

The California Department of Justice's  
Review of

# Immigration Detention in California

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# Immigration Detention Facility Review Team

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# Executive Summary

As the California Department of Justice (Cal DOJ) issues its second report under Assembly Bill 103 (2017) (AB 103) about the conditions within locked facilities housing immigration detainees in California, the nation is in the midst of a struggle to control and prevent outbreaks of COVID-19. Detainees and staff in immigration detention facilities are particularly vulnerable due to the congregate nature of detention, and all parties connected to immigration detention—U.S. Immigration and Customs Enforcement (ICE), facility leadership and staff, off-site community hospitals, advocates, federal courts, and immigration detainees themselves—have been forced to respond to the crisis. Cal DOJ’s AB 103 review of the three immigration detention facilities featured in this report took place before the COVID-19 pandemic began, and insights gained from these and prior facility reviews prompted Attorney General Xavier Becerra to write to the Acting Secretary for Homeland Security on April 13, 2020, urging the release of immigration detainees and the adoption of safety protocols to minimize the spread of COVID-19.<sup>1</sup> Nonetheless, while the average number of immigrants in ICE’s adult detention facilities across the nation decreased from 37,876 detainees in February 2020 to 19,989 detainees in September 2020, the overall average length of detention significantly increased during the same period from an average of 56.1 days to 91.3 days.<sup>2</sup>

This report presents Cal DOJ’s findings with respect to three privately-operated detention facilities: (1) the Adelanto ICE Processing Center (Adelanto), operated by The GEO Group, Inc.: (Geo Group); (2) the Imperial Regional Detention Facility (Imperial), operated by Management Training Corporation (MTC); and (3) the Otay Mesa Detention Center (Otay Mesa), operated by CoreCivic. Cal DOJ staff, along with correctional, medical, and mental health experts, toured each facility; interviewed staff and detainees; and reviewed and analyzed logs, policies, detainee records, and other documents to develop an understanding of the conditions of confinement and standard of care and due process provided to detainees at each facility. In addition, Cal DOJ administered two attorney surveys to analyze barriers and facilitation of due process in each of the three facilities, as well as the impact COVID-19 has had on detainees and their counsel.

The three facility reviews featured in this report took place in the context of a changing landscape for immigration detention facilities located in California. Following Cal DOJ’s February 2019 report on immigration detention facilities in the State, Orange County ended its contract with ICE to provide detention services and Yolo County ended its agreement with the Office of Refugee Resettlement to house juveniles in immigration detention, leaving Yuba County Jail as the only publicly owned and operated facility that houses immigration detainees in the State. Furthermore, the Legislature passed Assembly Bill 32 (2019), prohibiting private detention operations under contracts or contract extensions executed after January 1, 2020. Shortly before January 1, 2020, ICE contracted for additional beds at

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<sup>1</sup> Cal. Dep’t of Justice, Office of the Attorney General, letter to Acting Secretary Chad F. Wolf (Apr. 13, 2020), <<https://oag.ca.gov/system/files/attachments/press-docs/4.13.20%20-%20Letter%20to%20DHS%20Acting%20Secretary.pdf>> (as of Jan. 4, 2021).

<sup>2</sup> U.S. Immigration and Customs Enforcement (ICE), Detention Management, Detention Statistics, FY 2020 ICE Statistics, <<https://www.ice.gov/doclib/detention/FY20-detentionstats.xlsx>> available at <<https://www.ice.gov/detention-management>> (as of Jan. 4, 2021).

three of the four private facilities already operating in the State, including the addition of three former state prisons owned and operated by GEO Group. As a result, bed capacity for immigration detention within the State increased from approximately 4,160 to 7,408 between February 2019 and the present.

The report's discussion of the three reviewed facilities begins with a section addressing three areas of concern and how each facility's application of ICE's Performance Based National Detention Standards (PBNDS)—the federal standards for immigration detention—impacts each area of concern. First, Cal DOJ identified problems with the detainee security classification system, which can adversely impact detainees' conditions of confinement. Second, deficient conditions of confinement—such as extremely restrictive conditions for detainees in protective custody and placement of vulnerable detainees with mental health conditions in restrictive housing to the detriment of their mental health—were evident at the three facilities, with female detainees facing especially harsh conditions. Third, Cal DOJ found that all three facilities have been unsuccessful in meeting detainees' language access needs, which prevents detainees who do not speak or read English, or sometimes Spanish, from participating in offered educational and enrichment programs and services ("programming"), understanding facility rules, and/or accessing legal materials necessary to pursue relief in their immigration cases.

Cal DOJ's review of the **Adelanto** facility—and particularly of its delivery of medical care—was significantly hampered by the GEO Group's refusal to provide access to detainees and records to the same degree that Cal DOJ received at every other facility it has reviewed. Despite its limited access, Cal DOJ made several important observations, including:

- Facility staff fail to coordinate and communicate across different operational areas, which adversely impacts the delivery of services to detainees;
- The facility is focused on providing detainees with the bare minimum of services required by ICE's detention standards; for example, it offers some religious services, but no leisure or educational programs;
- The facility's intake and classification system fails to identify and address the health and safety needs of particularly vulnerable detainees. For example, the facility fails to acknowledge that it houses transgender detainees, thereby failing to provide for the safety and health needs of transgender detainees;
- Detainees face significant barriers to obtaining the materials and assistance they need for their immigration cases, and, in particular, law library materials are significantly outdated;
- Despite obstacles to reviewing medical files, Cal DOJ identified a number of healthcare concerns, including insufficient protection of patient confidentiality and deficiencies in chronic care management; and
- Mental health services are understaffed and patients experience delays in care.



At **Imperial**, Cal DOJ found, among other things, that in this facility:

- Staff foster positive relationships with detainees, and detainees reported being treated with respect;
- There is a telephone language interpretation service known as “language line”, but it may only be used with supervisor approval outside of the medical and intake areas;
- Detainees enjoy access to a robust offering of programs and activities beyond what is required by federal detention standards;
- There is a clear protocol for responding to allegations of sexual abuse and harassment;
- Due to the isolated geographic area of the facility, there is a lack of access to counsel which causes detainees to face impediments to due process; and
- The medical unit sees patients in need of medical care in a timely manner, but maintains poor healthcare records and lacks adequate mental health services.

**Otay Mesa** houses men and women for both the U.S. Marshals Service and ICE, and must maintain physical separation between the different populations, security classifications, and genders at all times. This complicates logistics for detainees’ access to medical services, court, and meal service, among other aspects of life in detention. In 2019, the facility added 512 beds in four new dorms but did not add capacity to its already strained medical unit. Physical plant limitations and logistical challenges, combined with custody and healthcare staff shortages prevent the facility from accommodating all of the detainees’ health needs. In addition to these concerns, Cal DOJ observed that the facility:

- Offers more programming than is required by national standards;
- Has language line capability within housing units, which provides greater opportunities for overcoming communication problems with detainees who have limited English proficiency;
- Has a higher rate of using force against immigration detainees than Imperial or Adelanto;
- Was unable to account for a notable recent increase in sexual assault and harassment reports; and
- Mental health care services suffer from significant deficiencies.

In each of the three comprehensively reviewed facilities, Cal DOJ observed that mandatory overtime is common, and understaffing is a concern for both custody and healthcare personnel. Mental healthcare for immigration detainees is critical, but mental healthcare at the three facilities reviewed in this report falls short of providing timely and accurate assessments, diagnoses, and referrals; adequate treatment plans; monitoring of psychiatric medication; and continuity of care, among other concerns. Rates of legal representation—based on Cal DOJ’s detainee interviews—vary significantly, with a much larger proportion of detainees represented by counsel at Adelanto and Otay Mesa than at geographically remote Imperial.

Finally, the report includes a section about how COVID-19 has impacted the facilities, their staff, and detainees. The pandemic presents particular challenges in immigration detention due to the near impossibility of maintaining social distance in a congregate setting. Detainees and advocates have

continuously challenged dangerous conditions and federal courts have ordered the release of some medically vulnerable detainees. Responses by ICE and facility leadership have ranged from different quarantining strategies to limiting in-person visitation and providing additional telephone access as an accommodation. These responses have impacted detainees' access to courts and counsel and have led to fluctuations in facility populations. Many detainees and staff have become ill, and at least one detainee housed in an immigration detention facility in California has died from COVID-19.<sup>3</sup>

**Figure 1. Overview of Immigration Detention Facilities in California since AB 103 Became Effective.**



\* The Desert View, Central Valley, and Golden State annexes are new facilities that were added to their respective ICE contracts in December 2019.

<sup>3</sup> ICE, Detainee Death Report: Escobar Mejia, Carlos Ernesto, <<https://www.ice.gov/doclib/foia/reports/ddrEscobarMejiaCarlosErnesto.pdf>> (as of Dec. 2, 2020).

# Glossary of Terms

AB 103	California Assembly Bill 103 (2017)
ACA	American Correctional Association
Cal DOJ	California Department of Justice
CDC	Centers for Disease Control and Prevention
CDCR	California Department of Corrections and Rehabilitation
CUP	Conditional Use Permits
DHS	U.S. Department of Homeland Security
OIG	Department of Homeland Security’s Office of the Inspector General
EOIR	Executive Office of Immigration Review
ERO	ICE Enforcement and Removal Operations
ICE	U.S. Immigration and Customs Enforcement
IHSC	ICE Health Services Corps
INA	Immigration and Nationality Act
LOP	Legal Orientation Program
LVN	Licensed Vocational Nurse
MHU	Medical Housing Unit
NCCHC	National Commission on Correctional Health Care
NDS	National Detention Standards (2000)
PBNDS	Performance-Based National Detention Standards (2008 and 2011)
PREA	Prison Rape Elimination Act
RHU	Restrictive Housing Unit
US DOJ	United States Department of Justice
USCIS	U.S. Citizenship and Immigration Services
USMS	U.S. Marshals Service



# Introduction

AB 103, codified as Government Code section 12532 and signed into law on June 27, 2017, requires the California Attorney General's office to conduct reviews of county, local, and private locked detention facilities in which noncitizens are housed or detained on behalf of ICE for purposes of civil immigration proceedings in California. The mandate runs through July 1, 2027.

The California Legislature enacted AB 103 in response to growing concerns regarding conditions in facilities within California that house noncitizens for purposes of civil immigration proceedings. These concerns are ongoing with respect to the five adult immigration detention facilities that remain operational in the State (Adelanto, Imperial, Mesa Verde, Otay Mesa, and Yuba), three of which have expanded their overall bed capacity (Adelanto, Mesa Verde, and Otay Mesa). AB 103 provides the California Attorney General with discretion to determine the order and number of facilities to be reviewed, and requires that facilities be reviewed with respect to the conditions of confinement, the standard of care, and

how the conditions of confinement affect the detainees' due process rights.<sup>4</sup> AB 103 does not impose substantive requirements on county, local, or private detention facilities in California. Instead, it contemplates increased transparency regarding the conditions in and operation of detention facilities across the State. Under the law, following the Attorney General's initial comprehensive report, published in February 2019, Cal DOJ is to provide updates and information to the Legislature and the Governor during the budget process, including a written summary of findings, if appropriate. This report constitutes such an update and further information pursuant to AB 103.

