations.

Moreover, there must be more oversight over ICE facilities and detention activities. Immigrant detainees have faced retaliation and backlash at detention centers for exercising their constitutional rights. Solitary confinement has been used a cruel method of retaliation. Detained immigrants, including those who are Bangladeshi, were punished with solitary confinement because they refused to work for one dollar a day.[34] South Asian asylum seekers who protested their detention by going on a hunger strike were not only placed in solitary confinement but force-fed for 2 weeks,[35] a process that 2 of the individuals have described as both painful and dehumanizing.[36] Additionally, South Asian and Sikh detainees in Victorville, California were not provided any religious accommodations.[37] They were banned from wearing their religiously mandated turbans and no accommodations were made for their religious dietary restrictions.[38] Detention centers are ripe with violations of ethics, international law, and constitutional rights.

AAPI detainees are subject to much of the same mistreatment as other immigrants and asylum seekers in ICE and CBP facilities. In OIG's inspection of 4 ICE detention centers, all 4 were noncompliant with ICE food safety standards, including refrigerators full of spoiled, moldy, and expired food. Three of the facilities violated the rights of the detained individuals, including prematurely placing individuals in disciplinary segregation. Two of the facilities presented health risks to detained individuals, with the Essex bathroom area covered in mold along the walls,

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[23] Id. at 62–63.
[24] Id. at 63.
[25] Id.
[26] Id.
[27] Id.
[28] Id.
[29] *What Will Indefinite Detention Do to Migrant Kids?,* The New York Times (August 27, 2019), *https://www.nytimes.com/2019/08/27/opinion/migrant-children-detention.html* (last visited September 23, 2019).
[30] Id.
[31] *A first-hand report of "inhumane conditions" at a migrant children's detention facility, PBS News Hour (June 21, 2019), https://www.pbs.org/newshour/show/a-firsthand-report-of-inhumane-conditions-at-a-migrant-childrens-detention-facility* (last visited September 23, 2019).
[32] Id.
[33] Id.
[34] Spencer Woodman, Private Prison Continues to Send ICE Detainees to Solitary Confinement for Refusing Voluntary Labor, The Intercept (January 11, 2018).
[35] Garance Burke & Martha Mendoza, ICE Force-feeding Detainees on Hunger Strike, AP News (January 31, 2019), *https://www.apnews.com/c4b201dac8bf48ebal7485a5c357b810* (last visited September 25, 2019).
[36] Moore, R. (2019, August 11). Two of the Asylum-Seekers Who Were Force-Fed at an El Paso Detention Center Are Now Free. Texas Monthly. Retrieved from *https://www.texasmonthly.com/news/asylum-seekers-hunger-strikes-force-fed-el-paso-detention-center-free/*.
[37] *Hundreds of Sikh Asylum Seekers Housed in Victorville Federal Prison Illegally Banned from Wearing Turbans,* India West (July 30, 2018), *https://www.indiawest.com/news/global__indian/hundreds-of-sikh-asylum-seekers-housed-in-victorville-federal-prison/article__cfb6f-080-9425-11e8-811b-5b3bfd2ed928.html* (last visited September 25, 2019).
[38] Id.

vents, ceilings, mirrors, and shower stalls.[39] Similarly, OIG observed serious overcrowding problems in the El Paso Del Norte Processing Center in their May report,[40] and again at 5 separate Border Patrol facilities and 2 points of entry in the Rio Grande Valley.[41] DHS's standards and internal oversight of these facilities are inadequate to protect the rights of detainees.

A June OIG report found inspections by the Nakamoto Group insufficient and the process compromised by notification of inspections given to detention facility staff. Though ODO's inspections are more comprehensive, OIG found that they are insufficient in their infrequency. Regardless, current inspection procedures are still insufficient given that 96 percent of waiver requests by ICE contractors with deficient conditions are granted and that "ICE does not adequately follow up on identified deficiencies or systematically hold facilities accountable for correcting deficiencies, which further diminishes the usefulness of both Nakamoto and ODO inspections."[42]

B. Lack of Due Process

Immigrants in deportation proceedings lack resources, due process, and access to legal counsel. Immigrants who are detained and in removal proceedings do not have the right to counsel at the Government's expense.[43] This leaves indigent immigrant populations vulnerable,[44] and they are forced to handle the intricacies and complications of the U.S. immigration system alone before a judge and an opposing DHS attorney. Moreover, detained immigrants face severe logistical challenges in accessing legal resources. For example, about 30 percent of immigrants detained in ICE facilities are more than 100 miles from the nearest Government-listed legal aid provider.[45] The representation rate for detained immigrants was only 14 percent between 2007 and 2012.[46] This representation rate is even lower at 10 percent for detained immigrants in a small city or rural area.[47] This lack of representation makes all the difference in court. A detained person who has a lawyer is more than 2 times likely to win their case.[48] These are life-changing cases that decide whether families stay together or are torn apart.

III. DESPITE EXISTING INADEQUATE FACILITIES, DETENTION CENTERS CONTINUE TO EXPAND

Despite these human rights abuses and dismal conditions in ICE detention centers, the number of immigrants detained has continued to increase under every single Presidential administration over the last quarter century. We have seen a sevenfold increase of detained immigrants since 1994.[49] As of February 2019, we have 45,890 detained immigrants compared to 6,785 in 1994.[50] We reached a historic high of 50,059 detained immigrants as of March 6, 2019.[51] Moreover, Congress con-

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[39] Id. at 3.

[40] Department of Homeland Security/Office of Inspector General. (2019, May 30). *Management Alert—DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center,* p. 2–3. Retrieved from *https://www.oig.dhs.gov/sites/default/files/assets/2019-05/OIG-19-46-May19.pdf.*

[41] Id. at 4.

[42] Department of Homeland Security/Office of Inspector General. (2018, June 26). *ICE 's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,* p. 1. Retrieved from *https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf.*

[43] Ingrid Eagly & Steven Shafer, *Access to Counsel in Immigration Court,* (September 28, 2016), *https://www.americanimmigrationcouncil.org/research/access-counsel-immigration-court* (last visited September 25, 2019).

[44] Id.

[45] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside The Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 62 (2019) (citing Ingrid Eagly and Steven Shafer, "Access to Counsel in Immigration Court," *American Immigration Council* (September 28, 2016); Kyle Kim, "Immigrants Held in Remote ICE Facilities Struggle to Find Legal Aid before They're Deported," *Los Angeles Times* (September 28, 2017), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-com__pressed.pdf.*

[46] Id.

[47] Id.

[48] Id.

[49] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside The Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 63 (2019) (citing Emily Kassie, "How Trump Inherited His Expanding Detention System," *The Marshall Project* (February 12, 2019); Spencer Ackerman, "ICE Is Detaining 50,000 People, an All-Time High," *Daily Beast* (March 9, 2019)), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-com__pressed.pdf.*

[50] Id.

[51] Id.

tinues to increase funding for detention. The ICE detention and deportation budget has actually increased 40 percent since Trump became President.[52] That 40 percent increase equates to an almost $1 billion increase from $4.3 to $4.1 billion.[53] Even with these increases, ICE overspends its Congressionally-appropriated budget.[54] Despite overspending, DHS still transferred $271 million from the Federal Emergency Management Agency (FEMA), the Coast Guards, and other accounts for detention spending.[55] Although, Congress has reprimanded ICE for what it considers to be a "lack of fiscal discipline", Congress still continues to increase funding. In fiscal year 2019, ICE was allocated a record-breaking amount of $4.2 billion for detention and deportation activities.[56]

IV. RECOMMENDATIONS

The Government must stop this escalation of immigration enforcement and keep families together. This escalation has only served to create an environment of fear for immigrant communities. Detention centers are cruel and not necessary. We should seek alternative avenues to enforce our civil immigration laws.

Congress should end mandatory detention. Currently, the Immigration and Nationality Act mandates that DHS detain all noncitizens who fall under select inadmissible and deportable grounds. This is particularly troubling given that roughly 80 percent of all deportable Southeast Asian refugees are subject to these mandatory detention requirements regardless of circumstance. Because the repatriation of these individuals are often subject to years and decades of uncertainty and bureaucratic delay, they are often prone to longer periods of detention. All immigrants should get an individualized determination as to whether they are a threat to public safety or a flight risk that can't be addressed by some less restrictive means.

Additionally, the use of private detention centers should be terminated. Depriving people of their liberty should not be an industry for profiteering. Congress must also require that there be stronger protections in facilities, increased oversight and transparency, and stronger protections for vulnerable populations. Many of these recommendations are contained in the Dignity for Detained Immigrants Act, which Congress should take up and pass.

We recommend budget cuts to ICE and CBP for enforcement, detention, and deportation. We recommend that there be stronger oversight and accountability mechanisms to ensure that ICE does not overspend past their budget constraints. This administration has criminalized immigrants, including asylum seekers who have the right to seek asylum. This administration must not undermine our refugee and asylum laws. Rather than criminalizing immigrants and punishing families, we recommend that the Government should focus on programs that make our communities strong and vibrant. We must disentangle local law enforcement and Government agencies with immigration enforcement. We should invest in education, infrastructure, health care, and housing. We should not be destabilizing communities and separating families. We should support naturalization and a pathway to citizenship for undocumented immigrants. We must promote the well-being of communities, and stand with our core American values.

V. CONCLUSION

Every day that our current immigration enforcement system continues is another day that the Federal Government is a part of a system of abuse that criminalizes immigrant communities. We urge Congress to stop the human rights abuses that occur due to our current immigration enforcement and detention system. We should turn to community-based solutions that help keep our immigrant communities strong and vibrant.

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[52] Advancing Justice—AAJC & Advancing Justice—Los Angeles, *Inside The Numbers: How Immigration Shapes Asian American and Pacific Islander Communities* 63 (2019) (citing Detention Watch Network, "ICE's Fiscal Mismanagement: Deceit and Abuse"; Department of Homeland Security Appropriation Act, 2017 (draft memorandum); Robin Urevich, "How the Spending Bill Can Hurt Immigrant Detainees," *The American Prospect* (February 15, 2019)), available at *https://www.advancingjustice-aajc.org/sites/default/files/2019-06/1153__AAJC__Immigration__Final__Pages__LR-com__pressed.pdf.*

[53] Id.

[54] Id.

[55] *As Puerto Rico Braces for Storm, DHS, FEMA To Move $271 Million to Border Operations,* NPR (August 27, 2019), *https://www.npr.org/2019/08/27/754838143/as-puerto-rico-braces-for-storm-dhs-fema-to-move-271-million-to-border-operation?fbclid=IwAR11GzYYw3Ge__Xmr7x9E-iT6RHFGKGnJwOI8mPuUXw4x1Q0UrJQP8AcAjoBc* (last visited September 25, 2019).

[56] Id.

ARTICLE FROM POGO.ORG

OUTSOURCED OVERSIGHT.—AT IMMIGRATION DETENTION FACILITIES, 'INSPECTORS FOR HIRE' MISS SIGNS OF NEGLECT, SAY CRITICS

BY KATHERINE HAWKINS—FILED UNDER INVESTIGATION—MARCH 12, 2019

This piece originally appeared on Yahoo News.

When government inspectors made an unannounced visit last year to the privately run immigration detention center in Adelanto, Calif., they found inadequate medical and dental care, improper use of solitary confinement and perhaps more shockingly, braided bedsheets facility staff called "nooses" hanging from ceilings in detainee cells.

