



# 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



DETENTION  
WATCH NETWORK

October 2015 Report

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## About the National Immigrant Justice Center

With offices in Chicago, Indiana, and Washington, D.C., Heartland Alliance's National Immigrant Justice Center (NIJC) is a nongovernmental organization dedicated to ensuring human rights protections and access to justice for all immigrants, refugees, and asylum seekers through a unique combination of direct services, policy reform, impact litigation and public education.

Visit [immigrantjustice.org](http://immigrantjustice.org)

## About the Detention Watch Network

The Detention Watch Network works through the collective strength and diversity of its members to expose and challenge injustices of the U.S. immigration detention and deportation system and advocate for profound change that promotes the rights and dignity of all persons.

Visit [detentionwatchnetwork.org](http://detentionwatchnetwork.org)

## Acknowledgements

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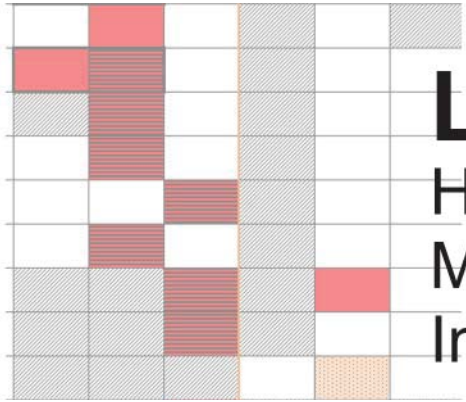
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The Immigration Detention Transparency and Human Rights Project  
October 2015 Report

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# I. Executive Summary

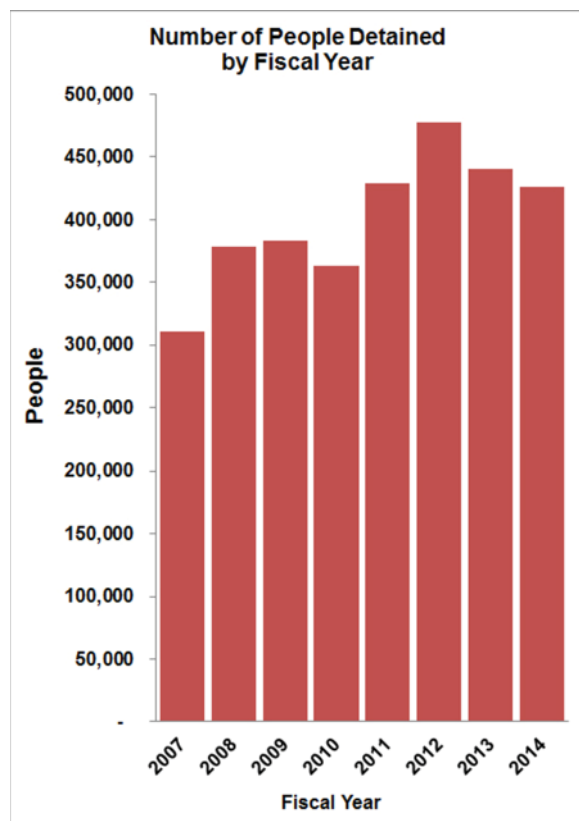
In the aftermath of September 11, 2001, when the immigration detention system began its unprecedented growth, the world slowly began to hear about the troubling conditions of detention that immigrants confronted in government custody while facing removal from the United States. Years later, the Obama administration would inherit a sprawling, broken immigration detention system with little oversight or accountability. In 2015, as the Obama administration winds down, its early promises of immigration detention reform have failed to materialize. The U.S. Immigration and Customs Enforcement (ICE) immigration detention inspections process—a key target of the Obama administration’s reform plan—remains non-transparent and ineffective at identifying pervasive and troubling conditions in detention. Instead, the inspections process remains a “checklist culture,” in which inspectors—employed by ICE directly or via subcontracts—engage in pre-planned, perfunctory reviews of detention facilities that are designed to result in passing ratings and to ensure local counties and private prison corporations continue to receive government funds.

A review of five years of ICE inspections for 105 of the largest immigration detention centers confirms that ICE’s oversight practices under the Obama administration remain fundamentally unchanged and unreformed. Public and private contractors who run detention facilities continue to make money without adequate oversight, and troubling conditions of detention persist for the more than 400,000 individuals who pass through ICE custody each year. In fact, detailed reviews of six facilities known to have troubling human rights records suggest that in some cases, ICE inspections allow facilities to obscure severe conditions problems and their inability to protect the rights and lives of detained immigrants.

## Immigration Detention Oversight Under the Obama Administration

The transition from the Bush to the Obama administration was accompanied by a tide of high-profile reports by journalists and advocates chronicling human rights abuses and unexplained deaths of people in ICE custody. In groundbreaking exposés in 2008, both *The Washington Post*<sup>1</sup> and *The New York Times*<sup>2</sup> examined allegations of negligent medical care and revealed that at least 83 people<sup>3</sup> had died in ICE custody between 2003 and 2008. That same year, a report<sup>4</sup> about the Northwest Detention Center in Tacoma, Washington, described inadequate medical care and food, deplorable daily living conditions, and impediments to legal information—conditions similar to what individuals in ICE custody experienced around the country. In 2009, advocates published ICE detention documents obtained in litigation, and concluded that the inspections process had failed.<sup>5</sup>

This public scrutiny prompted congressional inquiries into the sprawling system whose population had quadrupled within a span of 14 years.<sup>6</sup> Congress passed a 2009 Department of Homeland Security (DHS) appropriations bill which included a provision that ICE cannot expend



funds to immigration detention facilities that fail two consecutive inspections. On August 6, 2009, the Obama administration also responded by announcing a series of reforms which it said would create a more civil detention system.<sup>7</sup> Among the reforms was a revamp of ICE's compliance monitoring procedures and the establishment of the Office of Detention Oversight (ODO) to inspect immigration detention facilities and investigate the deaths of individuals in ICE custody.<sup>8</sup>

In addition to changes to the immigration detention system, in 2009 President Obama promised transparency across the federal government. On January 21, 2009, the president directed the heads of all federal agencies to "adopt a presumption in favor of disclosure ... and to usher in a new era of open Government." In a memorandum, he said, "The presumption of disclosure also means that agencies should take affirmative steps to make information public."<sup>9</sup> Nonetheless, such proactive transparency and commitment to open government failed to materialize in the immigration context. The ICE inspections regime is shrouded in secrecy. Information regarding facilities' compliance with ICE's detention standards has largely been hidden from the public. Since ICE released its first and only semiannual report on compliance with its national detention standards in 2007, information about how ICE oversees detention facilities, and what that oversight uncovered, has largely come from Freedom of Information Act (FOIA) requests and litigation.<sup>10</sup> The inspections released with this report were not made available voluntarily by DHS, but as the result of FOIA requests by the National Immigrant Justice Center (NIJC) and a federal court order following three years of litigation.

**NIJC has released all inspections from 2007 to 2012 obtained through the FOIA litigation at [immigrantjustice.org/TransparencyandHumanRights](http://immigrantjustice.org/TransparencyandHumanRights).**

## Overview of Findings

NIJC and Detention Watch Network (DWN) reviewed ICE detention facility inspections dating from 2007 to 2012, most of which were previously unreleased. A close analysis of the inspections, along with additional human rights reports that elucidate conditions in specific facilities, reveals that the Obama administration has done little to improve oversight or gain control over the sprawling immigration detention system and the conditions approximately 34,000 immigrants face in custody every night.

### The documents released include:

- Annual facility inspections by the ICE Office of Enforcement and Removal Operations (ERO). Under the 2009 DHS Appropriations Act, these are the inspections that determine whether detention facilities are allowed to maintain their contracts with ICE.
- Facility inspections by the ODO, the office under the ICE Office of Professional Responsibility purportedly created to ensure better monitoring compliance.<sup>11</sup>
- The deposition of the chief of ICE's Detention Monitoring Unit, which provides an overview of the immigration detention inspections process.<sup>12</sup>

This report contains an evaluation of the ERO and ODO inspections process itself as gleaned from the documents and a focused analysis of six detention facilities known to have detention conditions violations during the study period.

While the most recent inspections covered in this report are from 2012, there is no indication that any of the shortcomings identified have changed. Three years later, advocates and non-governmental organizations (NGOs) continue to raise complaints of systemic human rights<sup>13</sup> and due process vio-

lations<sup>14</sup> in the immigration detention system. In the first nine months of 2015 alone, ICE reported six deaths in detention.<sup>15</sup>

**Based on the review of the inspection reports, NIJC and DWN found:**

**1. ICE's Culture of Secrecy Persists**

- Neither information nor documents which would help the public to understand ICE's inspections and oversight processes are readily available.
- There is a lack of independent oversight because both entities which conduct inspections are paid and vetted—either through contracts or as direct employees—by ICE.

**2. ICE Inspections Fail to Adequately Assess the Conditions Detained Immigrants Experience**

- Both ERO and ODO inform facilities of inspections in advance.<sup>16</sup>
- There are significant inconsistencies within and between inspection reports for individual facilities, as well as between ODO and ERO inspections, raising questions about the reliability of either inspections process.
- As of FY 2012, most ICE detention facilities continued to be inspected using outdated standards.
- Inspectors fail to apply 2008 and 2011 Performance-Based National Detention Standards language that was intended to improve oversight of facilities that detain immigrants for ICE under contracts called Intergovernmental Service Agreements (IGSAs).
- ERO and ODO inspection reports are not designed to capture actual conditions of detention for the population at a given facility.

**3. Inspections are Designed to Facilitate Passing Ratings for Facilities, Not Identify or Address Violations**

- Even where human rights violations and unexplained deaths have been publicly documented, facilities rarely fail ERO inspections.
- Inspection reports may be edited before they are finalized and submitted to ICE's Detention Monitoring Unit by the inspections contractor.
- The checklist ERO inspectors use during their reviews does not include all components of the detention standards.