The first report, *Immigration Detention in California* (2019 Report), provided an overview of the ten detention facilities that were in operation at the time AB 103 was enacted (**Figure 1**), with a comprehensive review of three of those facilities (Theo Lacy, West County, and Yolo), including one youth detention facility (Yolo) that operated pursuant to a contract with the Office of Refugee Resettlement. The 2019 Report found that detainee experiences vary drastically within and across facilities, but some of the common issues amongst the facilities included: restrictions on liberty, language barriers, obstacles to accessing medical and mental health care, barriers to contacting family and other support systems, and barriers to obtaining legal representation or effectively representing themselves. Some of these conditions—including improper and overly restrictive housing conditions, substandard healthcare, and the consequences of low levels of legal representation—have also been documented by the federal government and nongovernmental organizations and have been the subject

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<sup>4</sup> AB 103 also directs the Attorney General's office to review circumstances surrounding the apprehension and transfer of detainees under section 12532 subdivision (b)(1)(c), however, following litigation brought by the federal government to challenge AB 103, the Ninth Circuit held that the United States is likely to succeed on its claim that this provision violates the intergovernmental immunity doctrine. (*United States v. California*, 9th Cir. 2019) 921 F.3d 865, 870, cert. den. (June 15, 2020) 207 L.Ed.2d 1072.) Cal DOJ continues to litigate this matter and defend AB 103.

of several lawsuits, research studies, and widespread media coverage.<sup>5</sup> Most recently, detention facility operators have been scrutinized over their mishandling of the spread of COVID-19 within their facilities. As of the publication of this report, one detainee died from COVID-19 while in immigration detention in California, and as of January 4, 2021, ICE has reported that over 500 detainees have tested positive for COVID-19 in immigration detention facilities throughout the State.<sup>6</sup>

This report continues to provide the people of the State of California with an understanding of the conditions in which many California residents or their family members are confined. This transparency is critical to our State's understanding of the welfare of every person in California—including those who are detained—regardless of immigration status.

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<sup>5</sup> See, e.g., *Fraihat v. ICE*, (C.D. Cal. Aug. 19, 2019, No. 5:19-cv-1546-JGB-SHKx) (nationwide class action challenging substandard healthcare in immigration detention facilities); U.S. House of Representatives, Committee on Oversight and Reform and Subcommittee on Civil Rights and Civil Liberties, *The Trump Administration's Mistreatment of Detained Immigrants: Deaths and Deficient Medical Care by For-Profit Detention Contractors* (Sept. 2020) <<https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-09-24.%20Staff%20Report%20on%20ICE%20Contractors.pdf>> (as of Oct. 26, 2020); U.S. House of Representatives, Committee on Homeland Sec., *ICE Detention Facilities Failing to Meet Basic Standards of Care* (Sept. 21, 2020) <<https://homeland.house.gov/download/staff-report-ice-detention-facilities&download=1>> (as of Oct. 26, 2020); Office of Inspector General, Dept. of Homeland Security, *Management Alert—Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (Sep. 27, 2018) <<https://www.oig.dhs.gov/sites/default/files/assets/Mga/2018/oig-18-86-sep18.pdf>> (as of Oct. 26, 2020); ACLU, et al., ACLU Research Report: *Justice-Free Zones: U.S. Immigration Detention Under the Trump Administration* (2020) <[https://www.hrw.org/sites/default/files/supporting\\_resources/justice\\_free\\_zones\\_immigrant\\_detention.pdf](https://www.hrw.org/sites/default/files/supporting_resources/justice_free_zones_immigrant_detention.pdf)> (as of Oct. 26, 2020); Human Rights Watch, *Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention* (Jun. 20, 2018) <<https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration>> (as of Oct. 26, 2020); California Coalition for Universal Representation, *California's Due Process Crisis: Access to Legal Counsel for Detained Immigrants* (June 2016) <<https://www.nilc.org/wp-content/uploads/2016/06/access-to-counsel-Calif-coalition-report-2016-06.pdf>> (as of Oct. 26, 2020).

<sup>6</sup> ICE, ICE Guidance on COVID-19, ICE Detainee Statistics, COVID-19 ICE Detainee Statistics by Facility (Dec. 30, 2020), <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021).

# Background: Significant Changes in Immigration Detention Facilities in California

The immigration detention facility landscape in California has significantly changed since Cal DOJ published its first report in February 2019. At the time there were eight detention facilities in operation. Currently, there are five detention facilities still in operation (Adelanto, Imperial, Mesa Verde, Otay Mesa, and Yuba), with three significantly expanding their capacities (Adelanto, Mesa Verde, and Otay Mesa) (**Figure 1**).

## 1. Local Governments' Termination of Contractual Relationships to House Immigration Detainees

### Counties

**James A. Musick and Theo Lacy.** On March 27, 2019, the Orange County Sheriff's Department announced the termination of its contract with ICE, effective August 1, 2019. In response to the facilities' impending closures, advocates sought an order preventing the transfer of detainees who were represented by counsel, or who had family in the area, outside of ICE's Los Angeles field office area of responsibility. While some detainees were transferred out of state,<sup>7</sup> a court entered an order preventing 75 detainees who were represented by counsel from being transferred outside of the Los Angeles area of responsibility.<sup>8</sup>

**Yolo County Juvenile Detention Facility.** The Yolo County Board of Supervisors voted to not renew its contract with the Office of Refugee Resettlement to house unaccompanied minors in the county juvenile hall on October 8, 2019. The contract terminated on January 31, 2020.<sup>9</sup> The facility reported that between October 2019 and January 2020, a total of 14 youth were housed at Yolo, and all were released from immigration detention or transferred to less restrictive facilities.<sup>10</sup>

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<sup>7</sup> *Arroyo v. U.S. Dep't of Homeland Security, et al.*, (C.D. Cal., June 20, 2019, No. 19-cv-815-JGB-SHKx) ECF No. 37, p. 25.

<sup>8</sup> *Id.* at pp. 25 & 32.

<sup>9</sup> Yolo County Board of Supervisors, Minutes & Supporting Materials, Item 29, Oct. 8, 2019. <[https://yoloagenda.yolocounty.org/docs/2019/BOS/20191022\\_2007/7979\\_10-08-19%20Minutes.pdf](https://yoloagenda.yolocounty.org/docs/2019/BOS/20191022_2007/7979_10-08-19%20Minutes.pdf)> (as of Oct. 26, 2020).

<sup>10</sup> Yolo County Board of Supervisors, ORR Program Closure/JDF Future Use Planning Update, Jan. 28, 2020 <[https://yoloagenda.yolocounty.org/agenda\\_publish\\_cfm?dsp=agm&seq=9231&rev=0&id=0&form\\_type=AG\\_MEMO&beg\\_meetmth=1&beg\\_meetyr=2020&end\\_meetmth=2&end\\_meetyr=2020&mt=BOS&sstr=&dept=ALL&hartkeywords=&sortBy=f.form\\_num,%20f.rev\\_num&fp=ADVSRCH&StartRow=1](https://yoloagenda.yolocounty.org/agenda_publish_cfm?dsp=agm&seq=9231&rev=0&id=0&form_type=AG_MEMO&beg_meetmth=1&beg_meetyr=2020&end_meetmth=2&end_meetyr=2020&mt=BOS&sstr=&dept=ALL&hartkeywords=&sortBy=f.form_num,%20f.rev_num&fp=ADVSRCH&StartRow=1)> (as of Jan. 4, 2021).

## Cities

**Adelanto ICE Processing Center.** On March 27, 2019, the City of Adelanto notified ICE and GEO Group of its intent to terminate its contract and subcontract, respectively, effective June 25, 2019.<sup>11</sup> The day after the contract ended, ICE entered into a nine-month, \$63 million contract directly with GEO Group to keep Adelanto open.<sup>12</sup> Adelanto's current operating contract is discussed in Section 2 below.

**Imperial Regional Detention Facility.** The City of Holtville's contract with ICE expired in September 2019. At that time, the City of Holtville was removed from the contract and ICE entered into a one-year direct contract with MTC, which was set to expire in September 2020. Imperial's current operating contract is discussed in Section 2 below.

**Mesa Verde ICE Processing Center.** On December 19, 2018, the City of McFarland gave ICE 90-days' notice of its intent to terminate its contract.<sup>13</sup> In March 2019, shortly before the 90-day deadline, ICE and GEO Group entered into a one-year, \$19.3 million contract to keep Mesa Verde open.<sup>14</sup> Mesa Verde's current operating contract is discussed in Section 2 below.

## 2. New ICE Contracts with Private Operators to Expand Immigration Detention

On October 11, 2019, the California Legislature passed AB 32, which prohibits private detention facilities from operating in the State, unless the facility was "operating pursuant to a valid contract with a governmental entity that was in effect before January 1, 2020, for the duration of that contract, not to include any extensions made to or authorized by that contract." Penal Code §§ 9500, 9505. Five days later, on October 16, 2019, ICE issued a Request for Proposals, seeking to expand bed capacity in ICE's San Diego, Los Angeles, and San Francisco areas of responsibility, which cover all of California.<sup>15</sup>

On December 19, 2019, ICE entered into direct contracts with the three private companies that operate immigration detention facilities in California—GEO Group, MTC, and CoreCivic. The contracts are valid for an initial term of five years, with the option to renew for two additional five-year periods, for a total of 15 years. The contracts expanded bed capacity at the GEO Group-operated facilities based upon the fact that the California Department of Corrections and Rehabilitation (CDCR) ended three contracts with GEO Group in McFarland and Adelanto. In the City of McFarland, CDCR terminated its contract for the Central Valley Modified Community Correctional Facility (Central Valley), effective September

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<sup>11</sup> City of Adelanto, Notice of Termination of EROIGSA-11-0003, March. 27, 2019.

<sup>12</sup> Plevin, *How a Private Prison Giant has Continued to Thrive in a State that Wants it Out*, Desert Sun (Jan. 25, 2020) <<https://www.desertsun.com/in-depth/news/2020/01/24/private-prison-giant-geo-thrives-california-state-wants-out/2589589001/>> (as of Oct. 26, 2020).

<sup>13</sup> City of McFarland, Notice of Termination of EROIGSA-15-005, Dec. 19, 2018.

<sup>14</sup> Luiz, *Mesa Verde Center Will Stay Open With New Contract*, The Bakersfield Californian (Mar. 14, 2019) <[https://www.bakersfield.com/delano-record/mesa-verde-center-will-stay-open-with-new-contract/article\\_6306aad4-4435-11e9-a45c-2b0e8f0bfd63.html](https://www.bakersfield.com/delano-record/mesa-verde-center-will-stay-open-with-new-contract/article_6306aad4-4435-11e9-a45c-2b0e8f0bfd63.html)> (as of Oct. 26, 2020).

<sup>15</sup> U.S. Congress, letter to Acting Secretary Chad F. Wolf and Acting Director Matthew T. Albence, Nov. 14, 2019 <<https://www.harris.senate.gov/imo/media/doc/11.14.19%20Bicameral%20Letter%20on%20ICE%20Procurement%20of%20CA%20Detention%20Centers%20FINAL%5B2%5D.pdf>> (as of Nov. 20, 2020).