Two weeks after the Department of Homeland Security's watchdog office issued a grim report based on that visit, another inspection took place. This one, however, was pre-announced and conducted by a company called the Nakamoto Group, which the Immigration and Customs Enforcement pays to inspect its detention facilities.

The Nakamoto Group, which wrote its own review of Adelanto, criticized the department inspector general's findings as "erroneous and inflammatory."

The inspector general "took a housekeeping problem and made it a suicide issue" in order to "sell their product" and get more attention for their report, Mark Saunders, a vice president of the Nakamoto Group, said in an interview with the Project on Government Oversight.

The spat between the Department of Homeland Security's inspector general and the Nakamoto Group over Adelanto epitomizes the debate over oversight of the immigration detention system at a time when DHS is locking up a record number of people for violating immigration laws. At stake are the health and safety of over 50,000 people kept in detention on an average day.

There have been a long series of credible reports of medical neglect in Adelanto since it opened in 2011, including at least two cases where ICE'S own investigations uncovered evidence that inadequate medical care contributed to detainees' deaths. In both 2017 and 2018, though, Nakamoto Group inspectors found that Adelanto complied with all Federal detention standards, including those for medical care and suicide prevention.

In May 2018, a team from the inspector general's office arrived at Adelanto unannounced. A report on their findings was published on Sept. 27, 2018. Hanging bedsheets, which some Adelanto staff called "nooses," were seen throughout their inspection.

"The contract guard escorting us during our visit removed the first noose found in a detainee cell, but stopped after realizing many cells we visited had nooses hanging from the vents. We also heard the guard telling some detainees to take the sheets down," according to the inspector general report, which contained pictures of the hanging bedsheets.

This finding was prominently featured in many news stories on the inspector general report.

In their review of Adelanto conducted 2 weeks after the inspector general's report was made public, the Nakamoto Group fired back at the inspector general, saying that it was misleading for the inspector general to call the bedsheets hanging in detainees' cells "nooses," since the sheets "were being used as privacy curtains or clotheslines" and there was "no evidence to suggest that any privacy curtain or clothesline" was used as a noose.

The inspector general report itself said that the bedsheets hanging in detainees' cells were used as privacy screens and clotheslines—but also noted that staff and detainees called them "nooses" and that there was a history of bedsheets being used in suicide attempts. Osmar Epifania Gonzalez-Gadba, a 32-year-old from Nicaragua, used bedsheets to hang himself in his cell in Adelanto in March 2017.

Nakamoto inspectors wrote that they observed no hanging bedsheets during their inspection, and that based on data provided by the GEO Group, Adelanto had experienced no "serious suicide attempts" in 2018.

However, according to a recently released investigation by the nonprofit Disability Rights California, it is "demonstrably false" that there were no suicide attempts at Adelanto in 2018. The organization, which under Federal law has a right to inspect any institution that houses people with disabilities, wrote that during 4 days of visits to Adelanto last year, "we encountered several people who, as documented by Adelanto health care staff . . . attempted suicide between January 2018 and September 2018."

In early 2018, Disability Rights California reported that a female detainee at Adelanto was found "in the shower in fetal position, fully dressed, and holding left

bleeding wrist," and was hospitalized for 5 days following what her medical records acknowledged as a suicide attempt. In August 2018, the report continued, "medical records describe a man experiencing auditory hallucinations and expressing plans to hang himself. A few days later, he attempted to strangle himself with clothing." Again, clinical staff at Adelanto recorded the incident as a suicide attempt, but GEO Group did not record it as one because it did not result in "serious self-harm." (GEO Group did not respond to an email asking for a comment on these allegations.)

A former Adelanto detainee also cast doubt on Nakamoto's finding that detainees were no longer hanging bedsheets in their cells. Alex Armando Villalobos Veliz, an asylum seeker from Honduras who was released from Adelanto on Jan. 31, 2019, said in a phone interview that detainees still routinely hung bedsheets for privacy, but GEO Group guards had told them to take them down and clean their cells the day before the Nakamoto inspection.

Villalobos was also instructed to do extra cleaning in the kitchen, where he worked. He said that the Nakamoto inspectors mainly interviewed GEO staff and English speaking detainees, and did not go into detainees' cells in the section of the prison where he was held.

Nakamoto took issue with other parts of the inspector general's report, including the inspector general's finding that Adelanto did not provide any detainees with dental cleanings or fillings for a 4-year period. Based on records that Nakamoto viewed, Saunders said, "they'd been doing them all along . . . We didn't talk to detainees that had a single dental complaint," he said.

In contrast, GEO Group's written response to the inspector general's report does acknowledge that there had been problems with medical and dental care, though the company said it had been resolved: "While we believe that a number of the [inspector general] findings lacked appropriate context or were based on incomplete information, we have already taken steps to remedy areas where our processes fell short of our commitment to high-quality care," a GEO statement read.

The Nakamoto Group alleged that one of the most disturbing cases described in the inspector general's report—that of a disabled detainee in segregation who "never left his wheelchair to sleep in a bed or brush his teeth" for 9 days—was based on a misunderstanding. According to the Nakamoto inspection report, "[a] medical record review and interviews with staff and the detainee during this annual inspection revealed that the detainee is in fact not confined to a wheelchair, but was rather issued a wheelchair out of courtesy."

Nakamoto wrote that the inspector general's office should "use inspectors with detention and corrections backgrounds for future inspections to avoid . . . embarrassment to their office and ICE, especially since the inaccuracies have now been reported by the news media as fact."

Tanya Aldridge, a spokesperson for the inspector general's office, wrote in an email to POGO that "[w]hile we understand that the Nakamoto Group, along with ICE and facility staff, was critical of our report, we stand firmly behind the results of our inspection." She declined to discuss Nakamoto's allegations in detail, instead referring to a June 2018 inspector general's report that found serious flaws in the contractor's inspections.

"Nakamoto's inspection practices are not consistently thorough," are "significantly limited," and "its inspections do not fully examine actual conditions or identify all compliance deficiencies," the inspector general found.

Eleven senators led by Elizabeth Warren, D-Mass., wrote to the Nakamoto Group last November to express concerns about the inspector general's findings in both the June 2018 report on inspections and the unannounced inspection of Adelanto. Saunders said that Nakamoto had written to Congress refuting the June 2018 report, but he declined to provide a copy of the company's response. Warren's office also declined to release the response. A spokesman for her office said that "Senator Warren's investigation of private immigration detention contractors CoreCivic and GEO Group, and auditor Nakamoto Group, regarding conditions at immigration detention facilities is ongoing."

Scott Shuchart, who worked for eight years for the Department of Homeland Security's Office of Civil Rights and Civil Liberties, said that "Nakamoto is not wrong that the OIG lacks specialized expertise in detention," and it was possible that the inspector general had gotten some details wrong in its report. But Shuchart said that "Nakamoto has no credibility because of the volume of problems it has failed to uncover at multiple facilities over multiple years . . . It is a checklist driven, superficial inspection process."

Nakamoto Group vice president Saunders said the company regularly identified problems at facilities although "overall they may pass." He thought Nakamoto, a small, minority-owned company with only 10 full-time employees based in Rockville, Md., was being unfairly grouped with "multimillion-dollar conglomerate companies"

like GEO and CoreCivic. "Our president's mother was born in a Japanese internment camp . . . That's our historical profile," he said.

The Nakamoto Group inspections publicly available on ICE's website show that detention facilities do occasionally fail—most often, county jails that hold a small number of immigration detainees. Nakamoto gave a "deficient" rating to the Grand Forks County Correctional Facility, in Grand Forks, Neb., in May 2018. The Kandiyohi County Jail in Willmar, Minn., failed its ICE inspection in March 2018. (It passed a follow-up inspection 6 months later.)

The Nakamoto Group has rarely failed or even found serious violations at large detention centers like Adelanto, which has a capacity of up to 1,940 immigration detainees.

Nakamoto's inspections of Stewart Detention Center in Lumpkin, Ga., found the facility was compliant with 39 out of 39 applicable detention standards in both May 2017 and May 2018. Stewart, like Adelanto, is run by a for-profit prison company, CoreCivic, which is GEO Group's largest competitor. Like Adelanto, it is one of the largest immigration jails in America, with a capacity of nearly 2,000 beds.

Andrew Free represents the families of three detainees who died in Stewart since January 2017: Jean Carlo Jimenez Joseph, a 27-year-old who hanged himself in May 2017; Yulio Castro-Garrido, who was 33 years old when he died of pneumonia in January 2018; and Efrain De La Rosa, a 40-year-old Mexican national who committed suicide in July 2018.

Free noted the disturbing parallels between Jimenez's suicide and De La Rosa's. Both men had previously been diagnosed with schizophrenia, and suffered from hallucinations and suicidal thoughts while at Stewart. Both hanged themselves after spending weeks in solitary confinement. In both cases, a CoreCivic guard was fired for failing to perform a required check of the prisoner's cell and then falsified logs to cover for that failure.

Amanda Gilchrist, a spokesman for CoreCivic, wrote in an email that she could not comment specifically on Jimenez's and De La Rosa's death other than to say that the company "has cooperated fully in the investigations by our government partners and law enforcement into these matters," and that "the safety and well-being of the individuals entrusted to our care is our top priority." She also noted that at the time of both deaths, "CoreCivic did not provide medical or mental health care services or staffing at Stewart Detention Center," which were instead provided by ICE's Health Service Corps.

Documents from Nakamoto's inspection of Stewart in May 2018 note Jimenez's death, but do not contain any mention of the guard's firing for falsifying detention logs, nor does it analyze whether Jimenez's extended stay in solitary confinement may have worsened his mental condition. It also does not discuss evidence that, in Free's words, Stewart was "woefully understaffed," as documented by the DHS inspector general in late 2017.

Free, the lawyer representing the detainees' families, wrote in an email that he viewed Nakamoto's certification that Stewart complied with all detention standards as a demonstration that the company's inspections were a "whitewash" rather than "actual, independent reviews."

Saunders, the Nakamoto executive, noted that the fact that a facility received an overall score of "acceptable," or was found to be in compliance with a particular standard, did not mean that Nakamoto had found no problems. Each standard has multiple subparts, and inspectors go "line by line by line" through each of them in reports that are over 100 pages long, he said.

Critics say that the checklist approach is inherently flawed. The inspector general wrote that the checklist includes more than 650 subparts, which left Nakamoto employees without "enough time to see if the [facility] is actually implementing" its written policies. Tara Tidwell Cullen of the National Immigrant Justice Center, which has done extensive analysis of inspection data, said that "it's very easy to gloss over conditions using only this checklist," particularly since Nakamoto inspections are announced in advance. "If you give facilities a chance to clean up once a year for the inspectors, you're not really getting an accurate view," she said.

In December 2016, a Department of Homeland Security advisory group issued a report addressing ways to improve oversight of private immigration detention. It recommended that ICE revise its inspection methodology and potentially abandon or scale back use of Nakamoto, stating that "inspections should make greater use of qualitative review of outcomes, rather than simply using a quantitative checklist. The point of inspections is to provide meaningful evaluation of actual on-the-ground detention conditions in each facility."