*(For a better understanding of the ICE offices involved in the detention center inspections system, see page 6 of this report.)*

## Recommendations

NIJC and DWN call on DHS and ICE to:

### 1. Increase Transparency and Oversight of the Inspections Process

- A. Make ERO and ODO inspections available to the public in a timely manner. To date, ICE has released its inspections to the public only as a result of FOIA requests. FOIA requests are unnecessarily time-consuming and expensive obstacles to accessing information about how the federal government treats thousands of people in its custody and spends billions of taxpayer dollars. Instead, this information should be freely available.
- B. 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.
- C. Submit quarterly reporting to Congress on inspection and oversight activities of detention facilities, to be made available to the public.

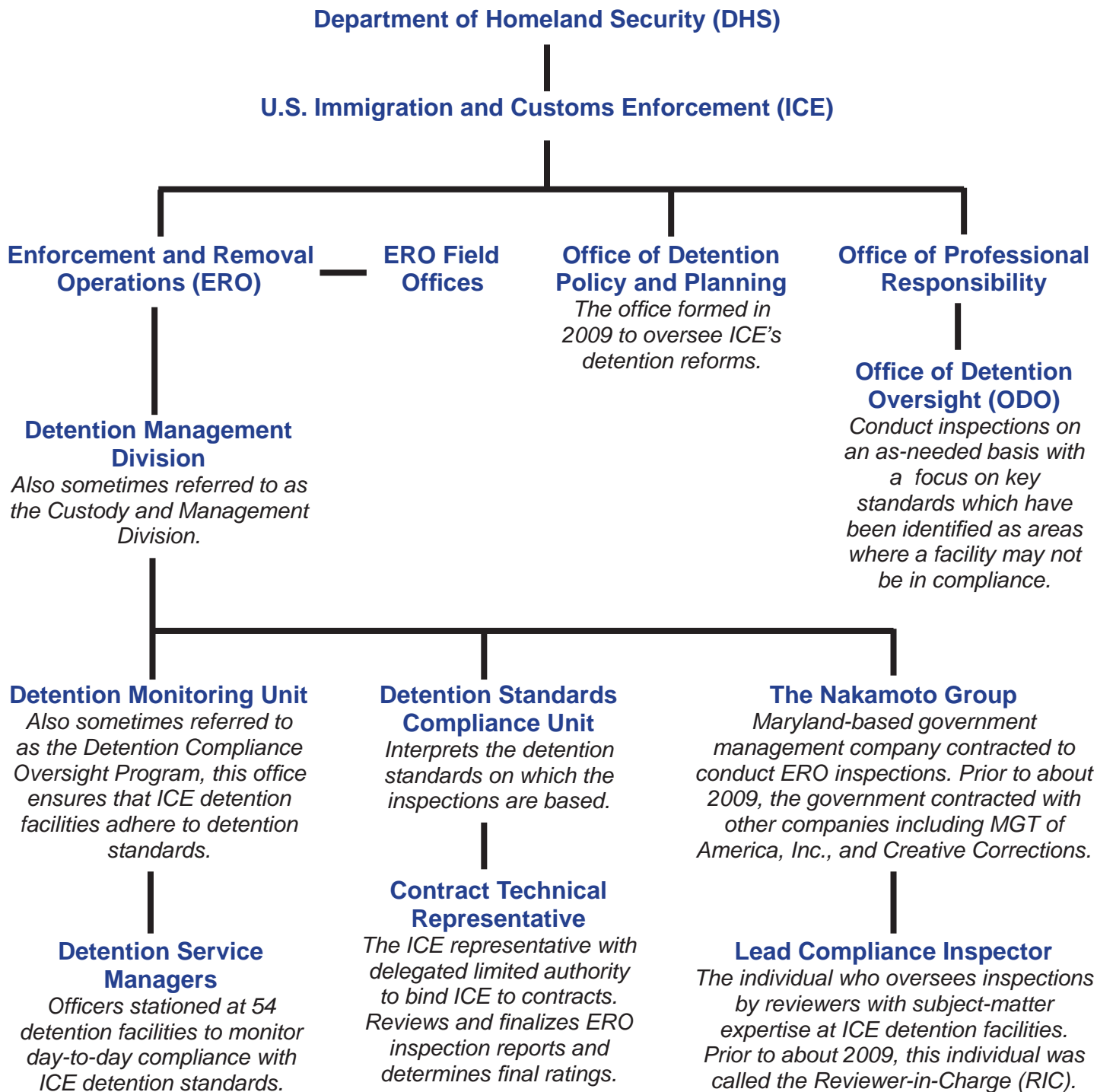
### 2. Improve the Quality of Inspections

- A. 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. These third-party inspections should examine compliance with applicable detention standards and determine whether contracts will be renewed in accordance with congressional appropriations requirements.
- B. Prohibit facilities from taking an “à la carte” approach to compliance and make all detention standards provisions mandatory during inspections. ICE must stop permitting some facilities to opt out of detention standards they have been contracted to apply. If a facility cannot abide by detention standards in their entirety then it should not be permitted to enter into or continue a contract with ICE.
- C. Ensure that inspections involve more than checklists. Inspectors must rely on more than assurances by jail administrators of compliance with detention standards and instead seek and document proof of their effective implementation.
- D. Engage detained immigrants during inspections, as well as other stakeholders such as legal service providers and those who regularly conduct visitation, in order to capture the range of concerns at a facility that may not be reported through formal institutional channels. Inspectors should document the content of those interviews.

### 3. Institute Consequences for Failed Inspections

- A. Place detention facilities on probation and subject them to more intensive inspections after the first finding of substantial non-compliance.
- B. Terminate contracts within 60 days for those facilities with repeat findings of substantial non-compliance, including inadequate or less than the equivalent median score in two consecutive inspections.

# ICE Offices Involved in Detention Center Inspections



Sources: January 2014 deposition in NIJC v. DHS of the head of the ICE Detention Monitoring Unit; ICE website; and Government Accountability Office October 2014 report



## II. Navigating the Inspection Reports

Each immigration detention facility is inspected according to a specific set of detention standards promulgated by ICE. Currently, three sets of detention standards primarily are in use: the 2000 National Detention Standards (NDS)<sup>17</sup> and the Performance-Based National Detention Standards (PBNDS) issued in 2008<sup>18</sup> and 2011.<sup>19</sup>

Even when facilities are inspected according to the same set of standards, the type of contract each facility holds determines exactly which specific requirements of each standard (called “components” on the inspection worksheets, *see Fig. 1*) apply during an inspection. Facilities run by local governments, which ICE contracts through Intergovernmental Service Agreements (IGSAs), are permitted to adapt certain components.<sup>20</sup> If a local government contractor subcontracts a jail’s operations to a private prison company, that company retains the ability establish alternatives to some components.<sup>21</sup> In contrast, Service Processing Centers (or SPCs, facilities owned and operated by ICE) and Contract Detention Facilities (or CDFs, those owned and operated by private companies) are not allowed such loopholes.

While the PBNDS contain more robust protections for detained immigrants, the ICE inspections process does not apply the same weight to all standards. Both the 2008 and 2011 PBNDS inspections checklists designate some components as “mandatory.” (*See Fig. 1*) For example, the 2008 PBNDS checklist includes 41 standards, which are broken down into a total of 889 components. Only 40 of these components are labeled “mandatory.” The introduction to the inspection form explains that mandatory items “typically represent life safety issues. A ‘Does Not Meet Standards’ on one of these components is very serious.”<sup>22</sup> Failure to meet any mandatory component will cause the facility to receive an overall deficient rating. But ICE only takes a small number of these components so seriously. Some critical components, such as those covering facilities’ response to hunger strikes or guaranteeing detained individuals have 24-hour access to emergency care, are not marked as mandatory. Many of these mandatory components ensure that there are written policies and plans in place for emergencies, but they do not reflect or even check for implementation. As much as the standards were purported to be written “with a focus on the results or outcomes that the required procedures are expected to accomplish,”<sup>23</sup> there remains a gap in truly evaluating efficacy.

**There are three types of inspections:**

### 1. ERO Inspections

Facilities that hold 50 or more people are subject to inspections conducted by ERO’s Detention Management Division.<sup>24</sup> The ERO inspections are conducted by private contractors on an annual basis.<sup>25</sup> Inspectors use a checklist of applicable national detention standards and each standard’s components (ICE Form G-324A). The ERO ratings system consists of three tiers: the components of each standard receive ratings, which determine the rating for each standard, which in turn inform the overall rating for the facility. (*See Figs. 2-4*) Facilities inspected under the 2008 and 2011 PBNDS are rated simply as “meets standards” or “does not meet standards.” Facilities inspected under the 2000 NDS can be rated “superior,” “good,” “acceptable,” “deficient,” or “at risk.” There is space for notes next to each of the components and for concluding remarks to summarize the full inspection, but the quality of comments varies greatly from inspector to inspector.

### 2. ODO Inspections

Facilities with average daily populations of 50 or more people may also be subject to ODO inspections. ODO inspectors, who may be ICE employees or contractors, focus on key standards which

**Fig. 1: Inspection checklist excerpt from Eloy Federal Contract Facility 2012 ERO inspection**

PART 4 – 20. FOOD SERVICE				
This Detention Standard ensures that detainees are provided a nutritionally balanced diet that is prepared and presented in a sanitary and hygienic food service operation.				
Components	Meets Standard	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 (FSA). The Responsibilities of cooks and cook foremen are in writing. The FSA determines the responsibilities of the Food Service Staff.	<input checked="" type="checkbox"/>			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 is off duty and vice versa.	<input checked="" type="checkbox"/>			
3. The FSA provides food service employees with training that specifically addresses detainee related issues. In ICE Facilities this includes a review of the "Food Service" standard.	<input checked="" type="checkbox"/>			
4. <b>(MANDATORY)</b> Knife 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	<input checked="" type="checkbox"/>			
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The facility does not use knives, 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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. The FSA monitors staff implementation of the facility population count procedures. These procedures are in writing. Staff are trained in count procedures.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assigned detention officers are trained in count procedures and are responsible for conducting counts.