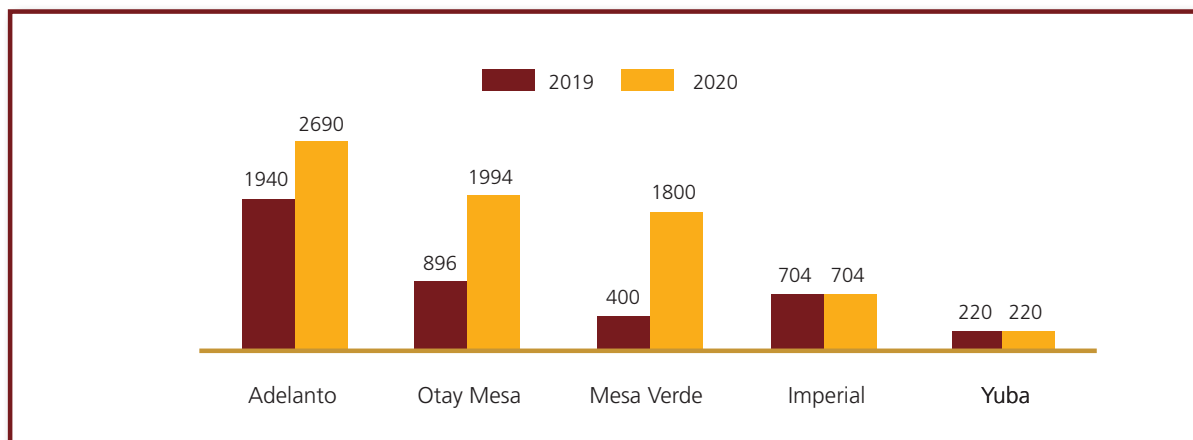


2019, and for the Golden State Modified Community Correctional Facility (Golden State), effective June 2020.<sup>16</sup> In the City of Adelanto, CDCR terminated its contract with GEO Group at Desert View Modified Community Correctional Facility (Desert View), effective March 2020.<sup>17</sup> ICE’s new contracts provide:

- GEO Group will continue to house 1,940 immigration detainees at Adelanto and incorporates the Desert View facility as an “annex” to house an additional 750 immigration detainees, for a total bed capacity of 2,690.
- GEO Group will continue to house 400 immigration detainees at Mesa Verde and incorporates the Central Valley and the Golden State facilities as “annexes” to house an additional 700 immigration detainees each, for a total bed capacity of 1,800.
- MTC will continue to house 704 immigration detainees at Imperial.
- CoreCivic will increase its immigration detainee bed capacity to 1,994 at Otay Mesa.<sup>18</sup>

As a result of these contracts, the total immigration detainee bed capacity in the State increased from approximately 4,160 to 7,408 between February 2019 and the present (**Figure 2**). Now, private facilities account for 97 percent of the total bed capacity for immigration detainees in California compared to 77 percent in February 2019.

**Figure 2. The increase in immigration bed capacity in California from 2019 to 2020.**



<sup>16</sup> Cal. Dep’t of Corrections and Rehabilitation, California Department of Corrections and Rehabilitation Ends Contract with Private Prison (Sept. 27, 2019), <<https://www.cdc.ca.gov/news/2019/09/27/california-department-of-corrections-and-rehabilitation-ends-contract-with-private-prison/>>, (as of Oct. 26, 2020).

<sup>17</sup> *The GEO Group, Inc. v. Newsom et al.*, (S.D. Cal., Dec. 31, 2019, No. 19-cv-2491-JLS-WVG) ECF No. 13, p. 21.

<sup>18</sup> CoreCivic, CoreCivic Reports Third Quarter 2019 Financial Results (Nov. 6, 2019), <<https://bit.ly/2YmBPzJ>> (as of Oct. 26, 2020).

For GEO Group to use the former CDCR facilities as annexes to Adelanto and Mesa Verde, it had to seek modifications to its Conditional Use Permits (CUPs) from the City of McFarland and the City of Adelanto, respectively. The City of McFarland's Planning Commission denied GEO Group's request to modify the CUPs for both Golden State and Central Valley to be converted to immigration detention facilities. However, the City of McFarland's City Council overruled the planning commission and approved GEO Group's appeal to modify the CUPs, with a July 15, 2020 effective date. Despite the newly executed contracts noting a period of performance beginning August 20, 2020, GEO Group planned to start housing detainees at Golden State and Central Valley effective July 15, 2020; however, a federal district court judge issued a preliminary injunction on July 14, 2020, based on advocates' challenge to the City of McFarland's process by which it modified the CUPs.<sup>19</sup> The Ninth Circuit vacated the preliminary injunction and the advocates dismissed the challenge.<sup>20</sup> The City of Adelanto's Planning Commission approved GEO Group's request to modify the CUP for Desert View to be converted to an immigration detention facility. Advocates appealed the decision to the Adelanto City Council, which appeal was heard and held for vote on September 9, 2020. The City Council took two separate votes, one to reject the appeal and another to accept the appeal, but neither vote resulted in a majority vote.

Cal DOJ toured Golden State and Desert View in February 2020, following the issuance of the new contracts. All three of the new "annexes" had identical layouts. The facilities include a small intake area with 13 single person cells that can hold up to five people at a time for processing. Adjacent to this area is the medical unit, which includes one doctor's office with two patient exam rooms, two medical isolation rooms, and a seven-person waiting room. The facilities' medical areas did not have any negative pressure rooms, which are used to prevent airborne diseases from spreading, and at the time did not have capabilities to conduct x-rays, which most other immigration detention facilities use during intake to screen for tuberculosis.

The living areas are split into two sides with four housing pods in each. At the time of Cal DOJ's visit, each pod consisted of a large open room with 88 beds for 88 people (**Figure 3**) for a total capacity of 704; however, the ICE-GEO Group contract states that Desert View's bed capacity is 750 detainees.

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<sup>19</sup> *Immigrant Legal Resources Center, et al. v. City of McFarland, et al.*, (E.D. Cal., July 10, 2020, No. 20-cv-966-TLN-AC) ECF No. 8.

<sup>20</sup> *Immigrant Legal Resources Center, et al. v. Geo Group, Inc., et al.*, (9th Cir., Oct. 28, 2020, No. 20-16557) ECF No. 74-1.

**Figure 3. Living Unit, Golden State.**



Each pod had six phones and a multipurpose room. At the far end of each pod there was a shoulder-high wall providing partial privacy for people using the toilets and showers (**Figures 4 and 5**).

Although the ICE-GEO Group contract was not set to house detainees until August 20, 2020, and both facilities were still under contract with CDCR, during its February 2020 visit Cal DOJ noticed postings in and around the housing units had changed from CDCR postings to ICE postings. Examples include settlement notices for immigration detainees, notifications from the Adelanto Warden, and phone services information provided by Talton.

**Figure 4. Toilets, Golden State.**



**Figure 5. Showers, Desert View.**



### 3. Pending Litigation Against AB 32

GEO Group filed suit against the State on December 30, 2019, challenging AB 32 as unconstitutional.<sup>21</sup> On January 24, 2020, the federal government also filed suit, challenging AB 32 as preempted by the Supremacy Clause and a violation of intergovernmental immunity.<sup>22</sup> The two lawsuits were consolidated. On October 8, 2020, the court granted a preliminary injunction barring California from enforcing AB 32 only as to GEO Group's and the United States' U.S. Marshals Service facilities, not privately-operated immigration detention facilities.<sup>23</sup> GEO has appealed the decision to the Ninth Circuit Court of Appeals.

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<sup>21</sup> *The Geo Group, Inc. v. Newsom, et al.*, (S.D. Cal. Dec. 30, 2019, No. 19-cv-2491-JLS-WVG) ECF No. 1.

<sup>22</sup> *United States of America v. Newsom*, (S.D. Cal. Jan. 24, 2020, No. 20-cv-154-MMA-AHG) ECF No. 1.

<sup>23</sup> *The GEO Group, Inc v. Newsom, et al.*, (S.D. Cal. Oct. 8, 2020, No. 19-cv-2491-JLS-WVG) ECF No. 53.

# Methodology

The findings contained in this report are the result of a multi-faceted methodology and extensive data analysis. Cal DOJ conducted comprehensive reviews of Adelanto, Imperial, and Otay Mesa. In addition, Cal DOJ toured two of GEO Group's new immigration detention facilities in the State—Golden State and Desert View. Important aspects of Cal DOJ's comprehensive reviews include researching publicly available information; obtaining stakeholder input; consulting with subject matter experts (see *Review Team Section*) about medical and nursing care, mental health services, and correctional standards; and conducting multi-day site visits to each facility to inspect, review files, and interview staff and immigration detainees. In addition to subject matter experts, Cal DOJ's review team consisted of attorneys, staff, and law clerks from the Civil Rights Enforcement Section, a special agent from the Division of Law Enforcement, and research associates from the Cal DOJ Research Center.

## 1. Review of Publicly Available Information and Stakeholders Input

In preparing the report, Cal DOJ consulted relevant publicly available government and nongovernmental entity reports, news articles, and legal filings related to the facilities. Cal DOJ additionally requested and obtained records from local governmental offices (i.e. Sheriff's Departments, Fire Marshal Departments, County Health Departments) to inform the comprehensive reviews.

In February 2019, Cal DOJ held a meeting with stakeholders in Southern California regarding the Imperial and Otay Mesa facilities. The meeting included a listening session with Detainee Allies, an organization which has published a collection of statements and letters from detainees at Otay Mesa. Cal DOJ received additional input from legal service providers.

In preparation for the publication of the first annual report on immigration detention facilities, Cal DOJ developed an online attorney survey tool to assess detainees' access to due process at all active ICE detention facilities within California. A revised online survey was administered for the present report and focused on attorneys who represented clients housed at ICE detention facilities during the past fiscal year (July 1, 2018, through June 30, 2019). Fifty-two attorneys from across California, with clients at all active detention facilities, completed the revised survey. Participants were asked questions pertaining to their and their clients' experiences with legal visitations, telephone calls, and access to legal materials at immigration detention facilities in California. The results of this survey are integrated into the discussion of detainees' access to due process for each detention facility included in this report.

Following the outbreak of the COVID-19 pandemic, Cal DOJ issued a targeted survey to elicit information about how facilities' responses impacted or accommodated attorney-client communications. The results of that survey are included in the section on COVID-19.

## 2. Consultation with Experts

Cal DOJ retained one correctional expert (Dr. Dora Schriro), two medical experts (Dr. Lisa Longano and Dr. Todd Wilcox), one nursing expert (Dr. Denise Panosky), and one mental health expert (Dr. Mariposa McCall) to assist in the reviews contained in this report.<sup>24</sup> The correctional, medical, nursing,<sup>25</sup> and mental health experts evaluated the three facilities in accordance with best practices and in consultation with applicable ICE national detention standards (PBNDS 2011, rev. 2016), Title 15 of California's Code of Regulations, and industry standards, including standards promulgated by the American Correctional Association (ACA), National Commission on Correctional Health Care (NCCHC), and the Prison Rape Elimination Act (PREA). These experts provided invaluable feedback as Cal DOJ developed and implemented the review methodology, sharing key analyses in accordance with applicable standards and best practices that informed the report's findings.