Even if a detention center fails a Nakamoto inspection, there may not be any consequences. Congress passed a law in 2009 requiring that ICE terminate the contract of any detention center that fails two consecutive inspections—but this has never

happened since the legislation was passed. ICE treats Nakamoto's inspection rating as a recommendation, which must be reviewed by ICE before it is made final. Saunders confirmed this in an interview saying, "everything we send to ICE is considered a draft . . . they have final approval." He did not recall ICE ever changing inspectors' conclusions.

But according to Tidwell Cullen, ICE may simply avoid issuing a final rating when its inspection contractors find that a facility is out of compliance. She wrote last year that based on her group's analysis of data on ICE detention facilities from November 2017, four jails had received a recommended rating in their last inspection of "deficient," "at-risk," or "does not meet standards." The final rating for all four of these facilities "had been pending for more than 100 days—by far the longest-pending inspections of more than 200 detention centers listed."

Matthew Bourke, an ICE spokesman, wrote in an email that "ICE has a strong record of holding detention facilities accountable when deficiencies are identified." Nonetheless, in response to the inspector general's findings "the agency is currently re-evaluating the existing scope and methodology" for contract inspections, he wrote.

Advocates were pessimistic about the outcome of this review given ICE's track record and the dramatic recent expansion of immigration detention. Tidwell Culllen said, "it's not a problem that's going away. It's getting worse."

ARTICLE FROM POGO.ORG

MEDICAL NEGLECT AT A DENVER IMMIGRATION JAIL

BY KATHERINE HAWKINS—FILED UNDER INVESTIGATION—MAY 21, 2019

This joint POGO-Yahoo investigation was originally published in full on Yahoo News.

On Nov. 17, 2017, Federal agents arrived at the home of 64-year-old Kamyar Samimi, who had lived in the United States for over four decades, and took him away. Samimi was a legal immigrant from Iran, who came to the United States as a student in 1976 and received a green card in 1979. But under Trump-era enforcement policies, a 12-year-old conviction for cocaine possession made him a target for detention and deportation.

Samimi was taken to the Aurora, Colo., detention facility, an immigration jail in the suburbs of Denver operated by the GEO Group, one of the largest private prison companies in the U.S. Just over 2 weeks later, he was dead.

He is one of 24 people to die in Customs Enforcement (ICE) detention since President Donald Trump took office. (That total excludes deaths of immigrants held in Customs and Border Protection custody or in Office of Refugee Resettlement shelters, including three Guatemalan children who have died since December.)

In at least a half dozen of these cases, there have been allegations that inadequate medical care preceded the deaths. Samimi's case appears to be one of those—and an example of how government contractors running facilities like Aurora have struggled to provide adequate care for a drastically increasing detainee population.

An internal ICE review of Samimi's death found there were major deficiencies in his medical care for severe opioid withdrawal before his death, according to a source who viewed the document. (See update at the bottom of this piece.) The source asked not to be named because they are not authorized to speak to the press and fear retaliation.

ICE's detention standards provide that "detainees experiencing severe or life-threatening intoxication or withdrawal shall be transferred immediately to an emergency department for evaluation" and returned to the detention facility only if it is "staffed with qualified personnel and equipment to provide appropriate care." Investigators found that Samimi's treatment violated this standard and many others, according to the Project on Government Oversight's source.

ICE's official review of Samimi's death has not yet been publicly released, despite multiple pending Freedom of Information Act lawsuits for such release. An ICE spokesperson said the agency could not comment on the case due to pending litigation.

According to an inspection report on ICE's website, the 64-year-old Samimi "was placed in medical observation directly from intake" because he reported suffering from depression, methadone and heroin addiction, and abdominal pain, and "began rather quickly complaining of nausea and vomiting and was observed to vomit blood."

On Nov. 28, 11 days after he was taken into custody, Samimi "was observed to have a bed sheet tied tightly around his neck" and was placed on suicide watch. On Dec. 2, "the detainee attempted to get into a wheelchair but vomited blood and

collapsed" and stopped breathing. Soon after, he was pronounced dead at a local hospital. The inspection report, quoting from a source that it does not identify, states that "the most likely cause of death was noted as 'the result of asphyxia secondary to aspiration of bloody vomitus.'"

The local coroner's autopsy states that Samimi's cause and manner of death are "undetermined," but that emphysema and gastrointestinal bleeding were likely contributing factors. The forensic pathologist wrote that Samimi had been addicted to methadone since 1990 and that "methadone withdrawal cannot be ruled out as the cause of death, however, deaths due to methadone withdrawal are rare."

Samimi's case is just one of many that critics of the Aurora detention center say shows a bigger problem with care there and throughout America's growing immigrant detention complex, where around 50,000 people are detained on an average day.

A complaint filed last year by the American Immigration Council and American Immigration Lawyers Association alleges a pattern of "dangerously inadequate medical and mental health care" at the jail in the Denver suburbs. Since the complaint was filed, ICE has drastically expanded the detention facility, putting even greater stress on its medical care system.

At the time of Samimi's death, Aurora's medical director—and sole full-time physician—was Jeffrey Elam Peterson, MD. He left Aurora a few months later, in approximately April 2018, to become medical director at the nearby Arapahoe County jail. It is unclear whether his departure was linked in any way to Samimi's death. GEO Group did not respond to the Project on Government Oversight's requests for comment.

Several former Aurora detainees and their attorneys have accused Peterson specifically of providing inadequate health care and attempting to intimidate detainees when they advocated for better treatment.

In one extreme case, a paralyzed detainee, Ronnie Keyes, alleged in a lawsuit against GEO Group that his leg had to be amputated as a result of Peterson's negligent medical care. GEO Group settled the case for an undisclosed sum shortly before it was scheduled to go to trial in March.

According to his legal complaint, Keyes had two mild pressure ulcers at the beginning of his detention. As soon as he arrived, he requested a specialized air mattress to prevent them from deteriorating or new sores from forming. He was never provided one, and his ulcers deteriorated and eventually became severely infected.

The complaint alleges that between his detention at Aurora in June and his hospitalization in September, Keyes filed over 50 written complaints about his medical care. "Not one was taken seriously," it says.

In July, Keyes wrote that Peterson had ordered that the dressing on his wounds be changed once every 3 days, when a daily change was required to avoid infection, and that several of the nurses at Aurora acknowledged that they were not equipped to properly treat him.

In August, he began requesting to be taken to the hospital, in part because his pressure ulcers "had gotten even worse, they were bleeding, and they smelled bad." He was finally taken to the emergency room after "staff at the facility found him passed out in his wheelchair."

The infection had spread to his blood and the bone in his foot. His left leg was amputated below the knee on Sept. 20, 2016.

Even after the amputation, Keyes's pelvic bone remained infected, requiring multiple hospitalization and surgeries. Keyes's attorney, David Lane, said in an interview, "The doctors believe it's a matter of time until it kills him."

Lane said that based on Keyes's experience, medical care at Aurora was "abysmal."

"I wouldn't let Dr. Peterson give me a haircut," he added.

Attorneys representing Aurora detainees have alleged that Peterson reprimanded their clients for filing grievances or seeking assistance from attorneys in obtaining medical care. Arash Jahanian of the ACLU of Colorado, wrote in a court declaration in 2017 that when a client of his filed grievances because he was not receiving treatment for an arterial blockage, Dr. Peterson and one other official "told him to stop filing grievances."

Another former Aurora detainee, René Lima Marín, recently filed a legal claim alleging that he had received inadequate treatment for multiple fractures to bones in his face resulting from a fall in his cell. Lima Marín was taken to the emergency room the night of Feb. 7, 2018, and told that he needed to return in a week or two for surgery to ensure the bones healed properly. On Feb. 16, his attorneys wrote to Aurora's warden, Johnny Choate, alleging that Lima Marín was not receiving adequate care.

In response, according to the legal claim, Peterson "berate[d] Mr. Lima Marín for involving his lawyers in his medical care," and "accused him of lying and exaggerating his injuries." Peterson also wrote in an email to Lima Marín's attorneys that he perceived their letter as "an unprofessional and threatening document," and was planning to file a formal complaint against them with the Colorado Bar Association.

Danielle Jefferis, one of Lima Marín's lawyers, said in an interview that other clients of hers had also had experience with Peterson "telling them they're faking it or they're lying."

Peterson did not respond to messages left with his previous and current employer, texts and calls to the mobile phone number listed on his State medical license, and letters sent to his home and work addresses.

Aurora isn't the only ICE detention facility where detainee grievances have allegedly been met with threats. The Department of Homeland Security's inspector general reported in December 2017 that detainees at other detention centers said "staff obstructed or delayed their grievances or intimidated them, through fear of retaliation, into not complaining. These deterrents may prevent detainees from filing grievances about serious concerns that should be addressed and resolved."

The American Immigration Council and American Immigration Lawyers Association complaint from last summer describes the experiences of seven Aurora detainees, all identified by pseudonyms. One of them, identified as "Abdo," a refugee from South Sudan, was placed in isolation for a month after a dispute with a guard despite suffering from post-traumatic stress disorder, as part of which he experienced auditory and visual hallucinations.

During fiscal year 2018, when most of these cases occurred, the Aurora detention facility had an average daily population of 644 ICE detainees. It now holds over 1,000—but there is still just one full-time physician. (Nationally, the United States has 2.56 doctors per 1,000 people. The ratios in jails and prisons tend to be lower, and detainees' medical needs higher.)

In late January, the GEO Group opened a 432-bed annex next door to the main detention center. The annex is the original Aurora detention center, where the GEO Group's business of contracting with the Federal Government to detain immigrants for profit began in 1987. It had been vacant for several years after the GEO Group opened its newer, larger detention site nearby.

ICE and GEO initially contracted to operate the annex for 90 days. In late April, the contract was extended another year, for $14 million.

ICE has said the annex was recently remodeled. Elizabeth Jordan, an attorney for the Civil Rights Education and Enforcement Center, said in an interview that she saw little sign of that when she visited the facility. "It's very clearly an old jail," she said, that appeared to have been abandoned and used for storage.

According to Laura Lunn, who manages the Rocky Mountain Immigrant Advocacy Network's detention program, the annex was filled with new detainees flown in from the U.S.-Mexico border "essentially overnight" after it opened in January 2019. Several flights of detainees arrived in quick succession, without a corresponding increase in guards or medical staff at the time.

"They were not scaling up to accommodate the needs of the people being detained," said Lunn, whose organization offers legal orientation to newly arrived detainees at Aurora. GEO has since hired more staff; Lunn said, though it is not clear whether the pace of hiring has matched the expansion of the jail.

Lunn said that her own organization was "overwhelmed and overburdened" trying to conduct intake interviews with recent arrivals.

Weeks after the expansion, 357 detainees in Aurora were under quarantine for exposure to chicken pox and mumps. Detainees' attorneys said that although Aurora had experienced quarantines for chicken pox before, they had not occurred on this scale, and quarantines for mumps were much rarer. Lunn said that "a shockingly high number of units" were quarantined and noted that there had been an "uptick of quarantines around the country."

As of March 7, there were 2,287 ICE detainees in quarantine across the country, Reuters reported. There were 236 confirmed or probable cases of mumps in ICE detention in the past year, as opposed to zero in the previous 2 years.

At Aurora, most detainees under quarantine had their immigration court hearings canceled, which had the practical effect of lengthening their time in detention. They also lost access to outdoor recreation and visits to families.