Summary of standard

List of components that comprise the standard

Some components are marked as "mandatory." A rating of "Does Not Meet Standards" or "Deficient" on one of these components should result in failure of the overall inspection.

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
10. For medical transfers, transporting officers receive instructions regarding medical issues.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transportation officers will receive specific instructions regarding medical issues.
11. Detainee's funds, valuables and property are returned and transferred with the detainee to his or her new location.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	All funds and personal property are returned to the detainee during the release process.

**Fig. 2:** First tier to the ERO checklist is a rating of individual components within a given standard. Taken from the Tri-County Detention Center's 2012 ERO inspection.

PART 7 - 41. TRANSFER OF DETAINEES	
<input checked="" type="checkbox"/> Meets Standard <input type="checkbox"/> Does Not Meet Standard <input type="checkbox"/> N/A <input type="checkbox"/> Repeat Finding	
Remarks: <i>(Record significant facts, observations, other sources used, etc.)</i> An interview with an ICE representative indicated that ICE staff are aware of the responsibilities regarding notification of a detainee's attorney of record when a transfer is made outside the Field Office area. Field Office staff are also aware of the case management issues regarding a medical transfer. In addition, interviews with Booking staff indicated that they are well versed in the procedures and issues involved in the transfer of detainees. All property and funds are signed for by the detainee upon departure. Safety and security are always a consideration in any movement of a detainee.	
(b)(6), (b)(7)(c)	02/24/2012 Reviewer's Signature / Date

**Fig. 3:** Second tier to the ERO checklist is a rating for an overall standard, which is based on the ratings of individual components. Taken from the Tri-County Detention Center's 2012 ERO inspection.

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.	
<b>Recommended Rating:</b>	<input type="checkbox"/> Meets Standards <input checked="" type="checkbox"/> Does Not Meet Standards

**Fig. 4:** Third tier to the ERO checklist is a rating for the overall facility, which is based on the ratings given to standards. Taken from the Tri-County Detention Center's 2012 ERO inspection.

have been identified as areas where a facility may not be in compliance. For their inspections, the ODO inspectors collect and analyze “relevant allegations, complaints and detainee information from multiple ICE databases”<sup>26</sup> and gather “facility facts and inspection-related information from ERO [headquarters] staff to prepare for the site visit.”<sup>27</sup>

### 3. Self Assessments:

Facilities that only hold immigrants for less than 72 hours at a time, or that hold 50 or fewer immigrants for more than 72 hours, are subject only to the Organizational Review Self-Assessment (ORSA) process.<sup>28</sup> ORSA inspections were not included in NIJC’s FOIA litigation, which focused on the largest 100 immigration detention facilities.

## III. Ineffective Inspections

### Why ICE Inspections Matter

ICE’s ERO inspections generate the ratings that determine, under DHS Appropriations Act requirements, whether the government continues funding a local government or private entity to detain immigrants. As early as 2007, Congress expressed concerns about the lack of compliance with detention standards in facilities managed by ICE as well as contractors, and directed ICE to improve the quality and frequency of oversight.<sup>29</sup> One year later, Congress added specific language to the FY 2009 DHS appropriations law prohibiting ICE from expending funds to facilities that are found deficient in two consecutive inspections. That bill stated:

*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.*<sup>30</sup>

This mandate signaled congressional intent that immigration detention facilities be monitored for adherence to humane standards of detention, and ICE subsequently acknowledged its understanding of this obligation. According to 2010 congressional testimony by former ICE Director John Morton, eight facilities had been closed because they had failed to achieve acceptable ratings.<sup>31</sup> However, because ICE does not share information publicly about which facilities it uses or contracts with at any given time, it is unknown which facilities Director Morton was referring to or how many additional facilities, if any, have since had contracts terminated on the basis of failure to meet adequate standards. This lack of transparency makes it difficult for taxpayers or members of Congress to ascertain whether ICE is indeed adhering to the intent encompassed in the Appropriations Act language. Further, passing ratings based on cursory checklists cannot be what Congress intended as a condition for expending taxpayer money to subsidize the detention of immigrants.

## Findings Regarding the ERO and ODO Inspections Process:

### 1. ICE's Culture of Secrecy Persists

- **Neither information nor documents which would help the public to understand ICE's inspections and oversight processes are readily available.** ICE does not publicly post inspection reports as a matter of practice. Rather, it took years of resource-intensive litigation for NIJC to obtain inspection reports. This record undermines President Obama's early promises of open government.
- **There is a lack of independent oversight because both entities which conduct inspections are paid and vetted—either through contracts or as direct employees—by ICE.** The ODO is housed within ICE's Office of Professional Responsibility, and ERO inspectors are employed by private companies contracted by ICE. While government agencies routinely are permitted to keep themselves accountable, the problems apparent in the inspections reviewed for this report show this is not sound practice, especially within the detention system which has been persistently plagued by sub-standard conditions and frequent reports of abuse.

### 2. ICE Inspections Fail to Adequately Assess the Conditions Detained Immigrants Experience

- **Both ERO and ODO inform facilities of inspections in advance.**<sup>32</sup> This warning provides ample time for facilities to prepare and "clean up" before inspectors arrive, seriously hampering the ability of inspectors to make honest and accurate assessment of the typical conditions under which detained individuals are held on a typical day.
- **There are significant inconsistencies within and between inspection reports for individual facilities, as well as between ODO and ERO inspections, raising questions about the reliability of either inspections process.** Such inconsistencies were identified for all five facilities for which DWN and NIJC conducted in-depth reviews of 2011 and 2012 ERO and ODO inspections (the sixth facility reviewed in this report has never been inspected by ODO). In October 2014, the Government Accountability Office (GAO) released a report criticizing the variation between inspections carried out by ERO and ODO during roughly the same time period for the same facilities.<sup>33</sup> Out of 35 facilities inspected by both ERO and ODO in fiscal year 2013, the findings between the two entities differed substantially for 29 facilities. The GAO's findings substantiate those which NIJC and DWN found in 2011 and 2012 inspections, and bring into question the credibility of the entire review system. The ERO and ODO inspections consistently fail to account for or acknowledge egregious human rights concerns raised in independent reports published by NGOs.
- **As of FY 2012, most ICE detention facilities continued to be inspected using outdated standards. (See Fig. 5)** Sixty-five of the 103 detention facilities for which NIJC obtained 2012 or 2011 inspections were still inspected against the least-rigorous 2000 NDS. Thirty percent of the population represented by the 84 inspections NIJC obtained for FY 2012 were in facilities still being inspected under 2000 NDS. Even the GAO, in its 2014 report, requested clarity regarding why ICE continued to contract with facilities operating on a 14-year-old set of standards.<sup>34</sup> Not only are the 2000 NDS irrelevant to the times, they are also

**Fig. 5: Standards applied for most recent inspection obtained**

DETENTION FACILITY	DETENTION STANDARDS APPLIED AT MOST RECENT ERO or 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)
CAMBERA COUNTY JAIL, PA	2000 NDS (2011)
GARVER 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 (2011)
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)
FLORENCE CORRECTIONAL CENTER, AZ (CCA)	PBNDS (2012)
SOUTH TEXAS DETENTION COMPLEX, TX (GEO Group)	2008 PBNDS (2012)
FRANKLIN COUNTY HOUSE OF CORRECTIONS, MA	2000 NDS (2011)
FREDERICK COUNTY DETENTION CENTER, MD	2000 NDS (2012)
FREEDOM ADULT DETENTION CENTER, MN	2000 NDS (2012)
GLADES COUNTY DETENTION CENTER, FL	2000 NDS (2012)
HAMPTON ROADS REGIONAL JAIL, VA	2000 NDS (2012)
HARDIN COUNTY JAIL, IA	2000 NDS (2012)
HENDERSON DETENTION FACILITY, NC	2000 NDS (2012)
BUFFALO FEDERAL DETENTION CENTER, NY	2008 PBNDS (2012)
HOWARD COUNTY DETENTION CENTER, MD	2000 NDS (2012)
HUDSON COUNTY JAIL, NJ	2008 PBNDS (2012)
HUTTO CORRECTIONAL CENTER, TX (CCA)	ICE Family Residential Standards
IMMIGRATION CENTERS OF AMERICA FARMVILLE, VA	2008 PBNDS (2012)
IRWIN COUNTY DETENTION CENTER, GA	2008 PBNDS (2011)*
JACK HARWELL DETENTION CENTER, TX	2000 NDS (2011)
JAMES MUSHICK FACILITY, CA	PBNDS (2012)
JEFFERSON COUNTY JAIL, MO	No inspection reports past 2010
JOE CORLEY DETENTION FACILITY, TX (GEO Group)	PBNDS (2012)
JOHNSON COUNTY LAW ENFORCEMENT CENTER, TX	2000 NDS (2012)
KARNES COUNTY CIVIL DETENTION CENTER, TX (GEO Group)	PBNDS (2012)
KENOSHA COUNTY DETENTION CENTER, WI	2000 NDS (2012)
KEOGH-DWYER CORRECTIONAL FACILITY, NJ	2000 NDS (2012)
CLINTON COUNTY CORRECTIONAL FACILITY, PA	2000 NDS (2012)
EL CENTRO SERVICE PROCESSING CENTER, CA	2008 PBNDS (2012)
LAREDO PROCESSING CENTER, TX (CCA)	2000 NDS (2012)
LASALLE COUNTY REGIONAL DETENTION CENTER, TX	2000 NDS (2012)
LASALLE PARISH, LA (GEO Group)	2008 PBNDS (2011)*
MCHENRY COUNTY CORRECTIONAL FACILITY, IL	2000 NDS (2012)
MONMOUTH COUNTY JAIL, NJ	2000 NDS (2012)
MONROE COUNTY DETENTION CENTER, FL	2000 NDS (2012)
MONROE COUNTY JAIL, MI	2000 NDS (2011)
MORGAN COUNTY ADULT DETENTION CENTER, MO	2000 NDS (2011)
MORROW COUNTY CORRECTIONAL FACILITY, OH	2000 NDS (2012)
NORTH GEORGIA DETENTION CENTER, GA (CCA)	PBNDS (2012)
EL PASO SERVICE PROCESSING CENTER, TX	PBNDS (2012)
ORANGE COUNTY CORRECTIONS DEPARTMENT, FL	No inspection reports past 2010
ORANGE COUNTY JAIL, NY	2000 NDS (2012)
OTERO COUNTY PRISON FACILITY, NM	2000 NDS (2012)
OTERO COUNTY PROCESSING CENTER, NM	2008 PBNDS (2012)
PIKE COUNTY CORRECTIONS, PA	2000 NDS (2012)
PINAL COUNTY JAIL, AZ	2000 NDS (2012)
PLYMOUTH COUNTY CORRECTIONAL FACILITY, MA	2000 NDS (2012)
POLK COUNTY ADULT DETENTION FACILITY, TX	2000 NDS (2012)
POLK COUNTY JAIL, IA	2000 NDS (2012)
FLORENCE SERVICE PROCESSING CENTER, AZ	2008 PBNDS (2012)
PULASKI COUNTY JAIL, IL (FORMERLY TRI-COUNTY JAIL)	2008 PBNDS (2012)
RAMSEY COUNTY ADULT DETENTION CENTER, MN	2000 NDS (2012)
RAPPAHANNOCK REGIONAL JAIL, VA	2000 NDS (2012)
RICE COUNTY DETENTION CENTER, KS	2000 NDS (2012)
ROLLING PLAINS DETENTION CENTER, TX	2000 NDS (2012)
SACRAMENTO COUNTY JAIL, CA	2000 NDS (2012)
KROME NORTH SERVICE PROCESSING CENTER, FL	2008 PBNDS (2012)
SANTA ANA CITY JAIL, CA	2000 NDS (2012)
SENECA COUNTY JAIL, OH	2000 NDS (2012)
SHERBURNE COUNTY JAIL, MN	2000 NDS (2012)
SOUTH LOUISIANA DETENTION CENTER, LA (GEO Group)	2008 PBNDS (2012)
PORT ISABEL SERVICE PROCESSING CENTER, TX (Ahtna, Inc.)	2008 PBNDS (2012)
ST. CLAIR COUNTY JAIL, MI	2000 NDS (2012)
STEWART DETENTION CENTER, GA (CCA)	2008 PBNDS (2012)
STRAFFORD COUNTY CORRECTIONS, NH	2000 NDS (2012)
SUFFOLK COUNTY HOUSE OF CORRECTIONS, MA	2000 NDS (2012)
TENSAS PARISH DETENTION CENTER, LA	2000 NDS (2012)
THEO LACY FACILITY, CA	2008 PBNDS (2011)*
TULSA COUNTY JAIL, OK	2000 NDS (2012)
UTAH COUNTY JAIL, UT	2000 NDS (2012)
WAKULLA COUNTY JAIL, FL	2000 NDS (2012)
WORCESTER COUNTY JAIL, MD	2000 NDS (2012)
YORK COUNTY PRISON, PA	2000 NDS (2012)
YUBA COUNTY JAIL, CA	2000 NDS (2012)

