



An Inside Look at the ICE Inspections System

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immigrantjustice.org/TransparencyandHumanRights

Today's Presenters

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Lives in Peril:

How Ineffective Inspections

Make ICE Complicit in

Immigration Detention Abuse



The Immigration Detention Transparency and Human Rights Project

NATIONAL IMMIGRANT JUSTICE CENTER A HEARTLAND ALLIANCE PROGRAM



October 2015 Report

immigrantjustice.org

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Our Findings:

- The Obama administration failed to improve oversight or gain control over the sprawling immigration detention system and the problematic conditions approximately 34,000 immigrants face in custody every night.
- The failures of the inspections system have made ICE complicit in obscuring human rights violations in detention facilities.
- Public and private contractors who operate the jails that detain immigrants are able to continue multi-million dollar contracts – funded by American taxpayers – even when they fail to comply ICE's own detention standards.

Obama's 2009 Reform Promises

- Increase government transparency
- 2. Fix detention oversight



December 12, 2011

Today, ICE Director John Morton announced substantial steps, effective immedi immigration detention system. These reforms will address the vast majority of commigration detention, while allowing ICE to maintain a significant, robust detent out serious immigration enforcement.

2009 DHS Appropriations Act:

"Provided further, That effective April 15, 2009, none of the funds provided under this heading 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."

ICE Enforcement and Removal Operations (ERO) inspections count toward this provision.

Fig. 5: Standards applied for most recent inspection obtained

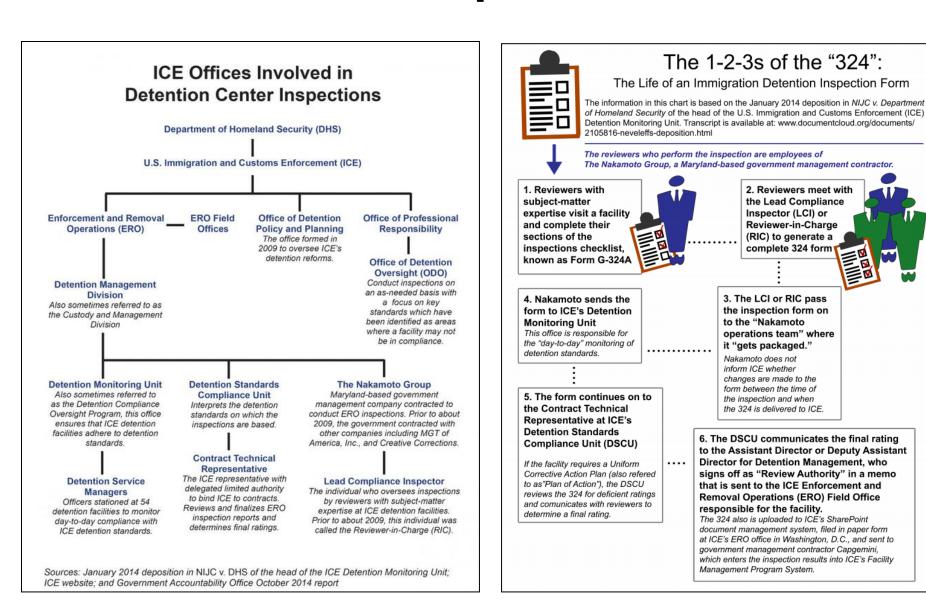
DETENTION FACILITY	DETENTION STANDARDS APPLIED AT MOST RECENT ERO or
DETENTION FACILITY	ODO INSPECTION (YEAR OF INSPECTION)
ADELANTO EAST CORRECTIONAL FACILITY, CA (GEO Group)	PBNDS (2012)
ADELANTO WEST CORRECTIONAL FACILITY, CA (GEO Group)	PBNDS (2012)
BAKER COUNTY SHERIFF DEPARTMENT, FL	2000 NDS (2012)
BEDFORD HEIGHTS CITY, OH	2000 NDS (2012)
BERGEN COUNTY JAIL, NJ	2000 NDS (2012)
BERKS COUNTY FAMILY SHELTER, PA	ICE Residential Standards
BOONE COUNTY JAIL, KY	2000 NDS (2012)
BRISTOL COUNTY DETENTION CENTER, MA	2008 PBNDS (2012)
BROWARD TRANSITIONAL CENTER, FL (GEO Group)	PBNDS (2012)
DENVER CONTRACT DETENTION FACILITY, CO (GEO Group)	2008 PBNDS (2011)*
BUTLER COUNTY JAIL, KS	2000 NDS (2011)
BUTLER COUNTY JAIL, OH	2000 NDS (2012)
CALDWELL COUNTY DETENTION CENTER, MO	2000 NDS (2012)
CALHOUN COUNTY CORRECTIONAL CENTER, MI	2000 NDS (2012)
CALIFORNIA CITY CORRECTIONAL CENTER, CA (CCA)	2008 PBNDS (2011)
CAMBRIA COUNTY JAIL, PA	2000 NDS (2011)
CARVER COUNTY JAIL, MN	2000 NDS (2011)
CASS COUNTY JAIL, NE	2000 NDS (2011)
CENTRAL ARIZONA DETENTION CENTER, AZ (CCA)	PBNDS (2012)
CHARLESTON COUNTY DETENTION CENTER, SC	2000 NDS (2012)
CHASE COUNTY DETENTION FACILITY, KS	2000 NDS (2011)
CLINTON COUNTY CORRECTIONAL FACILITY, PA	2000 NDS (2012)
CONTRA COSTA COUNTY JAIL WEST, CA	2000 NDS (2011)
DEKALB COUNTY DETENTION CENTER, AL	2000 NDS (2012)
DELANEY HALL DETENTION FACILITY, NJ	PBNDS (2012)
ELIZABETH CONTRACT DETENTION FACILITY, NJ (CCA)	2008 PBNDS (2011)
DODGE COUNTY JAIL, WI	2000 NDS (2012)
DOUGLAS COUNTY CORRECTIONS, NE	2008 PBNDS (2012)*
EAST HIDALGO DETENTION CENTER, TX (GEO Group)	2000 NDS (2011)
HOUSTON CONTRACT DETENTION FACILITY, TX (CCA)	2008 PBNDS (2012)
EL PASO COUNTY JAIL, CO	2000 NDS (2012)
NORTHWEST DETENTION CENTER, WA (GEO Group)	2008 PBNDS (2012)
SAN DIEGO CONTRACT DETENTION FACILITY, CA (CCA)	2008 PBNDS (2011)*
ELOY FEDERAL CONTRACT FACILITY, AZ (CCA)	2008 PBNDS (2012)
ESSEX COUNTY, NJ	PBNDS (2012)
ETOWAH COUNTY JAIL, AL	2000 NDS (2012)