Alethea Smock, an ICE spokesperson in Colorado, said in an email about the quarantines that "medical personnel are credited with reducing the further infection of detainees by their quick reaction." She added, "Each detainee receives a medical examination upon arrival at the facility to check for potential signs of illness, how-

ever ICE has no way of knowing what viruses a person may have been exposed to prior to entering the facility."

Detainees' lawyers dispute this. Jefferis noted that the mumps outbreak "coincided with arrivals of large numbers of people, as they were filling the annex" and medical intakes were not happening promptly. One of her clients told her that two detainees in his housing unit who contracted mumps had gone untreated for days as they got sicker, and at least one eventually had to be hospitalized.

The quarantines have now been lifted in Aurora, but the facility's chronic problems with medical care remain.

Another one of Jefferis's clients has Type 1 diabetes, which requires daily insulin treatment. Between his arrest in early February and mid-March, she said, he rarely received the correct dosage of insulin at the correct time. He began suffering increasingly severe nerve damage, vision loss and pain as a result, and was eventually hospitalized with a blood sugar level that placed him at risk of a diabetic coma. Jefferis said that since returning from the hospital, the client had begun receiving the proper medication, but was still suffering from nerve damage and vision loss.

Aurora is located in the Congressional district of Democratic Rep. Jason Crow. Anne Feldman, a spokeswoman for Crow, wrote in an email, "We've heard multiple reports of poor conditions and disease outbreaks at the GEO Group-run facility in Aurora from detainees themselves and some attorneys. Despite our concerns, DHS has yet to respond to our multiple letters on the topic."

Crow was also turned away twice when he tried to visit the facility in February and March, before finally receiving a tour 24 days after his first request. He and 20 colleagues are now seeking to pass legislation requiring that Members of Congress be given access to ICE detention facilities with 48 hours notice.

The medical care problems at Aurora, according to the American Immigration Council and American Immigration Lawyers Association complaint, are "the norm rather than the exception" in ICE custody.

Jordan, the attorney for the Civil Rights Education and Enforcement Center, agreed that medical care problems are pervasive in ICE detention centers, many of which are further from major hospitals and metropolitan areas than the jail in the Denver suburbs. Aurora, she said, is "an illustrative example of the entire way the system fails."

Update: After this story was posted, Rocky Mountain PBS investigative reporter Brittany Freeman published the full ICE review of Kamyar Samimi's death. The document, available here, is consistent with our source's description but contains many more details about problems with Samimi's medical care.

ARTICLE FROM POGO.ORG

ISOLATED: ICE CONFINES SOME DETAINEES WITH MENTAL ILLNESS IN SOLITARY FOR MONTHS

AUGUST 14, 2019

As Immigration and Customs Enforcement (ICE) detains more immigrants than ever before, detention centers have filed more reports of detainees being held in solitary confinement, according to Federal records obtained by the Project On Government Oversight (POGO). In solitary, detainees are locked in a cell and isolated from other people for up to 23 hours a day.

The records, obtained under the Freedom of Information Act, cover the last year of the Obama administration and the Trump administration through early May 2018. There are 6,559 records, each of which represents the confinement of a detainee in solitary (ICE has placed some detainees in solitary more than once). These records advance reporting on ICE's use of solitary by the International Consortium of Investigative Journalists and partner news organizations published earlier this year. The records POGO obtained are the first to cover a significant portion of the current administration.

About 40 percent of the records show detainees placed in solitary have mental illness. At some detention centers, the percentage is much higher.

Many experts view solitary confinement as tantamount to torture under certain conditions, especially if it is prolonged. Prolonged solitary confinement has been defined as longer than 15 days.

Slightly more than 4,000 of the 6,559 records show detainees in solitary for more than 15 days. One quarter of those roughly 4,000 records indicate the detainees in solitary had mental illness. The records show that some detainees were held in solitary for months, and in some cases, for more than a year. One detainee was held in solitary for more than 2 years.

Viewed alongside official watchdog reports and insider accounts, these records depict an immigration detention system in urgent need of more oversight. Indeed, an ICE policy instituted 6 years ago mandated the creation of these records so the agency could assess how its 200-plus detention centers use and misuse solitary, officially known as "segregation." But the records themselves have gaps and inaccuracies, hindering their potential to help overseers.

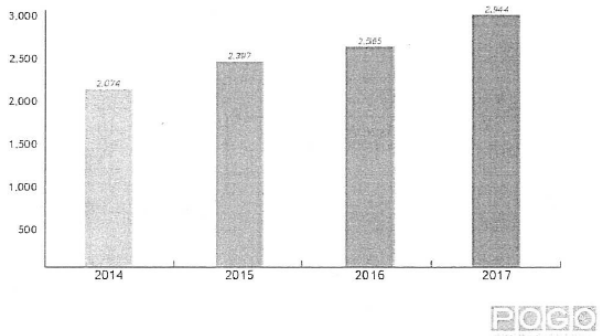
The problem has garnered bipartisan Congressional scrutiny. "It is imperative that ICE swiftly resolve any lacking oversight or improper documentation pertaining to the use of segregation," wrote Senators Chuck Grassley (R–IA) and Richard Blumenthal (D–CT) in a letter last month to the acting head of ICE. This isn't Grassley's first time weighing in on ICE's use of solitary. In 2015, he and then-Senator Al Franken (D–MN) wrote that information they obtained suggested "that ICE continues to place many detainees with mental health concerns in administrative or disciplinary segregation—also known as solitary confinement—contrary to agency directives."

IN URGENT NEED OF OVERSIGHT

POGO obtained Federal records documenting 6,559 instances where solitary confinement was used in ICE detention centers from January 2016 to May 2018.

Source: ICE data, obtained by the Project On Government Oversight through the Freedom of Information Act. Each record indicates one instance of a detainee in solitary confinement; some detainees were confined more than once.

Use of Solitary Confinement Reported by ICE Detention Centers



Sources: 2014 and 2015 ICE data obtained by the International Consortium of Investigative Journalists; 2016 and 2017 ICE data obtained by the Project On Government Oversight

The release of this data on solitary comes as the current administration has aggressively enforced immigration laws, including the mass prosecution of people for first-time illegal entry into the United States, a misdemeanor, under a "zero tolerance" policy carried out along the entire U.S.-Mexico border beginning in April 2018 (the last full month covered by the data). The administration has also ramped up so-called "interior enforcement" where immigrants, and some U.S. citizens, have been arrested away from the border and ports of entry. The aggressive enforcement has sent the number of people in ICE detention to record highs in recent months, including a growing number of detainees with mental illness.

ICE detention centers across the country use solitary confinement to house detainees with mental illness and other vulnerabilities apart from the general population. Solitary is also used to punish detainees who assault employees or other detainees, and for violating other rules. Some detainees allege they have been placed in solitary as retaliation for speaking out against forced labor, sexual assault, or other alleged abuses.

ICE provided no comment in response to POGO's queries.

Even when it's meant to protect rather than punish, placing individuals with preexisting mental illness in solitary confinement can make the psychological issues they are grappling with worse and can increase the risk they will die by suicide.

"There's no debate that for people with a mental illness, it's very clear that solitary exacerbates the mental illness," psychiatrist Terry Kupers told POGO. Kupers has testified in lawsuits involving mental health care in prisons. Among those who were not previously experiencing mental illness, time in solitary can also lead to mental health problems and a rise in suicidal thoughts.

During the first 2 years of the Trump Administration, at least three ICE detainees who were documented as having schizophrenia and were placed in solitary took their own lives, according to two official detainee death reviews by ICE and an inquiry by a State law enforcement agency in Georgia.

According to a 2015 study by experts at New York University's medical school, suicide was one of the top causes of death in ICE detention between 2003 and 2015. The study cites criticism of ICE for putting "patients with mental illness into detention instead of allowing them to receive community-based treatment."

Yet there is at least one less policy limit on detaining people with mental illness now than when that study came out. A month after President Trump's inauguration, the Department of Homeland Security rescinded a 2014 memo that stated ICE should not detain people "suffering from serious physical or mental illness" unless there were "extraordinary circumstances or the requirement of mandatory detention."

Opponents of solitary confinement have questioned whether its use for long periods of time violates the Constitution's ban on cruel and unusual punishment. In one case, a Federal judge wrote that placing those with mental illness in solitary confinement is akin to "putting an asthmatic in a place with little air to breathe." The discussion of solitary has predominantly been in the context of prison—a punish-

ment for those found guilty of a crime. Because immigrant detention, unlike prison, is not officially meant to be punitive, prolonged use of solitary may pose additional legal and constitutional concerns.

The ICE data obtained by POGO shows some detainees were kept in solitary for long periods, in nine cases exceeding a year, such as:

- A woman at the ICE detention center in Adelanto, California, who was "diagnosed with Other Specified Trauma and Stressor-related D/O [disorder]," was released from solitary in December 2017 after 454 days;
- Another woman at Adelanto, who was "diagnosed with PTSD/Major Depressive D/O (Severe)," was released in August 2017 after 372 days;
- A man at Yuba County Jail in California, who was "diagnosed with psychotic disorder," was released in April 2018 after 413 days; and
- A man detained at the ICE Service Processing Center in Buffalo, New York, was released from solitary in May 2018 after 790 days—more than two years. According to the ICE data, he did not have mental illness.

"Years on end of near-total isolation exact a terrible price," wrote then-Supreme Court Justice Anthony Kennedy in a 2015 concurring opinion. He cited research showing that "common side-effects of solitary confinement include anxiety, panic, withdrawal, hallucinations, self-mutilation, and suicidal thoughts and behaviors."

An independent expert on human rights appointed by the United Nations recommended all countries ban the use of "prolonged solitary confinement," solitary beyond 15 days. "At that point . . . some of the harmful psychological effects of isolation can become irreversible," U.N. special rapporteur Juan E. Mendez wrote in a 2011 report.

In recent years, some state prison systems have curbed their use of solitary: Texas has banned solitary as a punishment for breaking rules and Colorado has banned use of solitary exceeding 15 days.

In May, the International Consortium of Investigative Journalists quoted an ICE spokesperson who said solitary "protects detainees, staff, contractors, and volunteers from harm." Yet state prisons that have reduced use of solitary say it can be done without increasing risk. Officials from five states told the Government Accountability Office in 2013 that moving inmates out of restrictive housing, such as solitary, led to "no increase in violence" and officials from two states said millions of dollars were saved by reducing the number of people held in solitary.

ICE also isn't the only Federal agency under scrutiny for its use of solitary for people with mental illness. In 2017, the Justice Department's Inspector General wrote that the Bureau of Prisons had "inmates, including those with mental illness, who were housed in single-cell confinement for long periods of time, isolated from other inmates and with limited human contact." (The watchdog also wrote that the Bureau "states that it does not practice solitary confinement, or even recognize the term.")

However, in contrast with ICE, as Senators Grassley and Blumenthal wrote in their recent letter, Bureau prisons are in some ways better equipped to deal with the challenges faced by detained populations "who require special attention," such as those with mental illness. Many ICE detention facilities effectively have two options for holding detainees: keeping them in the general population or isolating them in segregation.

In 2009, an ICE official made a similar observation: "segregation cells are often used to detain special populations whose unique medical, mental health, and protective custody requirements cannot be accommodated in general population housing." The official further wrote that segregation is "not conducive to recovery."