\*The ERO PBNDS inspections worksheet does not distinguish between 2008 and 2011 standards, therefore when available the most recent ODO inspection was used to clarify which version of PBNDS the facility is being inspected to.

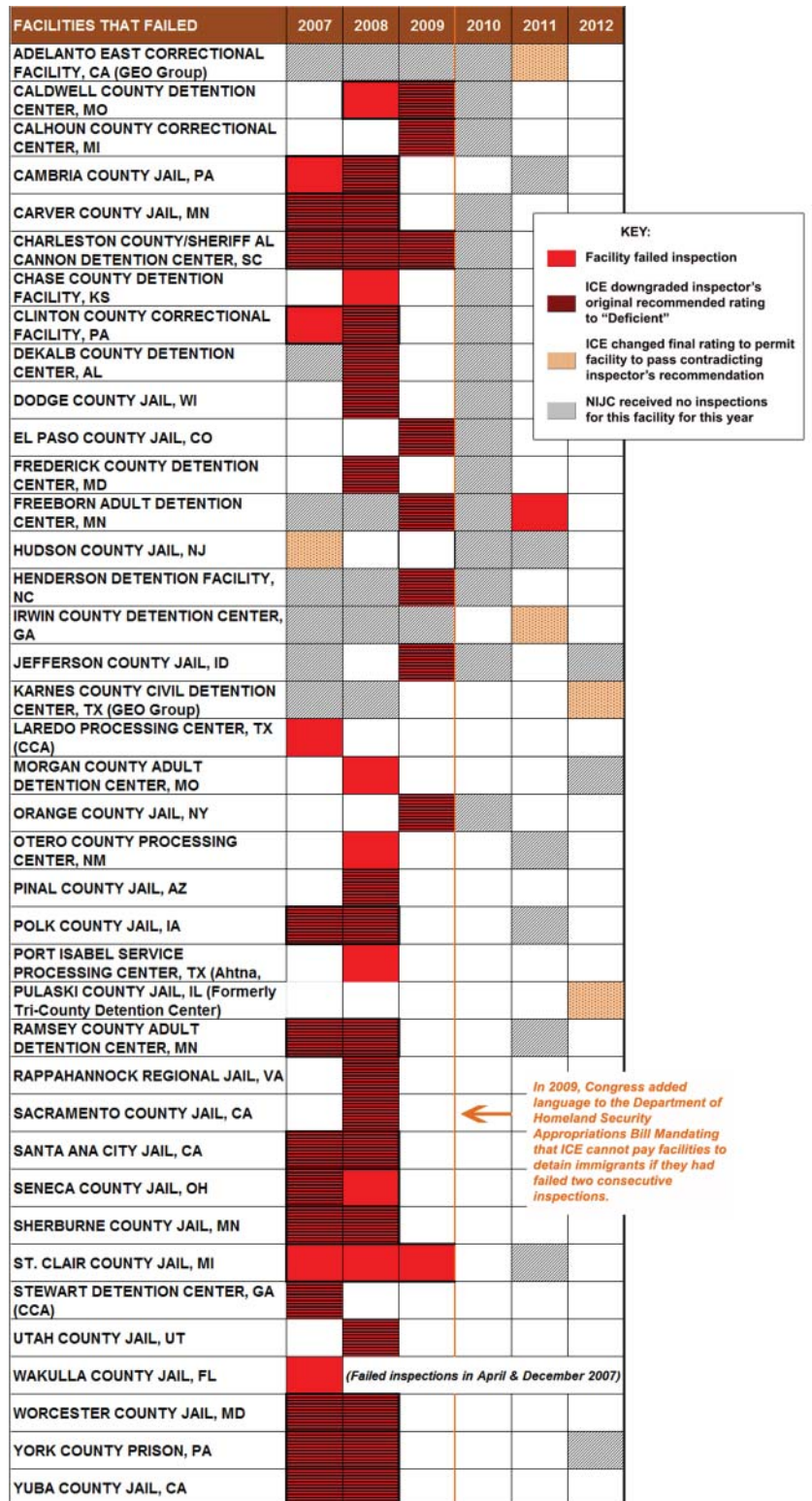
largely irrelevant to the needs of detained individuals. In fact, one of the 2000 NDS states that a facility is in compliance if the law library is adequately equipped with typewriters.<sup>35</sup> Nonetheless, while the 2008 and 2011 PBNDS contain more robust protections than the 2000 NDS, including sexual assault prevention guidelines and more detailed standards governing solitary confinement and hunger strike response, they too are problematic. Like the 2000 NDS, the PBNDS are derived from prison standards created within the criminal justice context, and therefore replicate many of the deplorable conditions and troubling human rights failings endemic to that system.

- **Inspectors fail to apply 2008 and 2011 PBNDS language that was intended to improve oversight.** The inspection form for the 2000 NDS states that some components are applicable only to Service Processing Centers and Contract Detention Facilities. IGSAs, which hold the majority of detained immigrants, are encouraged to use these components as guidelines but are not rated on them. For example, in IGSA facilities under the 2000 NDS, people placed in solitary confinement do not have a right to appeal that decision and their placement is not reviewed regularly by a supervisory agent.<sup>36</sup> Within these facilities, medical staff are not required to conduct daily check-ins with people on hunger strikes.<sup>37</sup> Even under 2008 PBNDS guards may read incoming mail without a warden's prior written approval and out of the detained individual's presence. This practice threatens attorney-client confidentiality and can make the difference in whether or not detained individuals can safely report complaints to their attorneys and seek redress without facing retribution. Language holding IGSA's to higher standards was strengthened in the 2008<sup>38</sup> and 2011 PBNDS<sup>39</sup> to require IGSA's to "adopt, adapt, or establish alternatives, provided they meet or exceed the intent represented by these procedures," but many inspectors

continue to mark these components as “not applicable” for IGSA’s being inspected under the PBNDS. The PBNDS were written to strengthen protections for immigrants detained at IGSA’s, but inspectors have failed to uphold that intent.