ICE Detention Standards

- 2000 National Detention Standards
- 2008 Performance-Based National Detention Standards
- 2011 Performance-Based National Detention Standards

"The PBNDS 2011 are crafted to improve medical and mental health services, increase access to legal services and religious opportunities, improve communication with detainees with no or limited English proficiency, improve the process for reporting and responding to complaints, and increase recreation and visitation."

ICE's Internal Inspections Process



3. The LCI or RIC pass the inspection form on to the "Nakamoto operations team" where "gets packaged."

Nakamoto does not inform ICE whether changes are made to the form between the time of the inspection and when the 324 is delivered to ICE.

5. The form continues on to the Contract Technical Representative at ICE's Detention Standards Compliance Unit (DSCU)

If the facility requires a Uniform Corrective Action Plan (also refered to as"Plan of Action"), the DSCU reviews the 324 for deficient ratings and comunicates with reviewers to determine a final rating. Q. Is there a paper trail that ICE has access to when the form Three Twenty-Four goes through the entity's hierarchy?

"The contractor has latitude to get to the final result"

 ICE Detention Monitoring Unit Director, January 2014 deposition in NIJC v. DHS THE WITNESS: I can only speculate.

• • • •

MR. OSWALD: And the cause for speculation is?

THE WITNESS: The cause for speculation is, you know, it's a contract mechanism the way we establish our contractor is basically performance based, meaning that the contractor has latitude to get to the final result.

BY MR. ANDALMAN:

- Q. Got it. So potentially a document could be modified within the outsourced entity and ICE would not have access to records of that?
- A. Again, I'm speculating that potentially.

Fig. 6: Failed inspections, 2007-2012

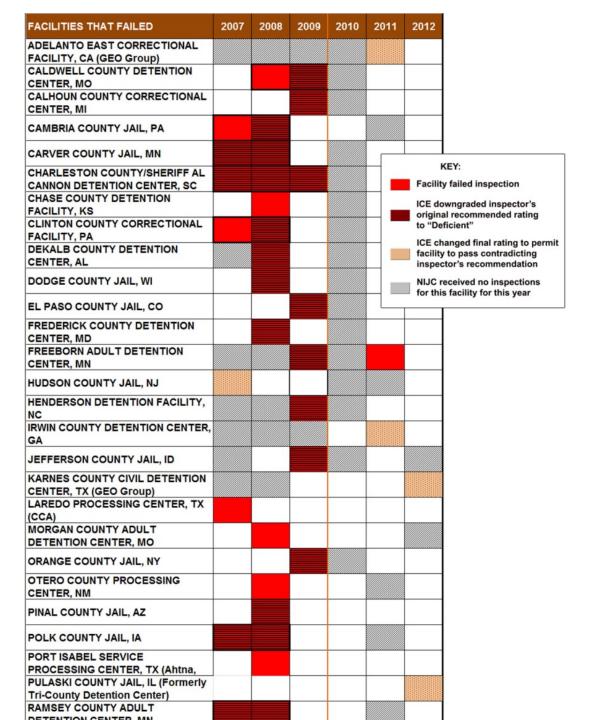


Fig. 1: Inspection checklist excerpt

(from Eloy 2012 ERO inspection)