## 3. Comprehensive Reviews

Cal DOJ's review process targeted two AB 103 focus areas: "conditions of confinement" and "the standard of care and due process provided." The comprehensive review for each facility consisted of an assessment of: (i) requested documentation, including policies and procedures, staff and training records, facility logs, operations schedules, and other documents; (ii) facility tours; (iii) on-site records review; and (iv) interviews with facility personnel and detainees.<sup>26</sup> To evaluate conditions of confinement, Cal DOJ reviewed detainee housing, daily schedule and programming, food, hygiene, visitation, access to telephones and mail, language access, grievances, discipline, and access to medical and mental health care, among other things. To evaluate standard of care and due process at each facility, Cal DOJ reviewed medical and mental healthcare, detainee access to legal materials, the ability to retain and consult with attorneys, and the ability to gather and present evidence to the immigration courts.

**Pre-Visit Meetings.** Through prior facility reviews, Cal DOJ learned that each facility operates and maintains records differently. For this report, Cal DOJ met with leadership from Imperial and Otay Mesa before starting those comprehensive reviews to better understand each facility, its staffing, and record keeping. Cal DOJ also attempted to meet with Adelanto's leadership, but GEO Group only agreed to meetings with their outside counsel.

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<sup>24</sup> Drs. Dora Schriro and Mariposa McCall accompanied the Cal DOJ to all three facilities. Dr. Lisa Longano accompanied the team to Imperial and Otay Mesa. Dr. Todd Wilcox accompanied the team to Adelanto. Dr. Denise Panosky accompanied the team to Otay Mesa.

<sup>25</sup> Cal DOJ did not have a nursing expert for the comprehensive review of Imperial. For the Adelanto comprehensive review, Dr. Wilcox subcontracted a nursing expert.

<sup>26</sup> Each facility maintains records differently, which will be reflected in different sections of this report.

**Requested Documentation.** The Cal DOJ team requested and received preliminary documentation from all three of the comprehensively reviewed facilities prior to each on-site facility review. In addition to facility logs (i.e. grievances, use of force, discipline, PREA, restricted housing), schedules, policies, detainee orientation materials, and other requested documentation, each facility provided a detainee roster that generally reflected gender, length of stay, country of origin, and security classification for detainees held at the facility. An updated roster reflecting the active population at the time of each site visit was also provided to the team. Cal DOJ summarized the data contained in the facility rosters and logs, and prepared tables and charts included throughout this report. Cal DOJ's retained experts also conducted an on-site review of detainee records (detention files and health records) during each site visit based on their subject-matter expertise.

**Detainee Interviews.** Cal DOJ interviewed 241 detainees across the three comprehensively reviewed facilities in order to evaluate the AB 103 focus areas. The review team developed a standardized sampling strategy to ensure that the interviewed detainees would be representative of each facility's population with respect to detainee nationality and gender, and sought to ensure representation from all possible housing units and duration of detention. In order to recruit volunteers for the Cal DOJ interviews, detainees were asked to sign up on a list placed in all detainee housing units prior to the Cal DOJ team's arrival at the facilities, and when possible, were also given the opportunity to volunteer prior to the start of the interview sessions during the Cal DOJ facility tours. Cal DOJ additionally recruited detainees to participate based upon pre-visit and on-site records review, and detainee or staff referrals.

All interviewed detainees provided verbal consent to be interviewed by the team following an initial explanation regarding the purpose of the review and why they were being interviewed.

Those who consented to be interviewed were interviewed by either Cal DOJ staff or experts. The individual standardized interviews with Cal DOJ staff consisted of a set of 72 questions pertaining to detainees' experiences within the facility based on 11 major categories: orientation and intake, due process, phone calls, visitation, mail, general facility conditions, food, interaction with staff, grievances and requests, medical care, and mental health. Due to the timing constraints of the interviews, 21 questions from the aforementioned categories were prioritized for all interviewees. Expert interviews were based on the subject-matter expertise of the team's retained corrections, medical, nursing, and mental health experts.

In general, interviews took place in an individual and private setting with either one or two Cal DOJ team members.<sup>27</sup> Cal DOJ interviewed detainees in their preferred language, either by Cal DOJ staff who were proficient in the language or through a telephone interpretation service.<sup>28</sup> The languages used during the interviews included English, Spanish, Punjabi, Arabic, Armenian, Bangla, Chinese, Farsi, French, Portuguese, Pulaar, Russian, and Tigrinya.

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<sup>27</sup> Group interviews were conducted at Imperial and Otay Mesa. At the Otay Mesa facility, eight interviews were led by a single interviewer due to the timing constraints of the team's last day on-site and in order to meet established sampling quotas.

Cal DOJ analyzed the data obtained from the individual interviews and the results were integrated into the discussion of the aforementioned topics for each detention facility included in this report. The retained experts analyzed the data obtained from the interviews they conducted and Cal DOJ integrated those findings into the comprehensive reviews of the facilities.

**Staff Interviews.** Cal DOJ and its experts interviewed facility leaders in the highest positions, such as wardens, chiefs of security, and healthcare services administrators; staff in charge of critical functions such as the grievance and PREA coordinators and safety managers; and mid-level and rank and file staff who either had expertise in particular functions—such as receiving & discharge, law library, and transportation—or who had a great deal of detainee contact. Although Adelanto and Otay Mesa required counsel to be present for these interviews, Cal DOJ advised staff that their participation was voluntary, that they would not be named in Cal DOJ’s report, and that they would not be subject to retaliation for participating in the interviews.

Further detail regarding the methodology used at each of the three comprehensively reviewed facilities can be found in their respective sections within this report.

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<sup>28</sup> Cal DOJ team members fluent in Spanish and Punjabi were present for all three of the facility reviews, while a team member fluent in Chinese was present for the Adelanto and Otay Mesa facility reviews.



# Detainee Demographics Snapshot

The following sections provide individual demographic snapshots for the active population of each detention facility at the time of Cal DOJ's site visits. The data included in each demographic profile generally reflects country of origin, gender, age, security classification, and length of stay information, though not every facility provided all data points. **Table 1** indicates the date in which each detainee roster was generated, as well as the detainee arrival date range for all active detainees at the time of the site visits.

**Table 1. Date Span of Data Provided by Facility.<sup>29</sup>**

Detention Facility	Date Roster was Generated	Detainee Arrival Date Range
Adelanto	August 7, 2019	October 2015 to August 2019
Imperial	June 3, 2019	October 2016 to June 2019
Otay Mesa	December 9, 2019	October 2015 to December 2019

## 1. Detainee Age, Gender, and Sexual Orientation

**Table 2** shows the age and gender composition of each facility at the time of the Cal DOJ site visits. Only Adelanto provided documentation regarding their LGBT population, with three percent of the total population identifying as bisexual (14), gay (29), or lesbian (14).<sup>30</sup>

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<sup>29</sup> Potential duplicate entries were identified as the same person having an identical name, birth date, date of arrival, and projected release date. For Imperial, a suspected duplicate case, which satisfied these conditions, was excluded from the demographic analysis, as it was unclear whether the entries reflected clerical errors.

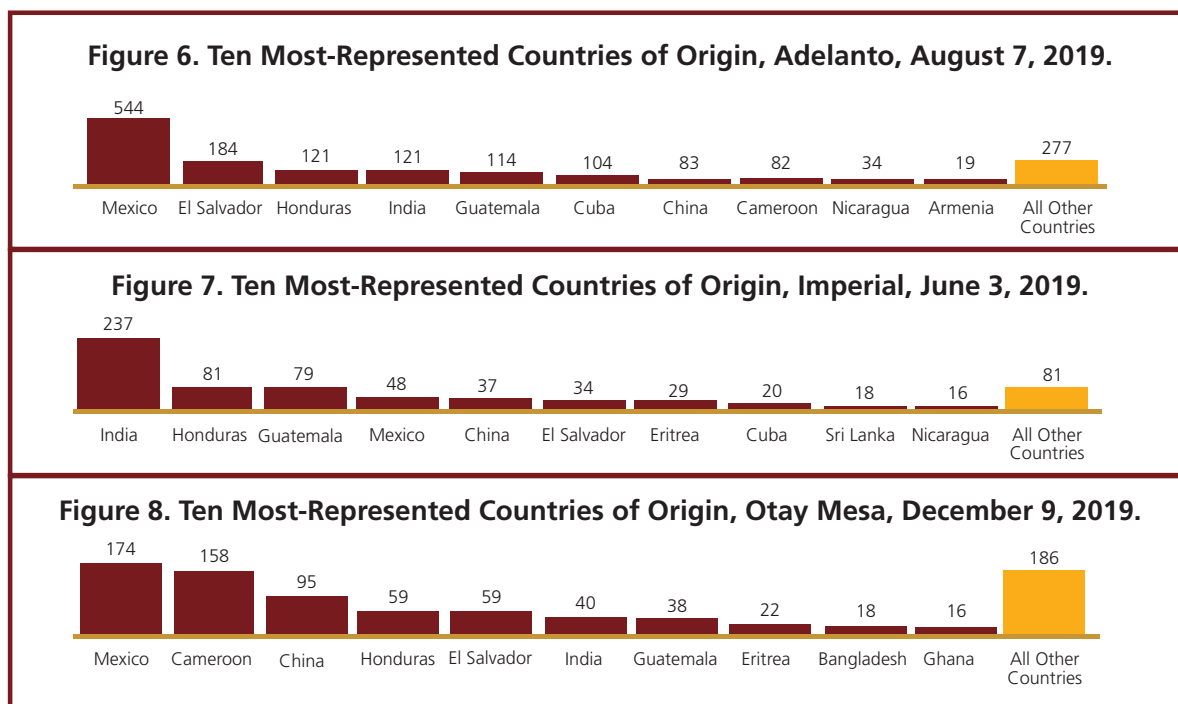
<sup>30</sup> A roster, listing detainees who had identified as lesbian, gay or bisexual, was provided to the team during the site visit. This document did not provide information regarding detainees who had identified as transgender.

Table 2. Detainees' Age and Gender by Facility.<sup>31</sup>

Demographic Characteristic	Adelanto	Imperial	Otay Mesa
<b>Age</b>			
Average	Not Reported	30.27	33.62
Average Women		31.25	33.69
Average Men		30.17	33.61
Youngest		17	18
Oldest		65	82
<b>Gender</b>			
Women	219 (13.01%)	64 (9.41%)	114 (13.18%)
Men	1,464 (86.99%)	616 (90.59%)	751 (86.82%)
<b>Total</b>	<b>1,683</b>	<b>680</b>	<b>865</b>

## 2. Detainee Country of Origin

Detainees at the comprehensively reviewed facilities came from over 90 countries. **Figures 6** through **8** illustrate the top 10 countries of origin for each facility at the time of the Cal DOJ site visits.



<sup>31</sup> Adelanto did not provide a roster including detainee birthdates or ages at the time of the Cal DOJ site visit. The detainee roster for Imperial showed a detainee who was 17 but it is unclear whether the facility entered an incorrect date of birth.