- ERO and ODO inspection reports are not designed to capture actual conditions of detention for the population at a given facility.** While there is an emphasis in both ERO and ODO inspections on the security of a facility and ensuring that detained individuals stay locked up, there is a de-emphasis on the humane treatment and protection of people imprisoned for their immigration status. As focused reviews of inspections at six detention facilities revealed (see *Section IV*), inspectors track whether or not policies exist rather than inquire into their implementation or effectiveness. Inspectors often take facility administrators at their word regarding issues such as the adequacy of medical staff, the efficacy of grievance procedures, or even basic and easily verifiable safety mechanisms such as whether fire alarms are functional. The checklist-driven inspections process obscures the conditions immigrants actually face in detention centers and whether standards are being implemented to their full intent. Even when critical aspects are included in the standards, they often are segmented into sterile lists of mundane details that are easy to check off because they do not immediately appear to be connected to anything important. For example, all three sets of detention standards include guidelines for telephone access, but are extremely limited in their provision of free phone calls. They fail to

**Fig. 6: Failed inspections, 2007-2012**



View a full-size version of charts at  
[immigrantjustice.org/  
 TransparencyandHumanRights](http://immigrantjustice.org/TransparencyandHumanRights)

# The 1-2-3s of the “324”:

## The Life of an Immigration Detention Inspection Form



The information in this chart is based on the January 2014 deposition in *NIJC v. Department of Homeland Security* of the head of the U.S. Immigration and Customs Enforcement (ICE) Detention Monitoring Unit. Transcript is available at: [www.documentcloud.org/documents/2105816-neveleffs-deposition.html](http://www.documentcloud.org/documents/2105816-neveleffs-deposition.html)



*The reviewers who perform the inspection are employees of The Nakamoto Group, a Maryland-based government management contractor.*

**1. Reviewers with subject-matter expertise visit a facility and complete their sections of the inspections checklist, known as Form G-324A**



**2. Reviewers meet with the Lead Compliance Inspector (LCI) or Reviewer-in-Charge (RIC) to generate a complete 324 form**



**4. Nakamoto sends the form to ICE’s Detention Monitoring Unit**  
*This office is responsible for the “day-to-day” monitoring of detention standards.*

**3. The LCI or RIC pass the inspection form on to the “Nakamoto operations team” where it “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 referred to as “Plan of Action”), the DSCU reviews the 324 for deficient ratings and communicates with reviewers to determine a final rating.*

**6. The DSCU communicates the final rating to the Assistant Director or Deputy Assistant Director for Detention Management, who signs off as “Review Authority” in a memo that is sent to the ICE Enforcement and Removal Operations (ERO) Field Office responsible for the facility.**  
*The 324 also is uploaded to ICE’s SharePoint document management system, filed in paper form at ICE’s ERO office in Washington, D.C., and sent to government management contractor Capgemini, which enters the inspection results into ICE’s Facility Management Program System.*



acknowledge that in many facilities, the high cost of telephone calls inhibit individuals' ability to communicate with lawyers, family, and other support systems. Telephone contact is critical to preserve due process and prevent isolation, but the inspections process provides no means for inspectors to document or even detect the financial hurdles that block immigrants from making calls in some facilities. ERO inspections rarely cite interviews with individuals in custody, and ODO inspections treat such interviews as footnotes. Therefore inspectors are able to check that a facility meets standards because "No restrictions are placed on detainees attempting to contact attorneys and legal service providers who are on the approved 'Free Legal Services List,'" even when a short conversation with the detained immigrants who have tried to use those phones would reveal otherwise. The checklist culture also leads to absurd interpretations of standards, a reality perhaps best demonstrated by the repeat finding that indoor rooms with windows count as providing outdoor recreation because air from the outside can enter the room.

### 3. Inspections Prioritize Facilities' Interests

- **Even where human rights violations have been publicly documented, facilities rarely fail ERO inspections. (See Fig. 6 and Section IV)** The number of failed facilities dropped significantly since 2009, when Congress implemented the appropriations requirement that ICE not expend funds to facilities with two consecutive failed inspections. No detention centers failed ERO inspections in 2010 or 2012, and only four failed in 2011. ICE has not failed any facility twice in a row since the 2009 law took effect.
- **Inspection reports may be edited before they are finalized and submitted to ICE's Detention Monitoring Unit by the inspections contractor.** The ICE Detention Services Management director explained during his litigation deposition that both inspections contractors and ICE personnel may edit the findings and ratings in a report before it is submitted to the facility's file. These edits are not tracked, and ICE has no knowledge of the frequency or types of edits that occur between an initial inspection and when the inspections contractor submits the inspection report.
- **The checklist ERO inspectors use during their reviews does not include all components of the detention standards.** As the focused review of inspections from Arizona's Eloy Detention Center reveals (see Section IV), such discrepancies could obscure important details of daily operations, such as medical care staffing, which are critical to ensuring detained immigrants' basic human rights.

**“The contractor has latitude to get to the final result”**

— ICE Detention Monitoring Unit Director,  
January 2014 deposition in NIJC v. DHS

Q. Is there a paper trail that ICE has access to when the form Three Twenty-Four goes through the entity's hierarchy?

...

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.

## IV. In Focus: Six Case Studies of Facilities with Known Conditions Problems, 2007-2012

The peculiarities and efficacy of the ICE inspections system are best understood through a focused review of facilities where human rights and due process conditions have been publicly documented, providing a basis for comparison with inspectors' observations. For this deep-dive approach, DWN and NIJC selected six detention centers which have been subjects of media reports, human rights investigations, and congressional inquiries. All but Eloy were included in DWN's 2012 Expose & Close (E&C) reports which surveyed immigrants detained at some of the worst immigration detention facilities in the United States.

### Featured Facilities:

**Eloy Federal Contract Facility, Arizona ..... Page 17**

**Baker County Detention Center, Florida ..... Page 19**

**Etowah County Detention Center, Alabama ..... Page 21**

**Houston Processing Center, Texas ..... Page 23**

**Stewart Detention Center, Georgia ..... Page 25**

**Pulaski County Jail, Illinois  
(formerly named Tri-County Detention Center) ..... Page 27**

## Eloy Federal Contract Facility, Arizona:

<b>Detention Standards (as of 2012):</b>	<b>2008 PBNDS</b>
<b>Facility Type:</b>	<b>IGSA</b>
<b>Private Contractor:</b>	<b>CCA</b>
<b>2012 ICE Average Daily Population:</b>	<b>1479</b>

2011 ERO		2011 ODO		2012 ERO	
<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	Nakamoto
<b>Rating:</b>	Meets Standards	<b>Rating:</b>	N/A	<b>Rating:</b>	Meets Standards
<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0
<b>Deficient Components:</b>	3	<b>Deficient Components:</b>	13	<b>Deficient Components:</b>	9

Eloy Federal Contract Facility in Arizona has the highest number of known deaths of any detention facility, including at least six suicides since 2003. Eloy is also the source of frequent reports of sexual assault, and the subject of an investigation launched by Rep. Raúl Grijalva (D-AZ) in June 2015.<sup>40</sup> Under these circumstances, it was expected that the facility's inspection reports would reveal a troubling history of failure to meet standards regarding medical care, suicide prevention, and sexual assault prevention. Instead, the inspection reports reveal ICE's complicity in obscuring the facility's failure to meaningfully address its violations. Based on the inspection reports NIJC received, Eloy has not failed an ERO inspection since 2006.<sup>41</sup> However, ICE did not provide the 2010 ERO inspection for Eloy. It is unclear whether this omission is because the facility was not inspected that year or because ICE failed to fully comply with the federal court order in NIJC's FOIA litigation to obtain the documents.

### **Suicide prevention**

The lack of accountability under the 2008 PBNDS Suicide Prevention and Intervention standard is apparent in Eloy's 2012 ERO inspection. Eloy passed on the overall suicide prevention standard despite failing to comply with one of its major components: the suicide watch room was found to contain "structures or smaller objects that could be used in a suicide attempt,"<sup>42</sup> including grates and a sprinkler head. Instead of questioning the judgment of the medical staff who signed off on the room's use, the inspector marked Eloy as compliant with the next component, which requires that "Medical staff have approved the room for this purpose." The inspector went on to minimize the concerns about the safety of the suicide isolation room by explaining that "a detainee placed on suicide watch would be under constant observation by a security officer sitting outside the room" but failed to address the requirement that medical or detention staff monitor individuals on suicide watch every 15 minutes. In 2015, questions regarding whether jail staff adequately monitor individuals at risk of suicide became a major focus of the investigation Rep. Grijalva demanded after an autopsy raised questions about the circumstances surrounding the suicide of 31-year-old Mexican immigrant Jose de Jesus Deniz-Sahagun.

The inspections documents raise additional concerns regarding Eloy's suicide prevention efforts and ICE's attempts to cover up or diminish the facility's deficiencies over time. One suicide, that of Em-

manuel Owusu in October 2008, seems to have been hidden by ICE for years. In a 2010 story about Mr. Owusu's death in *The New York Times*, there is no indication the reporter was informed he had committed suicide.<sup>43</sup> A list of in-custody deaths released by ICE in 2012<sup>44</sup> lists Mr. Owusu's cause of death as "Acute Cerebrovascular Accident," a medical term for stroke, but a list released in 2013<sup>45</sup> and updated in 2015<sup>46</sup> says Mr. Owusu died from suicide by hanging. The 2009 ERO inspection report does not mention Mr. Owusu's death at all aside from a tally in the "significant incident summary worksheet," where two deaths are attributed to "illness."<sup>47</sup> There also is no indication that the circumstances surrounding Mr. Owusu's death played into the determination of Eloy's rating on the medical care or suicide prevention standards. Notably, the Reviewer-in-Charge Assurance Statement, where inspectors discuss deaths on other inspection reports, is heavily redacted in the 2009 inspection.<sup>48</sup>

## Medical Care

The checklist ERO inspectors use during their reviews does not include all components of the detention standards, a discrepancy that could obscure important details of daily operations which are critical to ensuring humane treatment of those in custody. At Eloy, the ERO inspection failed to recognize that medical screenings and physical exams rarely were reviewed by physicians. According to an article in *The Arizona Republic* following a July 2015 media tour, Eloy has no doctors on staff.<sup>49</sup> The February 2011 ERO inspection rated Eloy as compliant on all components of the Medical Care standard, but the ODO inspection two months later found the facility was deficient on two points that are not even covered in the ERO checklist: the requirement that a "clinical medical authority," which the ODO interprets to mean a physician, reviews the medical screenings<sup>50</sup> individuals undergo within 24 hours of arriving at the facility and the physical examinations<sup>51</sup> people have within their first 14 days there. These exams determine individuals' priority for treatment. The ODO reviewed forms from 30 screenings conducted by registered nurses, nurse practitioners, or advanced practice nurses and found none had been reviewed by a physician; of 30 physical examinations within 14 days of arrival, only one had been reviewed by a physician.<sup>52</sup> The ERO findings regarding individuals' access to medical care also come into question in light of an October 2010 report by the Women's Refugee Commission, in which one woman who suffered from multiple sclerosis reported she made repeated requests to see a physician but was forced to wait two months to see a doctor about her condition.<sup>53</sup>

