



## **SUMMARY AND ANALYSIS: Office of the Inspector General’s report on the “Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities”**

### **Introduction:**

The Office of Inspector General (OIG) of the Department of Homeland Security (DHS) issued a report in December of 2006 outlining violations of the U.S. Immigration and Customs Enforcement’s (ICE) Detention Standards at five detention facilities across the United States. Violations outlined in the report, titled “Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities,” range from sexual assault to delayed healthcare services.

The results of this audit are troubling for two reasons. First, the violations seriously affect the rights and well-being of detainees. Second, no plans exist to institute significant institutional changes that will prevent future and on-going abuse. Instead, ICE intends to use the same self-review mechanisms that missed most of the violations outlined in the DHS Inspector General’s Report. Such institutional weakness will allow for continued violations of the rights of detainees, many of whom are given political refuge in our country and become a part of the fabric of U.S. society.

The National Detention Standards that are the subject of the report were formed through negotiations between the Department of Justice, American Bar Association, the former Immigration and Naturalization Service (INS), and organizations involved in pro bono representation and advocacy for immigration detainees. These standards cover the areas of health care, environmental health and safety, general conditions of confinement, and reporting of abuse. The detention sites that were visited were the Berks County Prison (BCP) in Leesport, Virginia, the Corrections Corporation of America (CCA) Facility in San Diego, California, the Hudson County Correction Center (HCCC) in Kearny, New Jersey, the Krome Service Processing Center (SPC) in Miami, Florida, and the Passaic County Jail (PCJ) in Paterson, New Jersey.

### **Healthcare:**

Eight detainees out of a sample of 101 did not receive required initial medical screening upon admission to four of the sample facilities, and 14 files did not contain sufficient documentation to make a determination. Further, 15 of 111 detainees whose files were reviewed did not receive a required physical examination. At three of the five detention facilities visited, 196 of 148 detainee non-emergency medical requests were not responded to in the timeframe required by the facility.

### **Hunger Strikes:**

At four of the five detention facilities reviewed, medical staff did not record weight for three detainees on hunger strike or monitor vital signs for five detainees on hunger sites at least once every 24 hours, as is required by the standards.

### **Suicide Watch:**

At four of the five facilities investigated, facility personnel did not record 15-minute security checks for five detainees, as is required by the Detention Standards.

### **Environmental Health and Safety:**

Detainees interviewed made 11 safety and 127 health complaints. Among these complaints were excessively hot water, a problem which was rectified, and detainees falling out of bunk beds lacking guardrails and ladders, which ICE determined to be too expensive to institute at some facilities and a barrier to removal of detainees because ladders could serve as an obstruction. Eight of nine reports at one facility indicated evidence of rats, mice, and cockroaches, but at a second institution the Inspector General was unable to determine whether treatment occurred because of insufficient documentation.

Inspectors noted obstructed air vents and dust build-up on unplugged fans that are supposed to be used for ventilation. They also observed dirty food trays and undercooked poultry. Detainees at one facility gave the Inspector General's office a grievance form signed by 57 detainees stating that 10 detainees became sick from eating chicken.

### **Staff-Detainee Communication:**

ICE deportation officials could not substantiate that they answered 38 of 39 detainee request forms within 72 hours as required by the ICE standard. Further, detention files, which must include formal grievances, property receipts, and other information, were missing and incomplete for some detainees at four of the five facilities visited.

### **Grievance procedures:**

ICE detention staff at one Detention and Removal Operations (DRO) Field Office did not maintain a logbook of formal grievances prior to June 2005. At one facility, none of the nine grievances were acted upon within the required five-day limit, and similar violations occurred at the other facilities. Further, grievance boxes that were supposed to be secure were accessible only to detention facility staff at one facility and had to be placed in this box by the staff, not by detainees. This system eliminated anonymity for grievances. At another facility, a supervisor collected grievances and read them before they were placed in the grievance box, whose contents are supposed to be anonymous.

### **Disciplinary Policy:**

The handbook at one detention facility stated that non-severe actions could include counseling, a written warning or reprimand, loss of privileges for up to four days, or confinement to a cell up to 24 hours for violations of a rule. However, violations associated with lockdowns included actions such as wearing a religious head garment.