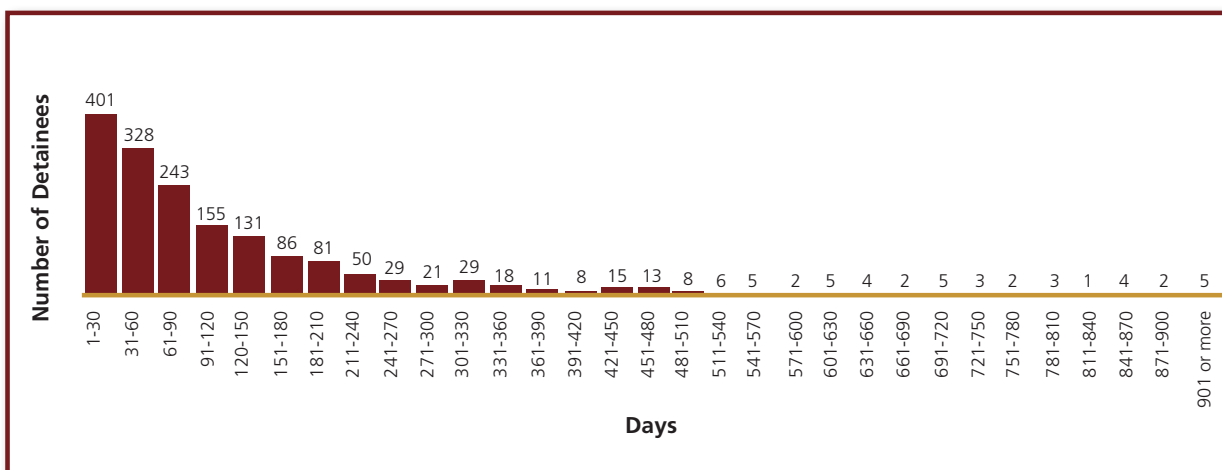
### 3. Detainee Length of Stay

**Table 3** shows the average detainee length of stay in days by facility. **Figures 9** through **11** provide a breakdown of detainees' length of stay in 30-day increments for each facility.

**Table 3. Detainees' Length of Stay in Days by Facility.**<sup>32</sup>

Length of Stay	Adelanto	Imperial	Otay Mesa
Average	119.66	103.20	126.00
Median	75	48	68
Min-Max	0-1,378	1-962	1-1,515
Standard Deviation	146.82	133.22	151.72

**Figure 9. Length of Stay in 30-day increments, Adelanto, August 7, 2019.**<sup>33</sup>



<sup>32</sup> The standard deviation for a data set provides context for averages. A low standard deviation indicates that the data points tend to be close to the mean of the set, while a high standard deviation indicates that the data points are spread out over a wider range of values.

<sup>33</sup> Seven detainees, who had a length of stay of zero, indicating that the detainee had arrived at the facility on the day the detainee roster was generated, were not included in the graph.

Figure 10. Length of Stay in 30-day Increments, Imperial, June 3, 2019.

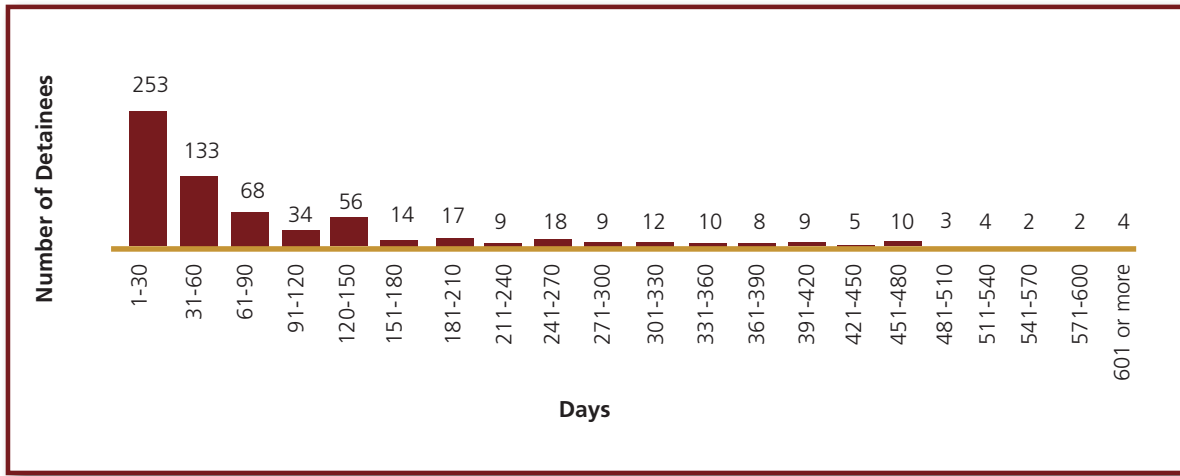
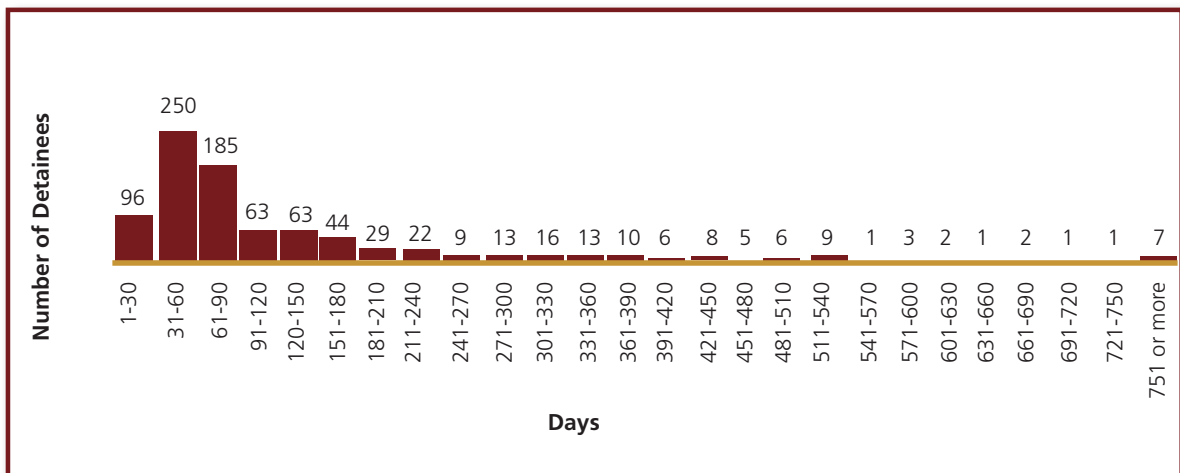


Figure 11. Length of Stay in 30-day increments, Otay Mesa, December 9, 2019.



# Systemic Issues with Detainee Security Classification, Restrictive Housing, and Language Access

The federal government houses immigration detainees in immigration detention facilities, pursuant to its authority under the Immigration and Nationality Act (INA), during removal proceedings, asylum proceedings, or pursuant to a removal order.<sup>34</sup> Detainees can be individuals who came to the United States without authorization—including asylum seekers, visitors whose visas have expired, and longtime lawful permanent residents whom the federal government asserts are subject to removal. ICE has discretion to release individuals from detention, but some detention is mandatory.<sup>35</sup> While an adult individual is detained, ICE is responsible for their care.

Each facility housing immigration detainees is subject to certain standards including constitutional standards, state standards, PREA, and federal detention standards. PREA protects individuals against, and ensures prompt investigation of and response to, allegations of sexual assault. Facilities housing county jail populations (Yuba) and U.S. Marshals Service detainees (Otay Mesa) are subject to the U.S. Department of Justice's (US DOJ) PREA standards.<sup>36</sup> Facilities that only house adult immigration detainees (Adelanto, Imperial, Mesa Verde) are subject to the DHS's PREA standards.<sup>37</sup> Public and private detention facilities in California are subject to both state and local health standards and are evaluated by local health officials.<sup>38</sup> ICE issues the federal detention standards applicable to immigration detention facilities.

ICE's National Detention Standards (NDS), first issued in 2000 and revised in 2019, are mostly applicable to public and private facilities that house both immigration detainees and incarcerated people for over 72 hours.<sup>39</sup> ICE's Performance Based National Standards (PBNS), first issued in 2008, reissued in 2011, and revised in 2016, apply to all five immigration detention facilities operating in California. The PBNS were modeled on American Correctional Association (ACA) standards, which set forth minimum

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<sup>34</sup> 8 U.S.C. § 1226 (detention on warrant issued by Attorney General).

<sup>35</sup> 8 U.S.C. § 1226(c).

<sup>36</sup> National Standards To Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106 (June 20, 2012).

<sup>37</sup> Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities, 79 Fed. Reg. 13100 (Mar. 7, 2014).

<sup>38</sup> Health & Saf. Code, § 101045; As a facility in California that houses a county jail population, Yuba is also subject to the State's detention standards—Penal Code (i.e., § 4000, et seq.) and Titles 15 and 24 of the California Code of Regulations. Title 15 and 24 minimum detention and building standards address health and safety, access to healthcare, personnel training, suicide prevention, grievances, administrative and disciplinary segregation, mail, library services, security, recreation, treatment of confined individuals, and the types and availability of visitation, among others.

<sup>39</sup> ICE, Dept. of Homeland Security, 2019 National Detention Standards for Non-Dedicated Facilities, <<https://www.ice.gov/detention-standards/2019>> (as of Oct. 26, 2020).

requirements for criminal detention facilities, and do not address the particular circumstances and needs of civil immigration detainees. Despite being subject to the same federal standards, services provided to detainees can vary vastly across facilities. Some facilities prioritize only meeting the minimum standards while others strive to exceed, at least, the programming standards; in either case, oversight of services provided is inadequate. A 2018 DHS Office of the Inspector General report found that many facilities do not meet the PBNDS requirements and ICE systematically fails to enforce its standards; yet it continues to use those facilities.<sup>40</sup> More recently, in August 2020, the U.S. Government Accountability Office found that while ICE, its contractors, and other DHS offices conduct facility inspections, ICE does not conduct analyses of its data to identify trends within facilities. This omission severely inhibits ICE's ability to monitor oversight.<sup>41</sup>

Through its reviews, Cal DOJ found that in many instances even when immigration detention facilities reported they meet PBNDS requirements, they face systemic issues that adversely impact the conditions of confinement of immigration detainees. Three of those systemic issues Cal DOJ identified are:

- A detainee security classification system that either fails to follow PBNDS standards or otherwise places detainees in very restrictive settings;
- Overuse and overly restrictive nature of restrictive housing units for disciplinary and administrative segregation; and
- Continuous language access barriers that limit detainees' ability to successfully navigate detention and prepare for their immigration proceedings.

These issues, including Cal DOJ's findings at Adelanto, Imperial, and Otay Mesa on each of these areas, are discussed below.

## 1. Security Classification System

ICE requires each facility to have a formal detainee classification system based on verifiable and documented information. A detainee is classified at admission and this classification is used throughout detainees' time in detention. Under PBNDS Section 2.2 *Custody Classification System*, facilities may classify detainees based on a standardized ICE Custody Classification Worksheet or other similar established system approved by ICE/ERO.<sup>42</sup> The classification must be reviewed and approved by a facility supervisor, as this classification will determine the detainee's housing assignment and access to activities and work in the facility.<sup>43</sup> The classification process must take into account any special vulnerabilities a detainee may have, including

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<sup>40</sup> Office of Inspector General, Dept. of Homeland Security, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* p. 4 (Jun. 26, 2018) <<https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf>> (as of Oct. 28, 2020).