## Sexual Assault

The 2011 ERO inspection was the first time Eloy was in compliance with the sexual assault prevention and intervention standards. This inspection report is notable because at least two sexual assaults (which later would become highly publicized) took place at Eloy in the 14 months prior to the inspection.<sup>54</sup> Unfortunately, inclusion of the standard does not guarantee that a facility is held accountable for preventing sexual assault. The ERO inspector notes 10 allegations regarding sexual assaults at Eloy in the past year, then dismisses them all as "unfounded or unsubstantiated" and refers the reader to a database for additional statistics.<sup>55</sup>

ERO's failure to ensure compliance with the sexual assault standards means facilities are not held accountable and those in custody remain at risk. Tanya Guzman, a transgender woman who was held in an all-male pod at Eloy, was assaulted in December 2009 by a guard who later was convicted. Despite the first assault and Ms. Guzman's frequent complaints of harassment and abuse, Eloy continued to detain her in the male pod and she was assaulted by another detainee in April 2010. She reported the assault to the police a week and a half later, saying she waited because she feared retaliation. She was released from ICE custody soon after making the report—likely the reason her claim was not substantiated in the records the ERO inspector reviewed. In December 2012 the ACLU of Arizona filed a lawsuit on Ms. Guzman's behalf against ICE, Corrections Corporation of America, and the City of Eloy regarding the 2009 assault.<sup>56</sup>

## Baker County Detention Center, Florida:

<b>Detention Standards (as of 2012):</b>	2000 NDS
<b>Facility Type:</b>	IGSA
<b>2012 ICE Average Daily Population:</b>	252

2011 ERO		2011 ODO		2012 ERO	
<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	Nakamoto
<b>Rating:</b>	Good	<b>Rating:</b>	Acceptable	<b>Rating:</b>	Acceptable
<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0
<b>Deficient Components:</b>	14	<b>Deficient Components:</b>	4	<b>Deficient Components:</b>	5

Although the Baker County Detention Center in Macclenny, Florida, has been cited as one of the worst immigration detention centers in the United States, it continues to detain a daily average of 228 individuals who have no access to outdoor recreation, no exercise equipment, no volunteer work program, and are forced to attend court hearings via video-conferencing (because the immigration court is 200 miles away) while dressed in jump suits and shackled.<sup>57</sup>

Nonetheless, in its 2011 inspection, ERO rated this facility as “good,” one standard below the highest rating of “superior.”<sup>58</sup> This is despite the fact that inspectors identified 14 specific deficient components (although no overall standards were found deficient)<sup>59</sup> and despite the ODO’s inspectors rating the facility as “acceptable”<sup>60</sup> that same year. In the following year,<sup>61</sup> the ERO inspectors found only five deficient components (two of which were repeat offenses) and rated the facility as “acceptable.”<sup>62</sup> The different ratings assigned by the ERO’s and ODO’s 2011 inspections already raise suspicions, but the downgrade from good to acceptable when there were fewer identified deficiencies brings into question the rigor and reliability of inspections. (For an explanation of the ERO’s three-tiered ratings approach, see *Figs. 2-4.*)

As with many of the ERO inspections, most of the deficiencies that were identified in the 2011 and 2012 inspections concerned the finer points of administration and security, including the absence of written policies regarding barbershop hours, head counts, and other similar procedures. The two repeat deficiencies referred to the policy of opening detained individuals’ mail without appropriate protocols and the absence of a separate area for the barbershop (currently in the facility’s common space).<sup>63</sup> DWN’s E&C report conveyed concerns about the facility’s physical isolation, the exorbitant cost of phone cards, and how visitors who traveled a great distance to the facility were only allowed to see their loved ones through a video feed upon arrival, yet ICE’s standards (old and new) fail to check for these concerns.



Detention Watch Network

## Recreation

DWN's E&C report notes that a lack of access to fresh air and sunlight is an issue at Baker because the "area for recreation is a room with concrete walls, floor, and a roof. The room's only window is high on a side wall and is covered with mesh to allow in fresh air." The 2012 ERO inspectors, contrary to common understanding of what these words mean, found that

*... each of the two housing pods includes an outdoor recreation area<sup>64</sup> with access to fresh air and natural light through a 12-foot long by 3-foot high security screen. The design of the rooms allow for a substantial amount of natural light and fresh air to enter the recreation areas. The natural light and the exchange of free flowing outdoor air reflect the outside climate and the time of day [emphasis added].<sup>65</sup>*

Equally unacceptable, the standard for outdoor recreation can also be satisfied if the facility provides the option for a detained person to be transferred after 180 days to a facility with an actual outside recreation area.<sup>66</sup>

## Telephone Access

Another standard requires the Office of Inspector General (OIG) phone number to be programmed into the facility's phone system (and the number to be checked during the inspection). The 2012 ERO inspectors wrote, "[c]alls placed to the OIG hotline were connected. The caller was not able to reach an actual person." Nevertheless, this was marked as complying with the standard—yet another example of the checklist culture that creates simplified shortcuts and fails to take into account the actual experience of detained individuals.

## Etowah County Detention Center, Alabama:

<b>Detention Standards (as of 2012):</b>	2000 NDS
<b>Facility Type:</b>	IGSA
<b>2012 ICE Average Daily Population:</b>	333

2011 ERO		2012 ERO		2012 ODO	
<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	Nakamoto	<b>Private Contract Inspector:</b>	Creative Corrections
<b>Rating:</b>	Acceptable	<b>Rating:</b>	Acceptable	<b>Rating:</b>	N/A
<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0
<b>Deficient Components:</b>	9	<b>Deficient Components:</b>	0	<b>Deficient Components:</b>	8

In 2010, ICE planned to close the Etowah County Detention Center (ECDC) in Gadsden, Alabama, because of the facility's poor conditions and because its remote location made it difficult for detained immigrants to obtain legal counsel or stay connected with their families and communities.<sup>67</sup> However, arguing that the facility was an important part of the local economy, Representative Robert Aderholt (R-AL), Senator Richard Shelby (R-AL), and other members of Congress pressured ICE into keeping the facility open by threatening DHS's budget.<sup>68</sup>

Despite previous censure of the facility, oversight and accountability did not improve, leading to five separate hunger strikes within the facility in the year preceding the 2012 ERO inspection.<sup>69</sup> The breadth of discrepancies from sequential years, different inspectors, and different oversight agencies are an ongoing problem in the ECDC inspections. In 2011 and 2012, ERO's inspectors (MGT and Nakamoto, respectively) rated the facility as "acceptable" (two levels below the "superior" rating) even though the 2012 inspection identified zero deficiencies. In fact, as explained below, a 2011 deficiency was remedied in 2012 through re-interpretation of the standards, meaning that the problem was not actually addressed, but that the standards were lowered to cure the problem.

Beyond inconsistencies between ERO inspections, the 2012 ODO inspection identified eight deficiencies within five standards. Some of the ODO's major concerns included a lack of policies concerning an emergency grievance procedure which "involves an immediate threat to detainee safety or welfare"<sup>70</sup> and the procedure for requesting ICE-certified copies of identity documents (e.g., passports, birth certificates) that are essential to legal cases. Both the 2011 and 2012 ERO inspections identify these standards as having been met.

### Recreation

ECDC's indoor recreation room was counted by inspectors as offering outdoor recreation, because a window with bars qualified as providing access to sunlight and free-flowing air. The 2012 ERO inspectors wrote, "[t]his component was rated deficient during the last inspection because the facility did not offer outdoor recreation. During this inspection, the designated outdoor recreation facilities were found to be enclosed areas with secure openings that allow natural lighting and air circulation."<sup>71</sup> The inspectors explicitly concluded that "outdoor recreation is provided at this facility."<sup>72</sup> DWN's E&C report describes the recreation area as "a cement room...the size of half a basketball court. Near the top of one or two of the walls, very high up, are relatively small windows with bars that allow outside air to enter the area. It is impossible to see anything out of these windows. People refer to it as

'the sweatbox.'"<sup>73</sup> The fact that indoor spaces are routinely counted as providing outdoor recreation demonstrates that the interpretation of the standards are a sham and again points to a checklist culture focused on technicalities that permit facilities to maintain their contracts, rather than upholding the intent of the standards.

## Legal Orientation Programs

All three inspections also found the standard regarding legal orientation programs was met despite the fact that a legal orientation program had not been offered at the facility at any time during the past 12 months. Because individuals in ICE custody do not have the right to appointed counsel, basic legal orientation programs are the only chance many have to understand what is happening to them and how they might represent themselves in court. Amazingly, this standard is considered to have been met as long as the facility has an appropriate written policy. The 2000 NDS checklist states that if "No group presentations were conducted within the past 12 months. Mark standard as acceptable overall."<sup>74</sup> In comments, the 2011 ERO inspector writes, "Although there have been no group legal rights presentations in the past 12 months or any requests to do so received, the facility does have a comprehensive written policy to address group presentations if any requests are received."<sup>75</sup>

## Visitation and Programming

In DWN's E&C report, detained individuals also reported difficulties in accessing phones (citing restrictive hours) and problems with the visitation policies. Although all of the relevant standards were rated as acceptable in the available inspections, it is striking that contact visitations are not permitted despite the distance of the facility from the nearest major metropolitan area (2.5 hour drive from Atlanta). The video visits (which still require in-person visits to the facility) are limited to 30 minutes, require prior ICE approval, and offer no privacy.



ECDC claims to offer a wide range of programs for detained people. These programs include the "World Aquaculture Program," "Puppies without Borders," and "Adventure Programming." Individuals interviewed for DWN's E&C report who were detained at Etowah said these programs were effectively nonexistent and in reality the facility had nothing more than a broken fish tank and a rock-climbing wall in a room the size of a cell.<sup>76</sup>

The inconsistent inspection findings and ignorance of detained individuals' publicly documented concerns underpin the necessity for increased independent oversight and meaningful responses when deficiencies are found. It is not enough to reinterpret standards by lowering the bar and allowing for subpar conditions to continue.