Little seems to have changed in the ensuing decade. Andrew Lorenzen-Strait, a former senior ICE official who left the agency in May, told Politico that ICE studied how prisons cared for the mentally ill to devise a 30-bed pilot program at its Krome detention center in Florida. He estimated 3,000 to 6,000 ICE detainees have mental illness.

The reliance on solitary for holding detainees with special vulnerabilities like mental illness reflects a "basic structural challenge for ICE," Senators Grassley and Blumenthal wrote to the acting head of the agency last month.

Some critics say the most fundamental problem is the detention of people with mental illness. "At the end of the day, the best way to get their treatment is not to be detained," Hannah Cartwright, supervising attorney at the National Immigrant Justice Center, told Politico.

What is clear is use of solitary in ICE detention is on the rise and more needs to be done to oversee how it is used and to stop its misuse and overuse.

As some state prison systems have shifted away from using solitary, the ICE data shows an increase in the reporting of use of solitary in immigrant detention centers from January 1, 2016, through May 4, 2018. The number of reports indicating the

detainees in solitary have mental illness also went up, though declined slightly as a proportion of the whole.

There are 2,565 reports of use of solitary confinement with a placement date during 2016, the last full year of the Obama Administration. Of those, 40 percent (1,030) indicate the detainees in solitary had mental illness.

There are 2,944 reports of use of solitary confinement with a placement date during 2017, most of which was during the Trump Administration. Of those, 39 percent (1,160) indicate the detainees in solitary had mental illness.

In the first third of 2018, out of a total 1,050 reports, 37 percent (389) indicate the detainees in solitary had mental illness. (If the rate of reporting held steady through the rest of 2018, total reports of use of solitary that year would top 3,100 and those involving mental illness would be about the same as in 2017.)

During the period covered by the data, ICE's detention center in Adelanto, California, accounted for the most reports of placements in solitary, perhaps in part because the facility has one of the largest detainee populations. (Another large detention center, in Stewart, Georgia, ranks second in reporting use of solitary.)

Adelanto also reported more detainees in solitary confinement lasting longer than 75 days—five times the maximum time the U.N. expert recommends governments use isolation—including some with severe mental illnesses, than any other ICE detention center. Adelanto filed 112 reports where a detainee was in solitary for at least 75 days. Across all detention centers, there are 485 reports of detainees in solitary for 75 days or more.

The GEO Group, the private prison corporation that holds close to one out of every three ICE detainees nationwide, wrote this year that about a third of the nearly 2,000 detainees at its immigration facility in Adelanto are "chronic medically ill, chronic mentally ill, or seriously mentally ill." Yet it appears that at Adelanto a disproportionate number of detainees with mental illness are being kept in solitary versus in the general population: two-thirds of Adelanto's reports indicate that the detainees being isolated have mental illness.

Over the last decade, ICE has strengthened its standards for detention centers, including standards dictating the minimum conditions for those being held in solitary, but some detention centers, such as Adelanto, haven't always fully complied. For instance, last year, the Department of Homeland Security Inspector General found during an unannounced inspection of Adelanto that "some detainees were not offered any recreation or showers while in segregation."

Adelanto detainee Osmar Epifania Gonzalez-Gadba, a 32-year-old Nicaraguan man, is one of the three detainees with mental illness who had been put in solitary and died by suicide during the current Administration. He used a bedsheet as a noose to hang himself in March 2017.

Last year, in 15 out of 20 Adelanto cells visited, an inspector general team "observed braided bedsheets, referred to as 'nooses' by center staff and detainees, hanging from vents," according to a report by the watchdog. Given that more than a year had passed since Gonzalez-Gadba's death, "ICE's lack of response to address this matter at the Adelanto Center shows a disregard for detainee health and safety," the inspector general wrote.

The inspector general team also found people wrongly placed in disciplinary solitary when they requested solitary for protective reasons (the conditions in disciplinary solitary are more harsh), the improper handcuffing and shackling of detainees in solitary, and "cursory" medical checks of some people in solitary, rather than the required once-daily "face-to-face" evaluations.

GEO Group did not respond to POGO's request for comment.

In contrast to Adelanto, some large detention centers report substantially less use of solitary, and for shorter periods of time and involving a lower percentage of detainees with mental illness, suggesting that solitary can be and is used far less at other facilities (see the table, "Top 15 Immigrant Detention Centers Reporting Use of Solitary"). However, given questions about how complete and accurate the data is—as described in detail in the next section—this data alone cannot provide a full picture of the state of solitary in ICE's detention complex.

The records also describe other ways ICE uses solitary. For instance, 1.8 percent state that detainees in solitary were LGBT individuals in protective custody, and 4 percent indicate that solitary was used to isolate individuals with medical problems (aside from mental illness).

ICE did not answer POGO's multiple, detailed queries about the data or use of solitary in detention, including how many people are represented by the records POGO obtained—a question the agency has the data to answer.

A 2013 *New York Times* investigation on ICE's use of solitary reported that Federal data covering a 5-month period showed "about 35 detainees were kept for more than 75 days" in solitary at the 50 biggest detention centers. The data was "the first

public snapshot of the number of immigrants held in solitary confinement, how long they were there and how many had mental health problems—about 10 percent."

Within days, that article sparked reactions from lawmakers, and the then-Secretary of Homeland Security Janet Napolitano told reporters she would seek a review of the agency's policies. ICE issued a policy later that year stating that for detainees with special vulnerabilities, including mental illness and pregnancy, solitary "should be used only as a last resort." It mandated more oversight of the use of solitary in immigration detention and more reporting to ICE headquarters when detainees are placed in solitary.

That 2013 policy directed ICE headquarters to use these records to continually review how detention centers use solitary confinement and to curtail its overuse and abuse. (This is a different policy from the one rescinded in the first months of the Trump Administration.)

But the records on ICE's use of solitary in recent years are not complete, according to both POGO's analysis of them and a 2017 Department of Homeland Security inspector general report.

Incomplete and inaccurate data can skew and impede oversight of solitary.

"Missing instances of segregation and late reporting of segregation of detainees with mental health conditions are of particular concern, especially for detainees who have been segregated multiple times or for longer lengths of time," wrote the inspector general. Gaps in the information mean it is harder for ICE to "mitigate the risk of deteriorating detainees' mental health," which can "put detainees and facility staff at risk of harm."

Additionally, a detention facility that provides complete, accurate information about its use of solitary may look like it uses solitary more often than a detention center that underreports its use of solitary. Thus, the available data may not truly reflect reality and could misdirect where overseers direct their attention.

Scrutiny of data from afar isn't the only way solitary confinement in immigration detention is officially overseen, but those other means of oversight, such as preannounced inspections, can fall short too, allowing problems to persist. (The inspector general began conducting surprise inspections in 2017, but preannounced inspections by ICE and one of its contractors are far more common.)

The 2013 ICE policy also gave the agency's Health Service Corps (IHSC) a role in evaluating whether detainees with mental illness should be in solitary. "Such detainees shall be removed from segregation if the IHSC determines that the segregation placement has resulted in deterioration of the detainee's medical or mental health, and an appropriate alternative is available," the policy states. But at remotely located detention centers, the Health Service Corps has struggled to hire and retain mental health professionals.

The 2017 inspector general review examined a sample of data on the solitary confinement of 127 detainees with mental health conditions between October 2015 and June 2016 at seven detention centers, including the aforementioned facilities in Adelanto and Buffalo.

Of the 46 30-day reports that should have been in the system, six were missing. The inspector general also found nearly three-quarters of reports required within 3 days of placing individuals with mental illness in solitary were missing or "not properly documented."

In January 2017, 2 weeks before President Trump was inaugurated, ICE headquarters sent a message to field offices "reiterating that segregation cases need to be reported within 3 days," according to the inspector general.

Even after ICE's message and the September 2017 inspector general report, the data is still incomplete. POGO found signs of missing and inaccurate data from the 7-month period following the release of the report.

For instance, in six of the 14-day reports filed after the September 2017 report, the placement and release dates are the same, suggesting at least one of the dates is incorrect.

There is also a reporting loophole in ICE's 2013 policy. While detention centers have to report any use of solitary within 3 days if the detainee has a "special vulnerability," detention centers do not have to report use of solitary for detainees deemed not to have such vulnerabilities until they have been in solitary for 14 days. (This may at least partially explain the lower percentage of reports of detainees with mental illness at the 15-day mark and beyond.)

"The data are very important to problem-solving, because one of the ways you figure out whether you have a problematic institution is by looking at its solitary confinement usage rate," Margo Schlanger, a former head of the Department of Homeland Security's Office for Civil Rights and Civil Liberties, told *The Intercept*.

"If the data are crappy, you can't evaluate usage. You need the data to be correct in order to use it in a diagnostic way," Schlanger said.

Under the 2013 ICE policy, Schlanger's former office, sometimes known by its acronym, CRCL, is the only Federal office outside of ICE that has regular access to the data on use of solitary. The policy carved out a role for the Office for Civil Rights and Civil Liberties in overseeing solitary confinement as part of ICE's Detention Monitoring Council, which is mostly made up of senior ICE officials and was created to review detention centers' compliance with policies and standards.

The office strives to ensure detainees, "particularly those with special vulnerabilities," are "appropriately cared for and monitored while placed in segregation to prevent mental decompensation and long-lasting harm," according to its latest annual report, covering fiscal year 2017. The office cited its regular examination of reports that ICE shares with it.

But the 2013 policy also limited how the office could use information that ICE provided, stating the office "shall not use information ICE shares" with it as part of its involvement in the Detention Monitoring Council "in any CRCL investigation or inquiry."

Ellen Gallagher, a whistleblower who previously worked in the Office for Civil Rights and Civil Liberties and is now at the inspector general's office, has said her former office was mostly focused on getting complete data and wasn't doing enough to keep detention facilities from routinely violating the rights of detainees or ICE's 2013 policy on solitary confinement. She pressed for her office to get more information from ICE on why detainees were put in solitary, and to intervene in individual cases when warranted.

"To place detainees with severe mental disabilities (e.g., schizophrenia or bipolar disorder) in segregation for the length of time indicated in ICE reports seems extremely concerning, to me at least," she wrote in an internal government email in 2014, published by the International Consortium of Investigative Journalists.

Others involved in examining conditions in detention facilities share similar concerns about how ICE is using solitary, and cite missing information as an ongoing oversight issue.

"It's a black hole. We don't have good statistics about the health status of people in ICE detention and that's a serious problem," said Marc Stern, a professor at the University of Washington's School of Public Health, in an interview with POGO.

Stern studies health care in prison settings and has conducted reviews of health care in ICE detention facilities on behalf of the Office for Civil Rights and Civil Liberties. He could not speak to the specifics of what he has found in those reviews because of nondisclosure agreements he signed with the Department of Homeland Security. (POGO has sued the Department under the Freedom of Information Act to gain access to these reviews.)

Stern said he doesn't have "a quantitative answer about how many people with schizophrenia get appropriate mental healthcare."

"We just don't have the data," he said.

THE VOICES

Some suicides in detention show that ICE and its contractors are not sufficiently curbing the use of solitary when detainees have mental illness, and that ICE is not always providing adequate care even when there are numerous warning signs.

A December 2017 Department of Homeland Security inspector general report raised concerns that ICE detention centers may have "misused" their solitary confinement units by isolating detainees without proper documentation and failing to provide assurance to the inspector general that the detainees in solitary had received daily meals and medical care.