<sup>41</sup> See U.S. Government Accountability Office, *Immigration Detention – ICE Should Enhance Its Use of Facility Oversight Data and Management of Detainee Complaints* (Aug. 2020) <<https://www.gao.gov/assets/710/708899.pdf>> (as of Oct. 26, 2020).

<sup>42</sup> ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, §A, p. 61.

the risk for victimization or perpetration of sexual abuse or assault.<sup>44</sup> Detainees must be reclassified 60-90 days after the initial classification and 90-120 days thereafter, or sooner if the detainee is placed in restrictive housing (for disciplinary or administrative reasons).

## A. Overarching Issues with the Detainee Security Classification System

PBNDS sets out three classification levels—low, medium, and high. Low custody detainees may be people with no criminal history, with minor criminal histories, or those with non-felony charges and convictions. They cannot be comingled with high custody detainees. Medium custody detainees may be individuals with minor criminal histories or those who do not have a history of assaultive behavior. Medium custody classification is not generally allowed to comingle with low or high custody unless “it becomes necessary” to house detainees of different classification levels in the same housing unit.<sup>45</sup> When that is the case, medium custody is split into medium-low and medium-high. This split allows facilities to house low and medium-low custody detainees together and medium-high and high custody detainees together—all three facilities reviewed follow this approach. Higher custody detainees may be people who are considered “high-risk,” “require medium-to-maximum-security,” and must always be “monitored and escorted.” Regardless of a detainee’s classification, PBNDS requires that they be assigned to the least restrictive housing setting.<sup>46</sup>

Based on ICE’s custody level guidance, it is relatively difficult for detainees to receive a low custody score and easier to receive a high custody score. ICE has no system to compare criminal charges and convictions between state and local jurisdictions and the federal system; instead, it assigns general crime categories such as “burglary,” to one of four degrees of severity—highest, high, moderate, and low—and a corresponding score.<sup>47</sup> As shown in **Figure 12**, a low custody detainee may not score higher than 2 points. A medium-low detainee may not score more than 5 points. A medium-high detainee may not score more than 11 points and cannot have had an arrest or conviction for a violent offense, or more than 6 points if there was an arrest or conviction for a violent offense. These are low thresholds when, as noted by Cal DOJ’s correctional expert through file review, **someone who is charged with “illegal entry” or “illegal reentry” into the U.S. will have a total score of at least four to six points, giving them a medium or even a medium-high custody classification based on an entry offense alone.**

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<sup>43</sup> ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, §A, p. 62.

<sup>44</sup> The Special Vulnerabilities and Management Concerns portion of the ICE Custody Classification Worksheet allows for consideration of the following factors when classifying a detainee: serious physical illness; serious mental illness; disability; elderly; pregnancy; nursing; sole caretaking responsibility; risk based on sexual orientation/gender identity; victim of persecution/torture; victim of sexual abuse or violent crime; victim of human trafficking.

<sup>45</sup> ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, §G p. 65.

<sup>46</sup> ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, §F, p. 65.

<sup>47</sup> See ICE, PBNDS 2011, Part 2.2 Custody Classification System, Appendix 2.2.B: Instructions for Completing the ICE Custody Classification Worksheet, pp. 70-73; ICE, PBNDS 2011, Part 2.2 Custody Classification System Appendix 2.2.C: Severity of Offense Scale, p. 74.

**Figure 12. Portion of the Last Page of the ICE Classification Worksheet Showing Point Totals.**<sup>48</sup>

Custody Level Guideline Ranges				
If there is no arrest or conviction for a violent offense, use this table.			If the person has an arrest or conviction for a violent offense, use this table.	
	Low Custody	0-2		
	Medium-Low Custody	3-5		
	Medium-High Custody	6-11		0-6
	High Custody	12+		7+

ICE’s threshold for assigning gang affiliation is also appreciably lower than industry standards. Although PBNDS Section 2.2 states its classification system is based on verifiable and documented information, ICE’s scoring instrument has only two choices, as noted in **Figure 13**, when it comes to determining gang involvement. Any documentation including a tattoo, or a self-admission is sufficient on its face, and no distinctions are made between traditional street gangs, traditional prison gangs, non-traditional gangs, transnational criminal organizations, and foreign and domestic terrorist organizations as to their dangerousness or the current level of a detainee’s involvement.

**Figure 13. Portion of the ICE Classification Worksheet Scoring for Threat Groups**

5	Security Threat Group (STG)			
	The individual has no known membership or affiliation with an STG	0	Enter the score here:	
	The individual is a member of an STG	5		

ICE’s classification instrument has other substantive deficiencies. Chief among them are the underlying assumptions that inform its key custody indicators: propensity for violence and flight risk. Neither indicator is normed for immigration detainees, validated for reliability, nor differentiated for gender. ICE’s “lookback” includes most prior arrests and convictions older than 15 years but includes none of the mitigation considered in correctional classification systems, such as having earned a high school equivalency, home ownership, and steady employment. **Unlike correctional systems where incarcerated people can lower their custody scores over time with good behavior, immigration detainees’ scores tend to remain constant or increase due to disciplinary action, unless the person conducting the classification analysis makes a scoring error and the error is corrected.** Indeed, PBNDS only allows high custody detainees to be reclassified to medium based on institutional

<sup>48</sup> See ICE, PBNDS 2011, Part 2.2 Custody Classification System, Appendix 2.2.A: ICE Custody Classification Worksheet, pp. 67-69.



behavior but this may only occur after the detainee is in custody for a minimum of 60 days.<sup>49</sup> At all three facilities, Cal DOJ's corrections expert did not see any files where detainees were reclassified into a lower custody level.

*Cal DOJ's corrections expert reviewed the file of someone previously incarcerated for a serious crime who—through good behavior—was classified at the lowest custody level in prison and allowed to participate in firefighting crew in the community, and a work release assignment with minimal supervision. Upon this person's release and subsequent detention by ICE, he was placed in high custody once again based on the original, and now quite old, sentence which severely limited this person's movement in the facility despite his continued good behavior. As a high-custody detainee, he was prohibited from working outside of his housing unit.*

Detainees may request reclassification to the facility in writing via a detainee request form but an appeal of a classification decision must be submitted through a grievance form. Although classification decisions are made at the facility level, PBNDS only requires that appellate procedures be outlined in the ICE Detainee Handbook, and not necessarily in the facility-specific supplemental handbook. This is a problem given detainees' reports across all three facilities that they do not consistently receive an ICE Detainee Handbook and when they do it is not always in a language they understand. Further, at Adelanto, the facility-specific supplemental handbook incorrectly instructed detainees to make classifications appeals to ICE, not the facility.

A detainee's classification level impacts their conditions of confinement. For example, high custody detainees may not have work assignments outside of their living areas and must always be monitored and escorted.<sup>50</sup>

## **B. Cal DOJ's Findings About Classification at the Three Comprehensively Reviewed Facilities**

At the time of Cal DOJ's visits to the three comprehensively reviewed facilities discussed in this report, the number of detainees in each classification level varied by facility (**Table 4**), with Imperial having more low-level detainees due, in part, to the large number of asylum seekers who were apprehended at the border and held at Imperial.

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<sup>49</sup> ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, §F, p. 64.

<sup>50</sup> *Id.*

**Table 4. Detainee Classification by Gender for each Facility.<sup>51</sup>**

Classification	Adelanto		Imperial		Otay Mesa	
	Women	Men	Women	Men	Women	Men
Low	123	559	64	555	97	595
Medium Low	16	140	None	10	6	24
Medium High	43	331	None	10	5	63
High	37	434	None	41	3	51
<b>Total</b>	<b>219</b>	<b>1,464</b>	<b>64</b>	<b>616</b>	<b>111</b>	<b>733</b>

Across the three reviewed facilities, detainees are classified at all four levels (low, medium-low, medium-high, high) and wear a uniform in the corresponding color. The color-coded uniforms at all three facilities are: blue for low custody, orange for medium custody—irrespective if they are medium-low or medium-high—and red for high custody. Otay Mesa also has a separate color—yellow—for those in the Restrictive Housing Unit (RHU). The practice of color-coding different custody levels is required by ICE; it is not a practice correctional facilities use. This is also true in comparison to the U.S. Marshals detainees at Otay Mesa who all wear a tan uniform regardless of custody level. Cal DOJ’s corrections expert found issues with this color-coding practice. Low custody detainees expressed concern that their blue uniform signals to other detainees that they are vulnerable, exposing them to bullying and extortion. For detainees who have never been in trouble, it is demoralizing to be issued orange or red uniforms for potentially non-violent rule breaking. During interviews, some detainees expressed concern that the uniforms may also impact their immigration proceedings because they must wear these color-coded uniforms to their immigration court hearings. Specifically, detainees expressed concern that their immigration judges are aware of ICE’s color-coded system, and that their custody classification could influence the judges’ decisions whether to release that detainee on bond or grant other immigration relief. Some detainees also reported that this concern was used by detention staff as a threat to control detainee behavior.

The classification procedure varies across the three facilities:

**Adelanto.** Although GEO Group conducts the initial and re-classification reviews at Adelanto, the facility handbook provided to detainees at the time of Cal DOJ’s visit had no information about the classification system. Further it stated that ICE conducts classifications and any appeals must be sent to ICE, instead of the facility grievance process as required by PBNDS. The facility has a Security Threat Group (STG) coordinator who exclusively maintains information about detainees who are or were purportedly associated with a gang or other groups and who could pose a threat to security.

<sup>51</sup> For Otay Mesa, twenty-one detainees were not included in this graph. Nineteen were classified as “DE”, an unknown code, and housed with low or medium low security detainees, and two had not been classified at the time the detainee roster was generated.

The information is primarily obtained during intake. Cal DOJ's expert was unable to review STG investigative files or to interview the STG coordinator due to GEO Group's delay in making witnesses available for Cal DOJ's review. However, out of the 25 detention files reviewed, Cal DOJ's corrections expert observed that very few detainees were identified on the ICE Classification Worksheet as gang affiliated for the purpose of informing housing decisions. The facility reported that detainees associated with different gangs can be housed in the same general population housing unit if they get along, but that the STG officer maintains a "do not house" list for those detainees who cannot be housed together. Cal DOJ received reports from at least 10 detainees across different housing units (male and female) about rival gangs and their gang "reps" (representatives selected by gang members to organize its activity in that housing unit as well as in the facility) housed in the same housing units operating openly. Detainees also reported fights between gangs. Due to GEO Group-imposed limitations on access, Cal DOJ was not able to ascertain the extent to which gangs are present and any impact on facility operations and detainees' safety.

**Imperial.** Cal DOJ's corrections expert found that Imperial accurately assessed detainees' risk to themselves and others during the intake process, at the conclusion of assignments to disciplinary segregation, and after other routine reclassifications. While Cal DOJ's corrections expert found that Imperial was adept at balancing a single incident with the detainee's overall institutional record when considering whether or not to raise a detainee's custody classification, at least eight detainees determined to be current or former gang members were permanently reassigned to protective custody, regardless of the classification level.