## Houston Processing Center, Texas:

<b>Detention Standards (as of 2012):</b>	2008 PBNDS
<b>Facility Type:</b>	CDF
<b>Private Contractor:</b>	CCA
<b>2012 ICE Average Daily Population:</b>	832.6

2011 ERO		2011 ODO		2012 ERO	
<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	None	<b>Private Contract Inspector:</b>	Nakamoto
<b>Rating:</b>	Meets Standards	<b>Rating:</b>	N/A	<b>Rating:</b>	Meets Standards
<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0
<b>Deficient Components:</b>	6	<b>Deficient Components:</b>	1	<b>Deficient Components:</b>	4

In 1984, the Houston Processing Center (HPC), located in Houston, Texas, became the first private prison ever built in the United States. It is owned and operated by Corrections Corporation of America (CCA), the nation's largest private prison company.<sup>77</sup> A 2012 DWN E&C report highlighted HPC as one of the worst immigration detention facilities,<sup>78</sup> but its 2011 and 2012 ERO inspections and 2011 ODO inspection reveal few deficiencies and paint a picture of a facility that seems to be in compliance with standards.

### Health Care and Solitary Confinement

For example, detained immigrants interviewed for DWN's E&C report described long delays in accessing medical care and the inappropriate use of solitary confinement<sup>79</sup> for individuals with mental health issues. Two people died at the facility in 2011—including a 31-year-old man who died at a local hospital after only six days in detention, three of which he had spent vomiting.<sup>80</sup> None of the inspections noted deficiencies or concerns within the Medical Care standard. The ERO inspectors explicitly mention reviewing medical records but they did not interview detained individuals about their experiences or follow up on any complaints or grievances. For example, one mandatory component under the special management unit (SMU) standard requires health care personnel to provide assessments and reviews for every detained individual placed in the SMU (also known as segregation or solitary confinement). The ERO inspectors reviewed medical records but failed to interview detained individuals. If they had, they might have heard about David Jameson, whose story a friend conveyed to DWN in July 2012. At that point, Mr. Jameson had been in solitary confinement at HPC for nine months, despite being diagnosed with schizophrenia and prone to panic attacks. In Mr. Jameson's case, either HPC failed to fully document his circumstances or the 2012 inspectors ignored basic health care standards; either explanation is alarming. By the time of DWN's visit, Mr. Jameson's psychological problems had caused him to refuse to bathe for nearly four months.<sup>81</sup>



## Food and Grievances

The rather stark contrasts between DWN’s E&C report and the inspections continue with 2012 ERO inspectors describing the food as “nutritious and attractively presented meals”<sup>82</sup> and that the “facility menu has been certified by a registered dietician, and has been analyzed with a daily average calorie count of 3100 calories.”<sup>83</sup> Individuals interviewed for the DWN report described the food as “insufficient to maintain one’s health” and unappetizing.<sup>84</sup> The E&C report goes on to describe a toxic environment where people had given up on filing complaints because they never received responses or because they feared retaliation, and in which guards verbally abused and threatened individuals with solitary confinement if they complained.<sup>85</sup>

## Telephone Access

The impact of designating some components as “non-mandatory” also is evident at HPC, where the requirement to afford detained people “a reasonable degree of privacy for legal calls” is met by taking them to “the shift commanders’ or unit managers’ office to place legal calls,”<sup>86</sup> This arrangement seems to assume that the requirement for privacy is only meant to protect conversations from being overheard by other detained people, rather than by facility staff, and even that protection is easily overridden. Even these phone calls can be monitored as long as “notification is posted by detainee telephones.”<sup>87</sup> Although the standard is “met,” any real hope for attorney-client confidentiality is eliminated.

## Stewart Detention Center, Georgia:

<b>Detention Standards (as of 2012):</b>	2008 PBNDS
<b>Facility Type:</b>	IGSA
<b>Private Contractor:</b>	CCA
<b>2012 ICE Average Daily Population:</b>	1632

2011 ERO		2011 ODO		2012 ERO	
<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	Nakamoto
<b>Rating:</b>	Meets Standards	<b>Rating:</b>	N/A	<b>Rating:</b>	Meets Standards
<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	0
<b>Deficient Components:</b>	2	<b>Deficient Components:</b>	25	<b>Deficient Components:</b>	3

Stewart Detention Center (SDC) in Lumpkin, Georgia, is one of the largest immigration detention facilities in the United States with the capacity to jail 2,000 people. Although the facility is owned by Stewart County and is contracted as an IGSA, the facility is actually operated by CCA. In 2012, SDC was inspected under the 2008 PBNDS, but because there are certain standards that only apply to CDFs and SPCs, CCA was provided leniency in its compliance with certain standards under Stewart County's IGSA contract. Out of 889 components, 144 were marked as non-applicable because the facility is an IGSA.<sup>88</sup>

Considerable discrepancies between the 2011 ERO and ODO inspections again bring into question their value and credibility. While the 2011 ERO inspection noted only two deficient components and zero deficient standards, the 2011 ODO inspection found 25 deficiencies in 12 standards. Among the most egregious deficits: Stewart lacked a written policy to ensure that medical grievances were received by the next business day,<sup>89</sup> ICE staff was reported to be generally inaccessible and failed to respond to the majority of detainee requests,<sup>90</sup> and the ODO inspection team witnessed a male detainee changing in full view of a female corrections officer.<sup>91</sup> The ERO inspection ignores or only cursorily examines other major deficiencies, and in some cases provides comical justifications. For example, the 2012 ERO inspector cites the use of floppy discs—technology that otherwise had been largely obsolete for at least a decade—as compliant with a standard requiring that detained individuals be allowed to store legal work in private electronic form.<sup>92</sup>

### Medical Care

Both ERO and ODO inspections managed to identify one major deficit regarding medical care: intake examinations were not reviewed by physicians or mid-level practitioners by the following business day. In fact, it sometimes took months before the examinations were reviewed by a doctor.<sup>93</sup> According to the 2012 DWN E&C report, SDC had only one doctor and seven nurses to provide medical care for over 1,500 detained men.<sup>94</sup> Several of the concerns raised by the DWN report were underscored by the 2012 ACLU of Georgia report, *Prisoners of Profit: Immigrants and Detention in Georgia*, which highlighted the death of Roberto Medina Martinez, who died from a treatable heart condition in 2009 after being detained for two months at SDC.<sup>95</sup> Nonetheless, ERO and ODO inspections stated that



the medical staffing was adequate at SDC, even with five vacant positions in 2011 and 2012 (two of which had been vacant for more than two years).<sup>96</sup> These staffing issues may explain why, according to the ERO inspection, SDC referred more than 775 people for outside medical care in 2012.<sup>97</sup>

## Sexual Assault

The 2012 ERO inspection mentions six allegations of sexual assault or abuse, and then proceeds to methodically dismiss or minimize them. Two were downgraded to verbal harassment, and another was relabeled as physical assault, despite the clear sexual nature of the incident: the victim was severely beaten after refusing to provide sexual favors for another detained person. The remaining three were found to be unsubstantiated,<sup>98</sup> though the slow nature of investigations—sometimes taking weeks or even months—means that witnesses, perpetrators and victims may have been transferred, deported, or released.

## Legal Rights Access and Visitation

SDC's remote location is a hindrance to attracting and retaining adequate medical staff, but it also creates barriers to visitation from attorneys and family members. Attorneys in the region told DWN in 2012 that visitation rooms at SDC were inadequate because they were forced to speak with their clients through a phone and Plexiglas, making it difficult to prepare for court and to provide clients confidential documents.<sup>99</sup> People detained at SDC in 2012 also claimed that they were allowed infrequent access to the law library and had unreliable phone access. None of these concerns were reflected in the ERO and ODO inspections.

## Pulaski County Jail, Illinois (formerly named Tri-County Detention Center):

<b>Detention Standards (as of 2012):</b>	2008 PBNDS
<b>Facility Type:</b>	IGSA
<b>2012 ICE Average Daily Population:</b>	224

2011 ERO		2012 ERO	
<b>Private Contract Inspector:</b>	MGT	<b>Private Contract Inspector:</b>	Nakamoto
<b>Rating:</b>	Meets Standards	<b>Rating:</b>	Does Not Meet Standards
<b>Deficient Standards:</b>	0	<b>Deficient Standards:</b>	1
<b>Deficient Components:</b>	8	<b>Deficient Components:</b>	9

The lack of consistency and accountability in the ERO inspections process is apparent in its 2011 and 2012 inspections of the Tri-County Detention Center (since renamed Pulaski County Jail) in Ullin, Illinois.<sup>100</sup> According to the 2012 E&C report by DWN and NIJC, grievances were largely ignored, essential medical care was delayed, and general overcrowding was exacerbated by inadequate medical staffing.<sup>101</sup>

In 2011, the ERO inspection marked the facility as having met its obligations under the 2008 PBNDS. However, internal inconsistencies raise concerns as to how meticulous the inspectors were in conducting their reviews. For example, although the hold rooms standard and its components were marked as N/A (not applicable), it was checked off as having met standards in the final summary of the inspectors' findings.<sup>102</sup> In comments, the inspectors also noted that there were no canines at the facility<sup>103</sup> yet in one of their comments (a portion of which has been redacted), they wrote that "[a]t this time there was a minor altercation between the canine and an ICE detainee which did not result in any serious injury."<sup>104</sup>

### **Medical Care and Lack of Accountability**

If internal inconsistencies were unsettling in the 2011 inspection, they intensified in the 2012 ERO inspection. Despite the Tri-County Detention Center receiving a "does not meet standards" rating according to the lead compliance inspector's recommended rating at the conclusion of the 2012 inspection worksheet,<sup>105</sup> the memorandum addressed to Field Office Director Ricardo Wong on May 29, 2012, which is affixed at the beginning of the inspection file, reflects an unexplained change in the final determination. The memo states that according to its final rating, the facility "meets standards."<sup>106</sup> The lead compliance inspector attributes the deficient finding to the detention center's failure to comply with a mandatory component under the Medical Care standard, specifically concerning oversight over needles. The 2012 inspectors wrote, "[o]nce needles and syringes are placed in the medication cart, no further accountability is maintained. While the current inventory of the bulk stock was inaccurate, the HSA [Health Services Administrator] had conducted an inventory two days ago which showed significant discrepancies in the inventories of Insulin syringes, 5cc syringes with needles, and 3cc syringes with needles."<sup>107</sup>



The facility also believed its medical staff to be adequate to serve its population, despite the fact that 185 medical cases were referred for outside medical care in 2011 and 411 were referred in 2012. The ERO inspections provide no analysis of whether the medical staff were meeting the actual needs of the individuals detained at Tri-County.