The Stewart Detention Center, an all-male facility in Georgia, was among those the inspector general report cited. Its solitary confinement cells have also been the site of two suicides by detainees with mental illnesses in the past 2 years.

Jean Jimenez-Joseph was taken into ICE custody around the beginning of March 2017. In the months before, he had been involuntarily hospitalized multiple times for schizophrenia and psychosis, and made repeated threats of and attempts at suicide. Jimenez-Joseph's family has alleged in a lawsuit that contrary to agency policies, when ICE officers took custody of him, initially at a county jail, they did not transfer over his "prior detention records, medical records, and his vitally necessary prescription medication for schizophrenia and psychosis."

He was transported to ICE's Stewart Detention Center. There, according to the lawsuit, Jimenez-Joseph eventually did receive an antipsychotic medication but he repeatedly requested that the dosage be increased because "the voices in his head were getting worse."

But due to "systemic, chronic understaffing" at Stewart, the lawsuit states, particularly for medical and mental health positions, this never occurred. Instead, he

was placed in solitary confinement multiple times as his psychiatric symptoms worsened, including for the 20 days before he died. Jimenez-Joseph hanged himself shortly after midnight on May 15, 2017. According to the lawsuit, on the eve of his death, there were ample warnings that his psychological state was dire. The lawsuit states, "Jean had written 'Hallelujah The Grave Cometh' in large, dark letters on the wall" of his solitary confinement cell.

Efraín De La Rosa, another detainee with a history of severe schizophrenia and psychosis, hanged himself in solitary confinement at Stewart in July 2018. An employee of ICE's Health Service Corps wrote in an email to agency leadership later that year that De La Rosa "could have been saved" if ICE had responded adequately to "a total of 12 SEN [Significant Event Notifications] reports prior to his death, depicting suicidal ideation and psychosis."

According to the email, which was recently obtained by The Young Turks, "Mr. De La Rosa was not being treated with psychotropic medication; instead, he was remanded to segregation."

Private prison company CoreCivic, which runs Stewart, declined to answer questions regarding De La Rosa and Jimenez-Joseph, citing pending legal claims. "What we can tell you is the safety and well-being of the individuals entrusted to our care is our top priority, and we take seriously our obligation to adhere to Federal Performance Based National Detention Standards (PBNDS) in our ICE-contracted facilities," emailed a company spokesperson. She wrote that issues found in the December 2017 inspector general report "were quickly and effectively remedied."

"Prior to November 2018, CoreCivic did not provide medical or mental healthcare services or staffing at Stewart Detention Center," the spokesperson wrote, referring POGO to ICE for comment on care provided by ICE's Health Service Corps.

ICE did not respond to POGO's request for comment.

Azadeh Shahshahani, an attorney at Project South, a civil rights organization that has represented Stewart detainees, told POGO, "We're seeing a pattern emerging of solitary confinement leading to people's deaths, especially people in a fragile, emotional mental health situation."

"Solitary is the modus operandi when someone is experiencing mental health care problems rather than giving them the help they need," she said.

Congress should codify the policy in the Department of Homeland Security's now-rescinded 2014 memo which mandated that ICE not detain people "suffering from serious physical or mental illness" unless there were "extraordinary circumstances or the requirement of mandatory detention." Further, the Department should formally reinstate that policy in the interim.

The Department of Homeland Security should revise the 2013 ICE policy on oversight of solitary confinement to eliminate the restriction on what the Office of Civil Rights and Civil Liberties does with information it receives in the course of its participation on the Detention Monitoring Council.

ICE, after consulting with independent subject matter experts, should collect adequate and appropriate data on the provision of mental health care to detainees with psychological issues and on the impact of detention on their mental illness. An independent entity should evaluate the data, and the data and independent evaluation should be made public.

ICE should revise its 2013 policy to require detention centers to report, within 72 hours, every time solitary is used, even when the detainee is not deemed to have a special vulnerability.

Congress should review and restructure the Department of Homeland Security's Office for Civil Rights and Civil Liberties to maximize its effectiveness and transparency.

Congress should mandate that ICE's Detention Monitoring Council function more transparently; for example, the findings from its "heightened reviews" of ICE facilities should be posted publicly on the agency's website.

The Department of Homeland Security Office of Inspector General should conduct an audit of a much larger and statistically significant sample of the segregation data from 2018 and 2019 to ensure ICE is completely and accurately reporting its use of solitary confinement. This audit would go well beyond the limited sample size used in the 2017 inspection report. The Office of Inspector General should also evaluate what ICE has done with the segregation data (for example, whether it has ever curtailed the use of segregation in favor of less restrictive alternatives and how often).

ICE should mandate that more detention centers follow its higher detention standards, contained in its Performance-Based National Detention Standards 2011 (as amended). Any detention center holding substantial numbers of immigrant detainees should be held to the higher standards. For instance, the York County Prison in Pennsylvania held 690 ICE detainees on an average day in fiscal year 2017

and is one of the top detention centers reporting using solitary. Yet ICE holds the York County Prison to its lower 2008 standards.

Caterina Hyneman, Vanessa Perry, and Nicholas Trevino contributed research.

Top 15 Immigrant Detention Centers Reporting Use of Solitary

From January 1, 2016, through May 4, 2018. Each record represents one detainee's placement in solitary. Some detainees have been placed in solitary more than once.

Detention Center	Location	Unique Solitary Placements	Solitary Confinement Placements for 75+ Days	Percent of Solitary Records Stating Detainee Has Mental Illness (Raw Number)	Facility's Average D Population FY 2017
Adelanto ICE Processing Center	California	1,191	112	68% (806)	1,713
Stewart Detention Center	Georgia	614	9	26% (160)	1,840
Otay Mesa Detention Center (San Diego CDF)	California	308	24	5% (15)	1,028
South Texas ICE Processing Center	Texas	290	14	80% (233)	1,640
Houston Contract Detention Facility	Texas	283	33	67% (190)	932
York County Prison	Pennsylvania	264	1	47% (124)	690
Eloy Federal Contract Facility (AZ)	Arizona	258	10	62% (161)	1,378
Lasalle ICE Processing Center (Jena)	Louisiana	244	19	9% (22)	1,117

Detention Center	Location	Unique Solitary Placements	Solitary Confinement Placements for 75+ Days	Percent of Solitary Records Stating Detainee Has Mental Illness (Raw Number)	Facility's Average D Population FY 2017
Buffalo (Batavia) Service Processing Center	New York	238	14	82% (194)	566
Immigration Centers of America Farmville	Virginia	208	8	25% (53)	713
Pine Prairie ICE Processing Center	Louisiana	165	20	2% (4)	707
Krome North Service Processing Center	Florida	153	1	49% (75)	551
Tacoma ICE Processing Center (Northwest Detention Center)	Washington	149	47	49% (73)	1,423
Pike County Correctional Facility	Pennsylvania	133	5	10% (13)	178
Henderson Detention Center	Nevada	121	16	8% (10)	245

ARTICLE FROM POGO.ORG

CONFIDENTIAL REPORT WARNED ICE OF "INHUMANE" USE OF SOLITARY CONFINEMENT

BY NICK SCHWELLENBACH—FILED UNDER INVESTIGATION—SEPTEMBER 12, 2019

An Immigration and Customs Enforcement (ICE) detention center has kept an "alarming" number of detainees with serious mental illness confined in solitary, and many have been isolated for "shockingly" long periods, according to a previously confidential Department of Homeland Security review obtained through a Freedom of Information Act lawsuit by the Project On Government Oversight (POGO).

The review says the Adelanto, California, detention center's reliance on solitary confinement to house detainees with mental illness—in one case, for a cumulative 904 days—is "both inhumane and in violation of" ICE policy.

Detainees in solitary are isolated from other people for up to 23 hours a day.

The review details myriad and long-standing medical and mental health care failures at Adelanto, ICE's second-largest adult detention center. Adelanto is run by the GEO Group, a private prison company that several former top ICE officials have gone to work for. In April 2018, the review was sent to current acting director Matthew Albence, who at the time was head of ICE's Enforcement and Removal Operations division, the part of the agency that arrests, detains, and deports immigrants.

Albence has been a stalwart defender of his agency's detention centers. This summer, during a Fox & Friends segment that also featured an arranged tour of Adelanto, Albence said the facility is "representative of all our detention centers," calling them "humane" and "safe."

The review paints a different picture. "Incompetent medical leadership," according to the review, was the root cause of Adelanto's failure to provide adequate care, and has "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."

"Major problems remain . . . almost all of those problems continue to be linked to one fundamental problem: incompetent medical leadership" (p. 38).

The review is based on a November 2017 examination by three independent experts on correctional facilities and medical and mental health care on contract with the Office for Civil Rights and Civil Liberties (often referred to by its abbreviation, CRCL). Those experts, whose names are redacted, interviewed staff and detainees at Adelanto, examined extensive ICE and contractor records, and wrote assessments that make up the body of the review. In an earlier review, in December 2015, the office also had found many of the same problems.

The 2017 review was prompted in part by the deaths of three Adelanto detainees earlier that year, including a suicide in March using a bedsheet as a noose, and detainee complaints. More than 6 months after that suicide, the review found "tie-off's" that heightened the risk of suicide by hanging in solitary confinement cells.

A week after the independent experts' onsite investigation, "due to the serious nature of certain health and safety-related findings," the Office for Civil Rights and Civil Liberties notified ICE's leadership of the problems and made informal recommendations for "immediate action."

There are signs that ICE's leaders did not make changes quickly enough once they had been warned of the dangers facing detainees. A week after the formal review and recommendations were sent to Albence in late April 2018, and months after the earlier notification, the Department of Homeland Security's Office of Inspector General conducted a surprise inspection at Adelanto, finding "nooses" in detainees' cells and continuing problems with care and use of solitary. The inspector general's report was published in September 2018 and was widely covered by the press.

Regarding the continuing ease with which detainees could hang themselves more than a year after the March 2017 suicide, the inspector general's office wrote that "ICE's lack of response to address this matter at the Adelanto Center shows a disregard for detainee health and safety."

While ICE didn't respond to POGO's detailed request for comment, a journalist for The Atlantic, with whom POGO shared the Office for Civil Rights and Civil Liberties review, wrote that an ICE spokesperson said the agency "disagreed with much of" the review even though the Office of Inspector General separately found many similar problems. Instead, the spokesperson held up the findings of an inspection company on contract with the agency. The company, whose approach has been criticized for frequently overlooking problems, had found that Adelanto met all of ICE's standards. (See "Contractor Impunity at ICE" at the end of this article for more details.)

Among numerous unanswered questions, POGO had asked ICE why the inspection company's findings should carry more weight than those of the inspector general and the Office for Civil Rights and Civil Liberties, and why ICE rejected many of the office's findings.

"A LAST RESORT?"

The Office for Civil Rights and Civil Liberties' review contains details about the use of solitary, officially called "segregation," and problems with care beyond those in the inspector general report.

"Detainees with serious mental health disorders are routinely and inappropriately housed in administrative segregation at ACF [Adelanto Correctional Facility]," the review found. (Administrative segregation is solitary confinement for reasons other than punishment.) "Detainees with serious mental disorders should only be housed

in administrative segregation as a last resort, as that environment is not conducive to improving mental health status."