	PART 4 – 20. F	OODS	ERVICE			
	s Detention Standard ensures that detainees are provide sanitary and hygienic food service operation.	ed a nut	ritionally b	alance	d diet that is prepared and presented	
	Components	Meas	Does Not Meet Standard	N/A	Remarks	
1.	The food service program is under the direct supervision of a professionally trained and certified Food Service Administrator (SA). The Responsibilities of cooks and cook foren an are in writing. The FSA determines the responsibilities of the Food Service Staff.	×	\	Sun	The Food Service Administrator (FSA), who is employed by Canteen Corporation, is responsible for the	
2.	The Cook Foreman is on duty on days when the FSA		9		of components that prise the standard	
	is off duty and vice versa.			Son	ne components are	
3.	The FSA provides food service employees with training that specifically addresses detained usual issues. In ICE Facilities this included review of the "Food Service" standard	×		A ra	ked as "mandatory." Iting of "Does Not Meet Indards" or "Deficient"	
•	(MANDATORY) Nife cabinets close with an approved locking device and the on-duty cook foreman maintains control of the key that locks the device. Knives and keys are inventoried and stored in accordance with the Detention Standard on Tool Control		ī	on one of these components should result in failure of the overall inspection.		
5.	All knives not in a secure cutting room are physically secured to the workstation and staff directly supervises detainees using knives at these workstations. Staff monitor the condition of knives and dining utensils	×			however, the condition of other dining utensils is monitored by food service staff.	
6.	Special procedures (when necessary) govern the handling of food items that pose a security threat.				Yeast, mace, nutmeg, cloves and other food items that pose a security threat are not used in the facility. Spices and sugars are secured in the dry storage room in a locked cabinet.	
7.	Operating procedures include daily searches (shakedowns) of detainee work areas.	\boxtimes				
8.	The FSA monitors staff implementation of the facility population count procedures. These procedures are in writing. Staff are trained in count procedures.	⊠			Assigned detention officers are trained in count procedures and are responsible for conducting counts.	

Fig. 2:
First tier to the ERO
checklist is a rating of
individual
components within a
given standard.

PART 7 - 41. TRANSFER OF DETAINEES This Detention Standard ensures that transfers of detainees from one facility to another are professionally and responsibly managed in regard to notifications, detainee records, safety and security, and protection of detainee funds and personal property.				
Components	Meets Standard	Does Not Meet Standard	N/A	Remarks
 For medical transfers, transporting officers receive instructions regarding medical issues. 	×			Transportation officers will receive specific instructions regarding medical issues.
 Detainee's funds, valuables and property are returned and transferred with the detainee to his or her new location. 	⊠			All funds and personal property are returned to the detainee during the release process.

Fig. 3:
Second tier to the
ERO checklist is a
rating for an overall
standard, which is
based on the ratings
of individual
components.

PART 7 - 41. TRANSFER OF DETAINEES				
⊠ Meets Standard	Does Not Meet Standard	□ N/A	Repeat Finding	
Remarks: (Record significant facts, An interview with an ICE representative detained's attorney of record when a tra- management issues regarding a medical the procedures and issues involved in the departure. Safety and security are always (b)(6). (b)(7)(c) 02/24/2012 Reviewer's Signature / Date	re indicated that ICE staff are aware ansfer is made outside the Field Offi Il transfer. In addition, interviews wi the transfer of detainees. All property	of the responsi ice area. Field C ith Booking stat y and funds are	Office staff are also aware of the case iff indicated that they are well versed in	

Fig. 4:
Third tier to the
ERO checklist is a
rating for the
overall facility,
which is based on
the ratings given to
standards.