### **Access to legal materials:**

Time allotted to use of a legal library, as required by the ICE Detention Standard for Access to Legal Material, was below the minimum required five hours of use at two of the facilities visited.

### **Detainee Classification:**

ICE Detention Standards prohibit detainees of certain levels of risk to be placed together. However, reviews of records showed that at two of the investigated facilities, high-risk detainees were housed together with low-risk detainees.

### **Correspondence and Other Mail:**

At one facility detainees complained that their “special mail,” which includes correspondence with counsel, was not opened in their presence, as is required. Further, detainees were not given access to free writing materials at a second facility as is also required under the Detention Standards.

### **Funds and personal property:**

At one facility, detainees’ funds and personal property was stolen and the property control officer was convicted of theft of over \$308,736 in U.S. currency in addition to theft of personal property such as jewelry, watches, and credit cards. There was also inadequate logging of detainee property and control over receipts for this property at some facilities.

### **Clothing:**

At one facility, detainees remained in their undergarments while their laundry was being cleaned. They were not issued clean clothes in exchange for their dirty clothes.

### **Outdoor recreation:**

At four of the five detention centers investigated, a significant portion of detainees did not receive required outdoor recreation time. At several detention centers logbooks for this recreation time either were incomplete or did not exist.

### **Telephone access:**

Privacy of telephone conversations was a key issue identified in the report. Detainees often use telephones to communicate with their counsel, and telephones at most facilities were located in areas where their conversations could be overheard by staff and other inmates. At one facility, the telephone used by detainees was located within a staff member’s office, and the staff member was present during telephone conversations. In six instances over three months at one institution, detainees had to file formal grievance requests in order to request permission to notify their family of their detained status. In one instance the Ombudsman’s office of the facility took at least 16 business days (as opposed to the required 24 hour limit required by federal standards) to allow a detainee to call an attorney.

According to the Detention Standards, each facility must permit detainees to make direct calls to legal service providers and to make calls regarding expedited removal cases. However, the inspector general found that many of the telephones could not be used to successfully reach a live person at a consulate or pro bono legal organization.

**Visitation:**

The Inspector General found that detainees at one facility were not given the required 30 minutes to meet with family members during visits. Many detainees also complained of insufficient time with family members at two other facilities, but these reports could not be substantiated.

**Ice Procedures for reporting detainee abuse:**

ICE Detention Standards do not address detainee reporting of abuse or civil rights violations. All five facilities investigated did not distribute handbooks that properly explain the process for reporting allegations of abuse and civil rights violations. In some facilities, detainee handbooks were not provided at all or were not provided in the languages spoken by many detainees. Further, handbooks did not explain the rights specific to immigration detainees, such as that they are allowed a hearing before an immigration judge, that they can request voluntary departure, or that pro bono legal services are available to them.

Some alleged detainee abuses covered in the Inspector General's report include allegations of rape, an abusive search, a wheelchair-bound detainee who was allegedly dislodged from his wheelchair when he tried to enter another area, a suicide death, and the use of a camera phone by a prison guard to take photographs of detainees as they came out of the bathroom and shower and as they slept in their cells, and the appearance of retaliation against one detainee who met with the Office of the Inspector General.

**Conclusion:**

The most significant finding in the report of the Office of Inspector General (OIG) of DHS is the response of Immigration and Customs Enforcement (ICE) to recommendations that it ensure that periodic oversight and inspection procedures are in place to address compliance with Detention Standards. The ICE response demonstrates that it is not significantly reworking its internal audit system, which fails to expose violations of Detention Standards. ICE management tried to justify large discrepancies between findings of ICE internal inspections (which are conducted over three to four days) and the Inspector's General's investigation by pointing to the in-depth nature of the Inspector General's report.

ICE also stated that it already conducts an annual review of the items for which the Inspector General recommended oversight be improved. Unfortunately, the current system of internal review of detainee conditions is not bringing out violations of Detention Standards, as the Inspector General's Report demonstrates.

The DHS Inspector General's report should not serve as encouragement for ICE to continue the same system of review that is failing to end systematic violations of Detention Standards. Rather, it should spark the creation of a new system of oversight of all immigration detention facilities to guarantee humane conditions for immigration detainees and the protection of their rights.