Adelanto "staff reported that 60 percent to 70 percent of detainees in administrative segregation had serious mental disorders." And when the experts conducting the review visited Adelanto in November 2017, 26 of the 50 detainees held in solitary confinement cells as punishment, called disciplinary segregation, had serious mental illnesses.

A POGO investigation into ICE's use of solitary published last month showed that Adelanto not only reported using solitary confinement far more than any other detention center, but that it appeared to confine a disproportionate number of detainees with mental illness. POGO's analysis of 6,559 records of solitary placements covering January 2016 to May 2018, obtained through the Freedom of Information Act, found that Adelanto placed detainees in solitary 1,190 times (some detainees were confined in solitary more than once). Two Adelanto detainees with mental illness had been held continuously in solitary for more than a year. The detention center reported 112 overall instances of detainees being kept in solitary for 75 days or longer.

All told, the agency's detention centers reported use of solitary confinement more than 4,000 times for more than 15 days, and nearly a quarter of those instances involved detainees with mental illness, the ICE data shows. A United Nations expert has recommended banning the use of solitary confinement beyond 15 days and banning it altogether when a person has a mental illness.

An ICE spokesperson has defended the agency's use of solitary confinement by pointing to internal studies from 2012 and 2013 that found 1.1 percent of ICE's population has been kept in solitary, versus the estimated 4.5 percent of incarcerated individuals in solitary in prisons nationwide. According to the data POGO obtained, those studies don't reflect the agency's recent practices: ICE detention centers reported about 42 percent more placements of detainees in solitary in 2017 than in 2014, even as States such as Texas and Colorado, as well as the Federal Bureau of Prisons have curbed their use of restricted housing, which includes solitary confinement. The Bureau of Prisons, unlike ICE, proactively makes data available online on how restricted housing is used.

Also unlike prison, ICE detention is officially not meant to be punitive. Although ICE's "civil detention" system is supposed to be different from the country's prison systems, the use of solitary confinement is perhaps the starkest illustration of their similarities.

"I HATE TO BE ALONE"

The Office for Civil Rights and Civil Liberties' review provides some details on individual detainees kept in solitary at Adelanto, including four who were isolated cumulatively for more than a year. One was isolated for a cumulative 904 days.

"No detainee should be held in the [Special Management Unit] for this amount of time. Isolation alone can create physical safety concerns and can result in mental decompensation," according to the review ("special management unit" is one name for restricted housing where detainees are isolated from the general population). "Continuous and prolonged segregation housing of the mentally ill," the review states, had led "to inadequate mental health care, and increased the likelihood of poor mental health outcomes."

"Adelanto inappropriately houses detainees with serious mental disorders ly [sic] in segregation, rather than housing them in an appropriate mental health housing arrangement. Continuous and prolonged segregation housing of the mentally ill, has lead to inadequate mental health care, and increased the likelihood of poor mental health outcomes" (p. 57).

One detainee who had been isolated for a total of 269 days was still without medication despite the presence of a "clear signal" in an electronic tracking system that he needed "robust psychiatric care." Another who had been isolated for a cumulative 68 days had a "profound mental health history" including several stays at mental health treatment centers, yet was on "no standing antipsychotic medication . . . and he was suffering as a result."

One detainee who was diagnosed with schizophrenia told the review team he "did not wish to be in segregation, and reported that his symptoms (namely auditory hallucinations) were worsening with so much time in isolation."

The review notes that "it is common for psychotic symptoms, such as auditory hallucinations, to get worse when persons with schizophrenia are alone in isolation (i.e. voices often quiet when a person is engaged with others)."

The review team's mental health expert recalled the detainee saying, "I hate to be alone."

Many detainees with mental illness had requested to be separated from the general population and placed in solitary, according to the review. But this was due to a lack of alternatives. Adelanto staffers told the Office for Civil Rights and Civil Liberties experts that solitary "is 'the best option' available for some of" the detainees with mental illness "because of the absence of other options for appropriate mental health housing." The review team recommended that Adelanto "develop a safe housing alternative with more intensive mental health services."

This wasn't the first time the office had raised issues regarding Adelanto's use of solitary. "In 2015 CRCL recommended that long-term segregation housing of detainees with serious mental health conditions at ACF should cease. This was not corrected," according to the review.

ICE's use of solitary has also sparked bipartisan congressional concern. In a letter to ICE's acting director Albence this July, Senators Chuck Grassley (R–IA) and Richard Blumenthal (D–CT) called detention centers' reliance on solitary to hold vulnerable populations, such as detainees with mental illness, a "basic structural challenge for ICE."

Another reason detainees were left to languish in solitary, according to the review: "Clinical staff did not consider themselves as responsible for the segregation and/ or ongoing segregation of their patients."

"INCOMPETENT LEADERSHIP"

The review cites hundreds of internal complaints at Adelanto in 2016 and 2017 related to medical and mental health care. Most of the complaints regarding "delays or denials of care" were confirmed, the review states, and were partly attributable to inadequate medical staffing.

"This large number of healthcare related grievances is not typical in a correctional setting, and is a key indicator that the healthcare needs of the detainee population is not being met," the review states.

Adelanto's problems with medical and mental health care fundamentally stemmed from poor medical leadership, according to the review.

"In 2015, CRCL clearly informed Adelanto that clinical leadership was not competent and that problematic medical care was occurring as a result. In 2017—two years since the 2015 onsite—the experts found no evidence that corrections were made to address this issue," states the review.

The GEO Group, which runs Adelanto, provided healthcare at the detention center until February 2016, when it hired a medical subcontractor called and Immigration Detention Medical Correct Care Solutions, recently rebranded as Wellpath. The head of Wellpath is a former GEO executive who worked simultaneously as a GEO consultant and as president of the healthcare company when GEO hired it to run healthcare at Adelanto.

But the change in the company providing care didn't affect Adelanto's top medical personnel. "That new contractor left the same incompetent leadership in place," the review states.

At the time of publication, POGO was not able to identify who led Adelanto's medical care.

The Office for Civil Rights and Civil Liberties' experts recommended Adelanto replace those heading up the detention center's medical care. "In the event that new leadership cannot be recruited immediately as it is likely that it will take some time to put new leadership in place-at-risk detainees should be immediately removed from the facility and transferred to other facilities with well-functioning medical programs," the review recommends.

The review contains nearly identical criticism of the mental health leadership at Adelanto.

Neither GEO nor Wellpath responded to POGO's requests for comment.

Last month, a massive Federal lawsuit was filed on behalf of 15 detainees—eight of whom were detained at Adelanto at the time of the filing—against ICE and the Department of Homeland Security, stating that the Office for Civil Rights and Civil Liberties "has no enforcement power, so ICE is free to disagree with CRCL recommendations or refuse to implement them." The lawsuit names top Homeland Security officials, including acting ICE head Albence. The officials' lax oversight of ICE detention centers, plaintiffs claim, has led to systemically poor medical and mental healthcare, deaths, and other adverse health and safety impacts.

Beyond his Fox & Friends interview, Albence has been vocal in his defense of contractors running many of ICE's detention centers as well as the conditions in the facilities, including family detention centers that he said last year are "like a summer camp." At a Senate hearing where he stood by that comparison, Albence refused

to answer when asked if he would send his children to his agency's detention centers.

"That question's not applicable," he said.

Mrs. WATSON COLEMAN. The Members of the subcommittee may have additional questions for the witnesses, and we may ask that you respond expeditiously in writing to those questions. Without objection, the committee record shall be kept open for 10 days.

Hearing no further business, the subcommittee stands adjourned.

[Whereupon, at 3:30 p.m., the subcommittee was adjourned.]

APPENDIX I

STATEMENT OF PETER E. MINA, DEPUTY OFFICER FOR PROGRAMS AND COMPLIANCE, OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES, U.S. DEPARTMENT OF HOMELAND SECURITY

SEPTEMBER 26, 2019

Chairwoman Torres Small, Ranking Member Crenshaw, and distinguished Members of the subcommittee, thank you for the opportunity to submit a statement for the record on behalf of the Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL).

I would like to make 4 overarching points in my statement: (1) Oversight of DHS immigration detention facilities is a key part of CRCL's mission, and we conduct our oversight in a unique manner, using contract subject-matter experts and with the focus on civil rights and civil liberties; (2) CRCL's prior recommendations have led to concrete improvements in conditions of detention at U.S. Immigration and Customs Enforcement (ICE) facilities; (3) ICE should strive to use the most comprehensive detention standards, in particular when detaining vulnerable populations; and (4) ICE and CRCL should continue to work together to address CRCL's recommendations following compliance investigations and ensure timely implementation of necessary corrective action.

INTRODUCTION

CRCL supports the DHS mission to secure the Nation while preserving individual liberty, fairness, and equality under the law. Established by the Homeland Security Act, CRCL's mission integrates civil rights and civil liberties into all of DHS activities by:

- Promoting respect for civil rights and civil liberties in policy development and implementation by advising Department leadership and personnel, and State and local partners;
- Communicating with individuals and communities whose civil rights and civil liberties may be affected by Department activities, informing them about policies and avenues of remedy, and promoting appropriate attention within the Department to their experiences and concerns;
- Investigating and resolving civil rights and civil liberties complaints filed by the public regarding Department policies or activities, or actions taken by Department personnel; and
- Leading the Department's equal employment opportunity programs and promoting workforce diversity and merit system principles.

CRCL is a DHS headquarters office, and the CRCL officer reports directly to the Secretary of Homeland Security. CRCL works collaboratively with, but independently of, the DHS operational components, including ICE.

CRCL'S UNIQUE ROLE IN DETENTION OVERSIGHT

Oversight of DHS immigration detention facilities is a key part of CRCL's mission. Pursuant to statutory authorities under 6 U.S.C. § 345 and 42 U.S.C. § 2000ee–1, CRCL reviews and investigates complaints from the public alleging violations of civil rights or civil liberties by DHS personnel, programs, or activities. Such complaints include allegations about inadequate conditions of detention. It is important to note that the DHS Office of Inspector General (OIG) has the right of first refusal to investigate allegations submitted to CRCL, and that my office has the authority to inspect, and regularly does inspect, ICE detention facilities. Further, CRCL coordinates a recurring meeting among the DHS oversight entities, including the OIG, which retains its statutory authorities and independence, to ensure appropriate coordination and/or deconfliction of oversight efforts.

CRCL investigates allegations and makes recommendations to DHS components, often related to the creation or modification of policies, or changes to implementation, training, supervision, or oversight. CRCL is also responsible for assisting the Department in developing, implementing, and periodically reviewing policies and procedures to ensure the protection of civil rights and civil liberties, including in immigration detention facilities.

As CRCL reports directly to the Secretary, CRCL is not part of the reporting structure of DHS components. Yet, CRCL is also internal to the Department, and works alongside components to formulate and change policies and practices.

CRCL's work is not, with limited but important exceptions,[1] remedial in nature. One notable exception, specifically related to this hearing's topic, is the medical referral process that CRCL uses to ensure anyone in ICE custody raising a medical or mental health care concern receives prompt attention. In fiscal year 2018, CRCL sent 416 medical referrals to ICE for immediate action. CRCL uses contract medical experts to review and evaluate information provided by ICE medical staff in response to referrals. We believe this process has been instrumental in helping to ensure that detainees receive timely and appropriate health care. Additionally, it has been essential in assisting CRCL to assess where broader, systemic issues might need further review.