LCI Review Assurance Statement				
By signing below, the Lead Compliance Inspector (LCI) certifies that all findings of noncompliance with policy or inadequate controls contained in the Inspection Report are supported by evidence that is sufficient and reliable. Furthermore, findings of noteworthy accomplishments are supported by sufficient and reliable evidence. Within the scope of the review, the facility is operating in accordance with applicable law and policy, and property and resources are efficiently used and adequately safeguarded, except for the deficiencies noted in the report.				
Lead Compliance Inspector: (Print Name)	Signature			
(b)(6), (b)(7)(c)	(b)(6), (b)(7)(c)			
Title & Duty Location	Date			
Lead Compliance Inspector, The Nakamoto Group, Inc.	February 24, 2012			
Team Members				
Print Name, Title, & Duty Location	Print Name, Title, & Duty Location			
(b)(6), (b)(7)(c) Food & Environmental Health and Safety- CI, The Nakamoto Group, Inc.	(b)(6), (b)(7)(c) Medical CI, The Nakamoto Group, Inc.			
Print Name, Title, & Duty Location	Print Name, Title, & Duty Location			
(b)(6), (b)(7)(c) Security-CI, The Nakamoto Group, Inc.				
Recommended Rating: Meets Standards Does Not Meet Standards				

What are the final ratings based on?

- 5 of 6 the facilities we review in this report, and 29 of the 35 reviewed by the GAO during roughly the same time period, have substantial variations in their findings.
- In 2011, Baker had 14 deficient components and received a "Good" rating. The next year, it had only 5 deficient components, but dropped to "acceptable."
- Etowah was given an acceptable rating despite having absolutely zero documented deficiencies. So what was that rating based on?

Deaths in Detention

- The Eloy Federal Contract Facility in Arizona has the highest number of known deaths of any detention facility, including at least six suicides since 2003.
- In 2012 Eloy passed on the overall suicide prevention standard even though:
 - Failed to comply with one of its major components: the suicide watch room contained objects which could be used to commit suicide.
 - Problem was quickly dismissed by the inspectors because of assurances that individuals on suicide watch are monitored.
 - Taking facility staff members' at their word is common
 - This inspection failure may be tied to the suicide at Eloy earlier this year

Inadequate Medical Care

- Inspections found that medical staffing was inadequate at Stewart despite 5 vacant positions (at least two of which had been vacant for over two years),
- At both Stewart and Eloy, intake exams were not promptly (or ever) reviewed by a physician as required.

Sexual assaults

- Although the number of sexual assault allegations are recorded, they are often swiftly and cursorily dismissed.
- Eloy's 2011 inspection references 10 allegations of sexual assault in the past year, but then dismisses them all as "unfounded or unsubstantiated."
- Stewart's 2012 ERO report mentions six allegations of sexual assault or abuse, and then proceeds to methodically dismiss or minimize them. Two were downgraded, three found unsubstantiated, and the final one relabeled as physical assault, despite the clear sexual nature of the incident: the victim was severely beaten after refusing to provide sexual favors.
- However, we know at least two sexual assault happened at Eloy in the 14 months prior to its inspection.
 - Tanya Guzman, a transgender woman who was held in an all-male pod at Eloy, was assaulted in December 2009 by a guard who was later convicted of the assault.
 - Four months later, despite the first assault and frequent complaints of harassment and abuse, Eloy continued to detain her in the male pod and she was assaulted by another detained person.

Flexible definitions

- And they contort the basic meaning of standards to allow facilities to pass.
 - At both Baker and Etowah, fully enclosed indoor rooms are counted as providing outdoor recreation essentially because they have windows which allow in light and air.

Statements versus evidence

- Inspectors often take facility staff at their word
 - In 2012, At the Tri-County Detention Center (now Pulaski County Jail), a new fire alarm system had been recently installed but had yet to be tested and emergency generators did not cover critical areas including medical.
 - However, because facility staff had plans to address these problems, the environmental health and safety standard was <u>preemptively</u> marked as having been fulfilled.
- Inspectors track whether or not policies exist rather than inquire into their implementation or effectiveness.

Recommendations

- Increase transparency and oversight of the inspections process:
 - Make ERO and ODO inspections available to the public in a timely manner.
 - Provide public reporting on suicide attempts, hunger strikes, work program stoppages, use of solitary confinement, use of force, and other significant events at detention centers.
 - Submit quarterly reporting to Congress on inspection and oversight activities of detention facilities, to be made available to the public.

Recommendations

Improve the quality of inspections

- Establish a DHS ombudsman outside of ICE to conduct unannounced inspections of immigration detention facilities at least once per year, with complete findings made available to the public.
- Engage detained immigrants during inspections, as well as other stakeholders, in order to capture a broader range of concerns.

Recommendations

Institute consequences for failed Inspections

- Place detention facilities on probation and subject them to more intensive inspections after the first finding of substantial non-compliance.
- Terminate contracts within 60 days for those facilities with repeat findings of substantial noncompliance.

Thank you for joining us

View the inspections, report, and a recording of the webinar where this presentation was featured:

immigrantjustice.org/TransparencyandHumanRights

Tell us how you've used these docs in your advocacy (and send us inspections or contracts you've obtained to add to the site): ttidwellcullen@heartlandalliance.org

Contact the presenters:

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