**Otay Mesa.** At Otay Mesa, Cal DOJ's corrections expert found that housing decisions are based on availability of particular beds rather than suitability of a given housing unit. With respect to reassignment, the facility lacks a clear gang management strategy, failing to differentiate between definitions and designations of active members and drop-outs; neighborhood street gangs and international gangs. Additionally, Otay Mesa's detainees' classification files were replete with coding errors and scoring mistakes, which suggests that classification and reclassification reviews were cursory at best. In addition, it is unclear how unit management staff can make proper housing reassignments given their limited familiarity with the security assessments of detainees in units outside their areas of supervision.

Senior facility staff estimated that most of the U.S. Marshals Service prisoners had some affiliation to a gang or STG, as compared to a much smaller portion of ICE detainees. The Gang Unit estimated that 10 percent of the overall population had current or prior STG involvement. Generally, gang members are dispersed across housing units to dilute the impact of any group, and efforts are made to stop gang members from congregating in communal areas or taking control of preferred times and locations for meals, recreation, and other activities. The facility convenes a gang intelligence meeting monthly and works closely with CDCR to identify and address gang threats. The facility is more successful at developing intelligence than some of the other detention centers Cal DOJ has visited.

**Security Re-Classifications.** With regard to the required reclassification that should occur within 60-90 days of initial classification, Adelanto was timely, but Imperial and Otay Mesa were not.

**Issues Identifying Detainees with Special Vulnerabilities.** Cal DOJ's corrections expert found that not every facility takes special vulnerabilities into consideration (i.e. serious physical or mental illness, disability, pregnancy, risk based on sexual orientation/gender identity) during classification, as required by PBNDS. For example, at **Imperial**, no detainee files reviewed by our corrections expert contained a completed "Special Vulnerabilities and Management Concerns" portion of the ICE Classification Worksheet. At **Adelanto**, detainees will not be deemed to have special vulnerabilities unless they are also identified as being at risk of being a victim or perpetrator for purposes of PREA. For example, one detainee identified as having a prior sexual assault, a history of domestic violence, and being LGBT was not identified as having a special vulnerability for classification purposes because the detainee did not have a high enough score in the PREA Risk Assessment form. Further, at Adelanto, detainees were not identified as having a special vulnerability over the course of their detention despite the frequency with which they were involved in sexual assaults, written up for other rule violations, and/or requested protective custody housing. At **Otay Mesa**, based on Cal DOJ's file review, PREA risk assessment forms were not always completed or maintained. Given that the facility had a notable increase of PREA complaints in 2019 (see *Comprehensive Facility Review: Otay Mesa*, Section 2.F below), more attention should be paid to detainees' vulnerability to sexual abuse and harassment. Further, one staff member suggested that the PREA inquiry during intake should be conducted in a private area, given the sensitivity of information sought.

Improper detainee classification and reclassification can have significant effects on detainees' access to services and opportunity for consideration of release, relief, and removal.

## 2. Restrictive Housing Conditions

Typically, there are two housing categories for detainees: general population and special populations. The majority of detainees are in the general population. There are two kinds of special populations: administrative segregation and disciplinary segregation. Administrative segregation includes detainees voluntarily or involuntarily placed in protective custody (i.e. whose placement in the general population would pose a threat to themselves or others), detainees held pending a disciplinary hearing, detainees scheduled for release or transfer, and detainees leaving disciplinary segregation who may not be ready to return to general population.<sup>52</sup> Pursuant to PBNDS, a detainee may be placed in disciplinary segregation only by order of the Institution Disciplinary Panel (IDP), or its equivalent, "after a hearing in which the detainee has been found to have committed a prohibited act and only when alternative dispositions may inadequately regulate the detainee's behavior."<sup>53</sup>

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<sup>52</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, §A, p. 173.

<sup>53</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, §B, p. 177.

As awareness of the harms associated with solitary confinement have grown, correctional systems have decreased their use of segregated housing; and in 2013, ICE issued Directive 11065.1, Review of the Use of Segregation for ICE Detainees (Segregation Directive). The Segregation Directive established policy and procedures for ICE review of detainees placed into segregated housing, including collaborative assessments by detention facility administrators and Field Office supervisory-level staff. In 2016, ICE revised Standard 2.12 Special Management Units to incorporate requirements from the Segregation Directive, including the requirement that the facility notify the Field Office of detainees held in the Special Management Unit (also referred to as Restricted Housing Units or RHU) continuously for 14 days, and immediately in the case of detainees with specified conditions and vulnerabilities. Additional changes were made to Standard 2.12 and Standard 3.1 Disciplinary System, to incorporate recommendations by the US DOJ as directed by a 2016 Presidential Memorandum.<sup>54</sup>

**Administrative Segregation.** “Administrative segregation status is a *nonpunitive* status in which restricted conditions of confinement are required only to ensure the safety of detainees or others...” PBNDS 2.12.V (emphasis added). The conditions of detention for people in general population and in administrative segregation should therefore be as similar as possible, taking into account operational needs. Moreover, administrative segregation should be used for the purpose of protecting detainees with special vulnerabilities only as a last resort.

Under the standard, the assignment of any detainee to protective custody shall be reviewed by a supervisor no later than 72 hours after placement, and again in 7-day intervals during the first month should the assignment last that long, and every 30 days thereafter. **However, unlike disciplinary segregation, administrative segregation may be indefinite; Cal DOJ found a detainee at Imperial who had been in administrative segregation for protective custody for 377 days.**

**Disciplinary Segregation.** Detainees can be placed in disciplinary segregation only after a finding that they are “guilty of a prohibited act or rule.”<sup>55</sup> Rules are classified as “greatest offense,” “high,” “high moderate,” or “low moderate.”<sup>56</sup> Each category has a range of authorized sanctions for violations. Rule violations can vary from assault (greatest offense) to making sexual proposal or threat (high offense) to refusing to clean assigned living area (high moderate) to feigning illness (low moderate).<sup>57</sup> PBNDS generally limits disciplinary segregation placement to 30 days per violation; to hold a detainee longer than that, the facility must send written justification to the ICE Field Office Director.<sup>58</sup> If a detainee is charged with multiple prohibited acts and receives multiple sanctions, those can be served concurrently.<sup>59</sup> However, Cal DOJ found all three facilities often imposed penalties consecutively, thus elongating a detainee’s placement in disciplinary segregation.

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<sup>54</sup> 81 Fed. Reg. 11995 (March 7, 2016).

<sup>55</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part II, §5, p. 171.

<sup>56</sup> ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, §C, p. 217.

<sup>57</sup> See ICE, PBNDS 2011, Part 3.1 Disciplinary System, Appendix 3.1.A: Offense Categories, pp. 224-227.

<sup>58</sup> ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, §K, p. 222.

<sup>59</sup> *Ibid.*

**At all three comprehensively reviewed facilities, Cal DOJ found the conditions for detainees in administrative segregation to be just as harsh, or nearly as harsh, as for those detainees in disciplinary segregation.** Although disciplinarily and administratively segregated detainees must not comingle, they are frequently placed in the same housing unit, separated solely by their assigned cell or adjoining recreation cage. The practice of combining these disparate populations creates unnecessary and impermissibly harsh conditions for all detainees in administrative segregation, many of whom are in protective custody and some of whom are involuntarily and indefinitely assigned. Adelanto was the exception with a separate male administrative segregation unit. **Cal DOJ also observed that all three facilities housed detainees with serious mental health conditions in RHU despite the isolation of segregation worsening the detainees' conditions. Further, Cal DOJ determined all three facilities impermissibly house female detainees in restrictive housing under conditions disparate to those of male detainees.**

### **A. Lack of Differentiation Between Administrative and Disciplinary Segregation**

At each of the three comprehensively reviewed facilities, detainees in protective custody were confined to their cells about 22 hours a day and used the same recreation cages as are used by detainees who are being punished in segregation. Detainees in administrative segregation were generally isolated and offered little or no out-of-cell time similar to detainees in disciplinary segregation.

**Adelanto.** At Adelanto, male detainees assigned to RHU recreate in cages in the enclosed outdoor area adjacent to the unit for one hour daily. Some of the protective custody detainees were given access to the large recreation field for one or two hours a day. Cal DOJ was told that cell doors in the administrative segregation housing units remain unlocked throughout the day; but everyone was in their cells during our tour.

**Imperial.** At Imperial, all RHU detainees generally remain in their cells for 22-23 hours per day. Only a few were able to go out for an additional hour in the recreation yard. One detainee reported that he does not go to the small recreation cages because *"they just throw you in another cage, isolated."* Other than recreation, court, and medical appointments, detainees make phone calls, shower, eat, sleep, and use bathroom facilities in their cell. They may leave their cell, one at a time, to use the tablet designated for videoconferencing.

**Otay Mesa.** Otay Mesa's RHU includes U.S. Marshals and ICE detainees in both administrative and disciplinary segregation—four categories of detainees that cannot comingle. Women in segregation are placed in a four-cell unit that is separated from U.S. Marshals women detainees with a chain link fence. Detainees in administrative segregation are offered one hour of out-of-cell time beyond the one hour of outdoor recreation time afforded detainees who are being disciplined. Detainees in protective custody may spend 22 hours a day in their cell for many months, isolated even when they are released to exercise or watch television from the inside of a chain link fenced section of the common area.

Cal DOJ understands that detention facilities may not release detainees of different designations at the same time. However, Cal DOJ's corrections expert noted, that this requirement should not be so narrowly construed as to prevent administratively segregated detainees from socializing outside of their cells in the recreation or common areas together.<sup>60</sup> At Otay Mesa, designating a housing unit for ICE detainees in protective custody may be necessary to allow for such greater liberties.

## **B. Mental Health Concerns Related to Restricted Housing**

PBNDS requires that medical and mental health staff evaluate a detainee prior to placement in RHU; this review must include whether the detainee has been previously diagnosed with a serious mental health condition. Where a concern exists, a healthcare professional must "conduct a complete evaluation."<sup>61</sup> PBNDS also has a clear prohibition on placing detainees with serious mental health conditions in RHU solely on the basis of that condition.<sup>62</sup>

At **Imperial**, mental health staff do not approve detainee placement in RHU and are unaware of their authority, per PBNDS and MTC policy, to intervene or recommend against RHU placement. At **Adelanto**, before detainees are placed in RHU, they do undergo a medical evaluation; it is usually done by a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN) who then signs off on the RHU placement. At **Otay Mesa**, mental health staff frequently sign off on placement in segregation despite detainees' significant mental health challenges.

Once a detainee with a mental health condition is placed in segregation, they are less likely to receive the critical care they need and that they were already not being provided in the general population. They are also more likely to decompensate, despite PBNDS requiring more mental health check-ins than provided to detainees in general population. **Across all three facilities, Cal DOJ's mental health expert noted that RHU is used to house detainees with mental health conditions who inevitably deteriorate in isolation. This deterioration can lead to increased severity of symptoms, suicidal ideation, or self-harm.** PBNDS requires healthcare staff to make daily face-to-face contact with detainees to check on their physical and mental well-being. Although the check-ins do occur at the three reviewed facilities, these check-ins do not promote the building of clinical relationships because they are brief, do not allow use of the language line, and do not afford the privacy for confidential conversations. PBNDS requires facilities to provide "out-of-cell time, confidential psychological assessments and visits for detainees whenever possible, to ensure patient privacy and to eliminate barriers to treatment."<sup>63</sup> This is not something Cal DOJ's mental health expert saw at any of the three facilities. Moreover, PBNDS states that if medical staff determines that RHU placement has resulted in deterioration of the detainee's mental health, the detainee is to be

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<sup>60</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, §L, p. 181 ("[D]etainees in administrative segregation may be provided opportunities to spend time outside their cells...for such activities as socializing...").