As previously mentioned, CRCL uses contract subject-matter experts, including medical doctors, mental health providers, conditions of detention experts, suicide prevention consultants, and environmental health and safety specialists to review detention conditions through the prism of civil rights and civil liberties and using the applicable detention standards, or relevant professional standards, as the yardstick. No other entity conducts detention oversight with external experts and with a particular focus on, and expertise in, civil rights and civil liberties.

I would also like to highlight the distinctive way CRCL uses the data we collect. All allegations received by CRCL involving civil rights or civil liberties issues are reviewed and recorded. We use the resulting information to track issues and identify potential patterns of alleged civil rights or civil liberties violations that may require further review. For ICE detention, this data is used to guide CRCL in identifying which facilities warrant on-site investigations to more closely examine potentially serious or systemic issues. Additionally, CRCL shares data with ICE annually to provide visibility into the civil rights related matters CRCL has received, and publishes data on complaints in the Annual and Semi-Annual Reports to Congress.

In fiscal year 2018, CRCL's Compliance Branch received 4,244 allegations that were considered for investigation as a complaint, an increase of 20 percent over fiscal year 2017 (3,513). Over the course of the year, CRCL opened 743 complaint investigations (an increase of 31 percent) and closed 750 of the open complaint investigations (an increase of 24 percent). Of the 743 new complaints in fiscal year 2018, CRCL opened 472 related to conditions of detention.[2] These included reviews of deaths in detention, allegations related to medical or mental health care, the use of segregation, sexual abuse or assault, disciplinary procedures, use of force, the grievance process, the disciplinary system, language access, religious accommodation, food service, and environmental or sanitation concerns. Overall, in response to recommendations made by CRCL (in cases where issues were identified, and recommendations were warranted), DHS components concurred with 60 percent of CRCL recommendations in fiscal year 2018; ICE concurred with 55 percent.

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[1] CRCL has remedial authority under Section 504 of the Rehabilitation Act of 1973, as amended, which states, "No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency. . . ." 29 U.S.C. § 794.

[2] Due to resource constraints, as well as to avoid duplication of component or OIG investigations, CRCL does not open every allegation it receives for investigation. CRCL focuses on allegations sent directly to our office. We evaluate other allegations that are being handled by component or DHS complaint redress avenues, and generally open for investigation those that involve: An issue or fact pattern that appears to be systemic or wide-spread; an issue or fact pattern that is egregious, raising serious concerns that warrant a civil rights or civil liberties investigation by a DHS Headquarters office; an issue or fact pattern that is novel, and where existing avenues may not be suited to address the civil rights or civil liberties issues presented; or despite the issue having been received directly and investigated by another DHS complaint avenue, the civil rights issues raised do not appear to be adequately addressed. CRCL may open and retain for investigation an allegation that was not initially opened.

FAMILY DETENTION OVERSIGHT

From November 2014 through the time of this hearing, CRCL conducted 10 on-site investigations at the Karnes County (Karnes City, Texas), South Texas (Dilley, Texas), and Berks Family Residential Centers, as well as the family detention facility in Artesia, New Mexico, which was later closed by ICE following CRCL on-site reviews and recommendations. Through these investigations, CRCL sought to verify that families were being treated according to Departmental and professional standards. These investigations included a review of medical and mental health care, food service and housing conditions, and other aspects of the facility conditions that relate to families. CRCL is planning to visit the South Texas Family Residential Center again in early in fiscal year 2020.

ON-SITE INVESTIGATIONS AND EXPERT RECOMMENDATIONS

CRCL conducts on-site investigations at ICE and ICE-contracted adult immigration detention facilities. In fiscal year 2018, CRCL conducted 10 on-site investigations at ICE adult detention facilities.[3] For these investigations, CRCL enlists the assistance of subject-matter experts in the areas of medical care, mental health care, facility security and operations, use of force, suicide prevention and intervention, and environmental health and safety. Following each investigation, CRCL provides the experts' reports to ICE. ICE is asked to review the recommendations and provide a written response, concurring, non-concurring, and to provide evidence of implementation of recommendations with which ICE concurs within a defined time frame. If ICE non-concurs, it must provide an explanation, which CRCL reviews to determine whether to continue discussions on the substance of the concern with ICE or consider raising to DHS leadership.

USE OF SEGREGATED HOUSING

Since the office was created, CRCL has regularly examined the use of segregated housing (sometimes referred to as solitary confinement) through complaint investigations, working groups, and advice to senior DHS leaders. In 2013, CRCL worked with ICE to conduct a full assessment of the use of segregation in ICE detention facilities, which led to a National directive on oversight of segregation and guidance for implementation of the directive, as well as reporting and tracking mechanisms. In succeeding years, CRCL continued to work with ICE to improve policy and reduce unnecessary use of segregated housing for ICE detainees and develop further policy approaches to recognize and respond to the needs, in particular, of vulnerable populations in segregated housing, including lesbian, gay, bisexual, or transgender (LGBT+) detainees and detainees with serious health concerns, mental health conditions, or disabilities. CRCL also collaborated with ICE to incorporate changes related to segregation into revisions of the 2011 Performance-Based National Detention Standards (PBNDS).

Over time, CRCL's Compliance Branch has continued to investigate civil rights allegations related to segregation, which has led to recommendations to ICE for additional changes related to the use of segregation. CRCL has also provided feedback to ICE on the placement of individual detainees in segregated housing. This has resulted in individuals who were in segregation being transferred to general population or to facilities specializing in mental health care.

EXAMPLES OF IMPROVEMENTS IN CONDITIONS OF DETENTION BASED ON CRCL RECOMMENDATIONS

ICE has made concrete improvements in the conditions of detention based on CRCL recommendations and assistance. In addition, over the last several years, ICE has removed detainees from a number of facilities that had serious issues affecting the safety of the detainees being held there, and some facilities were permanently or temporarily closed following CRCL recommendations.

DEVELOPMENT OF DETENTION STANDARDS

CRCL contributes to proactively develop DHS policy related to conditions of detention. For example, in fiscal year 2017, CRCL participated in ICE's working group to develop a new set of detention standards for its non-dedicated immigration deten-

[3] These on-site investigations involved the following ICE facilities: Adelanto Correctional Facility (CA), Bergen County Jail (NJ), Contra Costa West County Detention Facility (CA), Denver Contract Detention Center (CO), El Paso Processing Center (TX), Etowah County Detention Center (AL), Folkston ICE Processing Center (GA), Glades County Detention Center (FL), Orange County Correction Facility (CA), and West Texas Detention Facility (TX).

tion facilities. The new standards are a revision of ICE's 2000 National Detention Standards (NDS). The working group focused on updating and streamlining the standards, as well as including critical elements that are not currently part of the NDS. CRCL, with the assistance of its contract subject-matter experts, provided feedback on important civil rights and civil liberties issues during the working group's review, such as suicide prevention, mental health care, disability accommodation, and sexual abuse and assault prevention and intervention.

DISABILITY-RELATED COMPLAINTS

CRCL's Compliance Branch reviews and adjudicates allegations of disability-based discrimination under Section 504 of the *Rehabilitation Act of 1973,* as amended, for almost all DHS components. During the current fiscal year, CRCL has opened 18 complaints from across the Department under Section 504, including 4 allegations involving ICE. CRCL did not issue any determination letters finding a violation of Section 504 during the fiscal year; however, through its complaint review, CRCL helped arrange for reasonable accommodations for numerous complainants, including ensuring a video phone was available for a detainee in ICE custody. CRCL also facilitated numerous informal resolutions between complainants and components.

PRISON RAPE ELIMINATION ACT AUDITS

After considerable work helping develop DHS's *Prison Rape Elimination Act* (PREA) Standards and other sexual abuse and assault prevention and intervention policies, and conducting investigations into the handling of sexual abuse allegations, CRCL assisted ICE in developing the required PREA instruments to audit ICE's immigration detention and holding facilities. ICE is now using these tools to audit PREA compliance and implementation in their facilities, as required by regulation. In addition to working on the specific audit instruments, CRCL personnel developed and delivered a portion of the ICE training to certify the auditors who now conduct the audits and observed ICE PREA audits to assist with evaluation of the auditors and planning for future audits.

THE PATH FORWARD FOR IMMIGRATION DETENTION: EXPANDING APPLICATION OF DETENTION STANDARDS

ICE should continue to strive to use the PBNDS 2011 standards, which are ICE's most comprehensive standards, in particular when detaining vulnerable populations, such as those with serious medical or mental health conditions, and LGBT+ detainees. Taking into account operational and resource challenges, ICE should continue to expand the application of the PBNDS 2011 standards to new or existing detention facilities where they are not currently in place. As a further means of promoting compliance with these standards, CRCL looks forward to working with ICE to build greater consensus regarding CRCL's recommendations and to ensure timely implementation of any applicable corrective action plans pursuant to those recommendations.

APPENDIX II

QUESTION FROM RANKING MEMBER MIKE ROGERS FOR DIANA R. SHAW

Question. The Detention Service Managers (DSMs) provide on-site monitoring at numerous facilities and can provide real-time information on the conditions at a facility. Would ICE benefit from the use of more DSMs or from an expanded role for DSMs? What recommendations would you make to ensure the information from the DSMs is being communicated to relevant personnel so that deficiencies can be corrected?

Answer. In our report OIG–18–67, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements,* we concluded, based on our fieldwork, that Detention Service Managers (DSMs) provide an important layer of oversight because they are specifically trained in the applicable detention standards. DSMs run regular weekly or, in some facilities, daily checks for compliance with the detention standards in the facilities they monitor. We performed our fieldwork in 2017, when on average more than 35,000 detention beds were occupied and 35 DSMs were monitoring conditions at approximately 50 facilities. The growth in detention beds to approximately 52,000 to 54,000 in fiscal year 2019, and the increase in the average daily populations ICE detains, is likely to put additional strain on the already taxed DSM program. If it has not done so already, ICE will likely need to review its staffing model and determine whether additional DSMs should be hired to ensure adequate oversight in keeping with the detention expansion.

Additionally, our still-opened recommendation 5 from OIG–18–67, copied below, should contribute to a better process for correcting deficiencies, when ICE implements the actions responsive to this recommendation:

Recommendation 5: Develop protocols for ERO field offices to require facilities to implement corrective actions resulting from Detention Service Managers' identification of noncompliance with detention standards.

In the initial response to our report and in the September 19, 2019 update to this recommendation, which is still opened, ICE committed to exploring various options to enhance collaboration between field offices and DSMs as well as expand detention standards training to field office personnel so that ICE ERO could better support DSMs.

QUESTIONS FROM RANKING MEMBER MIKE ROGERS FOR TAE JOHNSON

Question 1. Has ICE made any changes to how it processes and responds to recommendations from Detention Service Managers (DSMs)?

Answer. Response was not received at the time of publication.

Question 2. The IG recommended that ICE develop protocols to ensure both Contracting Officer Representatives (CORs) and Detention Service Managers (DSMs) have access to the documents that relate to the conditions of the contract. Has ICE taken steps to address this recommendation and ensure information regarding deficiencies at facilities is being communicated to all the relevant personnel?

Answer. Response was not received at the time of publication.

Question 3. You indicated that ICE has created a Quality Assurance Team (QAT) to address a number of the concerns raised by the IG. Who will the individuals on this team report to and how will the information discovered by this team be communicated to ensure shortcomings are addressed?

Answer. Response was not received at the time of publication.