## Environmental Health and Safety

Additionally problematic in the 2012 ERO inspection are the various components which were not found deficient but should have required follow-up before being marked as having met standards. In particular, a new fire alarm system had been recently installed but had yet to be inspected by the fire marshal and emergency generators did not cover critical areas such as administration, medical, booking, and food service.<sup>108</sup> But because facility staff indicated that they had plans to address these problems, the environmental health and safety standard was preemptively marked as having been fulfilled.

## Telephone Access

Collectively, the inspection reports for Tri-County present a puzzling picture of the reality in the facility. In early 2012, Senator Richard Durbin (D-IL) visited the facility and expressed his shock at the conditions—particularly referencing the high price of phone calls and inoperable telephones<sup>109</sup>—yet the 2011 and 2012 ERO inspections reflect no issues with the telephone system, finding that the standard was met and even exceeded.<sup>110</sup> Of course, as discussed earlier, the ERO inspections process leaves no room to even consider whether the exorbitant cost of phone calls undermines the PBNDS's phone access requirements.

## Grievance Procedures

Also troubling are the facility's grievance procedures. In the 2011 inspection, a component regarding the absence of a secure box through which detained individuals could drop in written comments to communicate with ICE staff was marked deficient but was subsequently remediated later that year. Prior to the box's existence, "ICE Staff receive[d] all requests from facility staff." With this lack of confidentiality, it is not surprising that there were only six grievances in 2011 and 10 in 2012.<sup>111</sup>

## V. Conclusion and Recommendations

These six case studies demonstrate that the ICE inspections system is inadequate and has failed to resolve the substantial and pervasive human rights violations detained immigrants face in ICE custody. In many cases, the poor conditions and mistreatment individuals suffer are explicitly prohibited under ICE detention standards. Instead of reporting on these violations, the inspectors focus on completing checklists and fail to engage with detained immigrants or follow up on issues raised in public reports. It is easy for facilities to pass inspections without actually upholding the standards' intent.

According to the 2009 congressional mandate, the ICE inspections process creates a threshold which determines whether or not ICE can continue to contract with local governments and private prison companies to run immigration detention facilities. Unfortunately, NIJC and DWN found that ICE's inspections mechanisms whitewash problems and ensure that even the worst detention facilities pass inspections and maintain contracts. Without a credible system of oversight, there is no humane way to incarcerate immigrants.

### Based on the findings of this report, NIJC and DWN call on DHS and ICE to:

#### 1. Increase Transparency and Oversight of the Inspections Process

- A. Make ERO and ODO inspections available to the public in a timely manner. To date, ICE has released its inspections to the public only as a result of FOIA requests. FOIA requests are unnecessarily time-consuming and expensive obstacles to accessing information about how the federal government treats thousands of people in its custody and spends billions of taxpayer dollars. Instead, this information should be freely available.
- B. 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.
- C. Submit quarterly reporting to Congress on inspection and oversight activities of detention facilities, which should be made publicly available.

#### 2. Improve the Quality of Inspections

- A. 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. These third-party inspections should examine compliance with applicable detention standards and determine whether contracts will be renewed in accordance with congressional appropriations requirements.
- B. Prohibit facilities from taking an "à la carte" approach to compliance and make all detention standards provisions mandatory during inspections. ICE must stop permitting some facilities to opt out of detention standards they have been contracted to apply. If a facility cannot abide by detention standards in their entirety then it should not be permitted to enter into or continue a contract with ICE.
- C. Ensure that inspections involve more than checklists. Inspectors must rely on more than assurances by jail administrators of compliance with detention standards and instead seek and document proof of their effective implementation.
- D. Engage detained immigrants during inspections, as well as other stakeholders such as legal

service providers and those who regularly conduct visitation, in order to capture the range of concerns at a facility that may not be reported through formal institutional channels. Inspectors should document the content of those interviews.

### 3. Institute Consequences for Failed Inspections

- A. Place detention facilities on probation and subject them to more intensive inspections after the first finding of substantial non-compliance.
- B. Terminate contracts within 60 days for those facilities with repeat findings of substantial non-compliance, including inadequate or less than the equivalent median score in two consecutive inspections.

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78. Detention Watch Network, *Expose & Close: Houston Processing Center, Texas* (Nov. 2012), at 6, <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-houstonnov12.pdf>.
79. See Christy Carnegie Fujio & Mike Corradini, *Buried Alive: Solitary Confinement in the U.S. Detention System*, Physicians for Human Rights, Apr. 2013, <http://physiciansforhumanrights.org/library/reports/buried-alive-solitary-confinement-in-the-us-detention-system.html?referrer=http://www.immigrantjustice.org/end-solitary-confinement-immigration-detention>; National Immigrant Justice Center & Physicians for Human Rights, *Invisible in Isolation: The Use of Segregation and Solitary Confinement in Immigration Detention*, Sept. 2012, <http://www.immigrantjustice.org/publications/report-invisible-isolation-use-segregation-and-solitary-confinement-immigration-detention>; *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*, Aug. 5, 2011, [http://www.immigrantjustice.org/files/2011\\_08%20United%20Nations%20Report%20on%20Solitary%20Confinement.pdf](http://www.immigrantjustice.org/files/2011_08%20United%20Nations%20Report%20on%20Solitary%20Confinement.pdf).
80. *Expose & Close: Houston Processing Center, Texas*, at 6.
81. *Expose & Close: Houston Processing Center, Texas*, at 4; Authors of the report visited the facility in July 2012.
82. 2012 Houston CDF ERO Inspection, at 73, <https://www.documentcloud.org/documents/1736877-houston-cdf-cca-tx-2012-ero-inspection.html>.
83. 2011 Houston CDF ERO Inspection, at 69, <https://www.documentcloud.org/documents/1736874-houston-cdf-cca-tx-2011-ero-inspection.html>.
84. *Expose & Close: Houston Processing Center, Texas*, at 4.

85. *Expose & Close: Houston Processing Center, Texas*, at 5.
86. 2011 Houston CDF ERO Inspection, <https://www.documentcloud.org/documents/1736874-houston-cdf-cca-tx-2011-ero-inspection.html>.
87. *Id.*
88. 2012 Stewart ERO Inspection, <https://www.documentcloud.org/documents/2065390-stewart-detention-center-ga-2012-ero-inspection.html>. “IGSAs must conform to these procedures or adopt, adapt or establish alternatives, provided they meet or exceed the intent represented by these procedures” (written into the 2008 PBNDS in regards to how IGSAs should conform to standards that apply to CDFs/SPCs).
89. 2011 Stewart ODO Inspection, at 2, <https://www.documentcloud.org/documents/2065395-stewart-detention-center-ga-2011-odo-inspection.html>.
90. *Id.* at 17.
91. *Id.* at 7.
92. 2012 Stewart ERO Inspection at 127.
93. 2011 Stewart ODO Inspection, at 15, <https://www.documentcloud.org/documents/2065395-stewart-detention-center-ga-2011-odo-inspection.html>.
94. Detention Watch Network, *Expose & Close: Stewart Detention Center, Georgia* (Nov. 2012), at 3, <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-stewartnov12.pdf>.
95. ACLU of Georgia, *Prisoners of Profit: Immigrants and Detention in Georgia* (May 2012), [http://www.acluga.org/files/2713/3788/2900/Prisoners\\_of\\_Profit.pdf](http://www.acluga.org/files/2713/3788/2900/Prisoners_of_Profit.pdf).
96. 2011 Stewart ODO Inspection at 15; 2012 Stewart ERO Inspection ,at 78.
97. 2012 Stewart ERO Inspection.
98. *Id.*
99. *Expose & Close: Stewart Detention Center, Georgia* (Nov. 2012), at 4, <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-stewartnov12.pdf>.
100. There was no ODO inspection.
101. Detention Watch Network & National Immigrant Justice Center, *Expose & Close: Tri-County Detention Center, Illinois* (Nov. 2012), <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-tricountynov12.pdf>.
102. 2011 Pulaski ERO Inspection, marked as “N/A” at 36 (<https://www.documentcloud.org/documents/2065596-tri-county-jail-il-2011-ero-inspection.html#document/p171/a250934>) and “Meets Standard” at 2012FOIA3030.010009 (inspection page number not legible in document, view at <https://www.documentcloud.org/documents/2065596-tri-county-jail-il-2011-ero-inspection.html#document/p171/a250934>).
103. *Id.* at 68.
104. *Id.* at 69.
105. 2012 Pulaski ERO Inspection, <https://www.documentcloud.org/documents/2065597-tri-county-jail-il-2012-ero-inspection.html>.
106. *Id.*
107. *Id.* at 88.
108. *Id.*
109. *Expose & Close: Tri-County Detention Center, Illinois* at 5.
110. The 2012 inspectors wrote that “Telephones are available in numbers that exceed the minimum ratio required” and continues on that “Any repairs needed are promptly reported.”
111. 2011 Pulaski ERO Inspection. Information regarding drop box deficiencies is annotated at <https://www.documentcloud.org/documents/2065596-tri-county-jail-il-2011-ero-inspection.html#document/p170/a250975>