<sup>61</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part II, §7, p. 172.

<sup>62</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part II, §8, p. 172.

<sup>63</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, §P, p. 182.

removed from RHU if an appropriate alternative exists.<sup>64</sup> Throughout the three facilities, Cal DOJ's mental health expert witnessed the opposite happening. **Detainees who were suffering from a mental health condition were housed in RHU because staff felt it was the best place for them despite some detainees reporting that the isolation worsened their symptoms.**

### C. Women Subjected to the Restrictive Housing Unit

Restrictive housing for women is far more severe than it is for men at all three facilities. At **Adelanto**, a women's general population unit and RHU are located in the same housing area. The two-story unit includes a top level with open bay bunk beds for the general population and a first floor dayroom area with cells in the far back which include cells for administrative segregation and a caged off section for disciplinary segregation cells. Having RHU in a general population unit limits all women's access to phones, recreation, and the dayroom. In interviews, GEO Group staff suggested that the facility could improve upon the treatment of women in administrative segregation by giving them more dayroom time. At **Imperial**, the women's RHU consists of two or three cells, caged off, within the male RHU unit. At **Otay Mesa**, the women's segregation unit is a dark, caged off portion of the high security general population unit that houses both ICE and U.S. Marshals detainees. Since the two populations cannot comingle but must use the same common spaces, ICE detainees have very limited dayroom and recreation time.

**Regardless of whether segregated detainees—men or women; administrative or disciplinary—are housed in a separate restrictive housing area or are collocated with other custody levels, the lack of recreation, exercise, and socialization is severe. Most detainees in segregation are in their cells for 22 hours a day and when they are allowed outside they are generally recreating in individual cages.**

Given the severe restrictions faced by detainees in RHU, PBNDS requires facility management to convene a multidisciplinary committee that meets weekly to review segregation placements. During these meetings, the committee should "ensure all staff are aware of each detainee's status, current behavior, and physical and mental health, and to consider whether any change in status is appropriate."<sup>65</sup> **Otay Mesa** and **Imperial** conduct these weekly multidisciplinary meetings. Meeting participants at Otay Mesa were provided a list with each detainee's circumstances and detainees had an opportunity to engage with leadership about their housing assignments, but at Imperial the discussion failed to review each detainee in the detail required by PBNDS. Indeed, Cal DOJ's corrections expert witnessed a mental health staff member who attended the weekly RHU meeting at Imperial and was unaware that a detainee in RHU had attempted suicide.

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<sup>64</sup> *Ibid.*

<sup>65</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, §A(3), pp. 176-177; ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, §B(3), p. 178.



### 3. Language Access

Language access affects a detainee’s experience within a facility from the moment they arrive to the moment they leave. In a variety of contexts throughout the PBNDS, language access requirements are emphasized as follows:

“[t]he facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP)...The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities...All written materials provided to detainees shall generally be translated into Spanish. Where practicable, provisions for written translation shall be made for other significant segments of the population with limited English proficiency...Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate.”<sup>66</sup>

English is not the primary language for a great number of individuals in immigration detention. Each of the three comprehensively reviewed facilities vary in the proportion of bilingual staff—and the languages of bilingual staff is not tracked at any facility, except for a medical staff roster Cal DOJ observed at Adelanto, which listed staff’s spoken languages. **Moreover, bilingual staff at each of the facilities tend to only speak English and Spanish. This presents a particularly significant problem when, for example, 30 to 40 percent of a facilities’ population may speak Punjabi, as was the case at Imperial in June 2019.** While many of the non-English speaking detainees speak Spanish, Cal DOJ also conducted interviews in Punjabi, Mandarin, Russian, Bangla, Pulaar, Arabic, Armenian, Farsi, French, Tigrinya, and Portuguese. As discussed below, all three facilities have been unsuccessful in meeting detainees’ language access needs.

#### A. Language Barriers at Intake and Classification

The failure to meet detainees’ language needs begins with intake and classification where a detainee is oriented to the facility. PBNDS requires translation services be used during this process when necessary. While staff at each of the three facilities claimed they could use translation services to teach detainees the rules of the facility, detainees Cal DOJ interviewed at Adelanto and Imperial did not report that staff used the language line to orient them. At Otay Mesa, six detainees who did not read English or Spanish reported that an officer used the language line to explain the rules of the facility to them, but—based on their lack of awareness of basic rules and processes—it is clear that even when this additional step is taken, it is insufficient to fully orient detainees. At all three facilities, detainees unable to understand English or Spanish reported that they were unable to fully understand the facilities’ orientation videos.

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<sup>66</sup> ICE, PBNDS 2011, Part 2.1 Admission and Release, Part II, §9, p. 49.

PBNDS also requires that facilities distribute an ICE Handbook and facility-specific handbook. At each of the three facilities reviewed, facility handbooks are available only in English and Spanish. Although ICE handbooks are published in some additional languages, it is not always available in those languages according to detainee reports. For example, at least three detainees at Adelanto reported receiving English handbooks, but they only understood Punjabi, Russian, or Mandarin; others received Spanish handbooks but they only understood Punjabi.

Most detainees who could not read the handbook themselves learned the rules from other detainees. At Otay Mesa, the facility makes a point of housing together detainees who speak the same language for the detainees' benefit, and it is clear the facility also relies on detainees to translate for each other. **If, however, a detainee does not find another detainee who speaks the same language as they do, then they are left to learn the rules by trial and error. As a result, detainees may face disciplinary action due to their unfamiliarity with rules, and understandably perceive this discipline as arbitrary, abusive, and discriminatory. For example, at Otay Mesa, seven of the nine Chinese language-speaking detainees interviewed by Cal DOJ were unaware of basic features of the facility, such as the grievance system, mental health services, and programming opportunities.** Three minority language speakers also described being disciplined or yelled at by detention staff because they did not understand instructions or were unaware of rules.

## **B. Limited Availability of the Language Line**

All three facilities have contracts with companies that provide language lines so that staff may communicate with detainees. Generally, medical and mental health staff use the service more often than detention staff. However, medical staff only use the language line once they are in a medical examination room and not when conducting pre-visit procedures like taking a detainee's height, weight, and blood pressure, or during pill call or wellness checks for detainees in segregation. The implementation and frequency of use of the language lines varies across facilities:

**Adelanto.** Language lines are available in the intake and medical areas, and also accessible through the attorney visiting room. However, supervisor approval is required to access the language line outside these areas. Most detention officers reported using the language line two or three times, or not at all, during their 3-5 year tenures. Detention staff also reported using hand signs and utilizing other detainees or bilingual officers to assist as needed; there is currently no policy in place prohibiting the use of detainees as translators when conducting official business. Cal DOJ observed staff wearing several laminated cards on lanyards, one of which had country flags to interact with detainees with whom staff was unable to communicate in English or Spanish. The facility's use of the language line was also limited—the most recent bill provided for the language line was December 2018 for 1,841 calls, about one per detainee per month, in a total of 34 languages.

**Imperial.** The language line is not available to detention staff in the housing units. Consequently, detention officers rely on hand gesturing or other detainees to translate for non-English and non-Spanish speaking detainees. Detention staff are trained to use language line services only for "official correspondence," such as disciplinary panels, PREA-related communication, and investigations.

When needed, the housing unit detention officer must call for a supervisor to take the detainee out of the housing unit to an office in order to use the language line. Because language lines are not located in the housing units and only supervisors are trained to use this service, language lines are not a viable means of affording detainees timely, confidential, or reliable translation assistance to communicate with detention personnel and others, thus undermining PBNDS requirements.

**Otay Mesa.** The language line is regularly used during the intake process and for medical appointments, and it is available in the unit management offices in each housing unit. Despite this easy access and significant need, among the nine minority language speaking detainees who discussed the language line with Cal DOJ, three had been afforded the opportunity to use the language line, three had requested use of the language line to communicate with facility staff and been denied, and three had not made any request. Although unit management staff use the language line to resolve issues with detainees, detention officers rarely do. Detention staff interviewed by Cal DOJ most often said that they used hand gestures or utilized other detainees to overcome language barriers. **Several staff who did not regularly utilize the language line stated that language barriers have an impact on their jobs and services, and they provided several suggestions for addressing the challenge, such as: providing the detainee handbook in more languages; making hand-held translation devices available to staff, especially for medical emergencies; and making language instruction available to staff.**

### C. Language Barriers Exhibited Through Different Aspects of Detainees' Conditions of Confinement

**Programming.** When educational or community based programming is available to detainees, it is often only offered in English and sometimes in Spanish, but no other languages. This means that many of the detainees cannot take advantage of the few opportunities available to help them. This is the same with respect to religious services across the three facilities. Moreover, the majority of the leisure reading material at all three facilities is in English with a limited selection in Spanish. Being unable to engage in activities or speak to anyone in the facility can be isolating. Two Chinese language-speaking detainees at Otay Mesa also conveyed that they were not able to work in the facility because they did not speak English and could not understand what was being said.

**Posting and Signs.** At the time of Cal DOJ's comprehensive site visits, the three facilities did not routinely provide or post required notices and essential communication in the population's primary languages. At all three facilities, posted signs in the housing units were limited to English and Spanish, and sometimes, only in English.

**Legal Materials.** PBNDS requires detainees get meaningful access to a law library (electronic legal research) and other legal materials (paper publications) to prepare for immigration proceedings.<sup>67</sup> The facility may additionally provide published legal material submitted by outside organizations.<sup>68</sup>

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<sup>67</sup> ICE, PBNDS 2011, Part 6.3 Law Libraries and Legal Material, pp. 421, 423.

<sup>68</sup> *Id.* at p. 424.

Legal materials available to detainees at the three facilities were largely only available in English, and, to a lesser extent, Spanish. Detainees are often left to prepare for immigration cases pro se (on their own) and are expected to learn immigration law applicable to their cases through an electronic legal database called LexisNexis, which is provided by ICE to be updated into the facilities' law library computers. The LexisNexis interface is difficult to use, especially because it is only available in English and, to a lesser extent, in Spanish. Detainees may also access the American Bar Association's Know Your Rights Presentation in multiple languages on the computer, but this resource may be difficult to find, depending on how the facility's computers are configured. For example, at Otay Mesa, Cal DOJ staff found the Know Your Rights materials clearly available on the desktops of some computers, but harder to find within folders on other computers. PBNDS requires no legal reference books to be made available to detainees in any language other than English, except for an English-Spanish legal dictionary.<sup>69</sup> Detainees may receive legal orientation programs (LOP) through contracts between nongovernmental organizations and US DOJ's Executive Office of Immigration Review (EOIR).<sup>70</sup> LOP is not available at every facility and are generally limited to English or Spanish speaking detainees.

**Medical Requests.** Medical request forms and grievances are only available in English and Spanish, with the exception of Imperial, where there are French and German translations available through a tablet. This often results in a lack of medical privacy for detainees who need to seek language assistance from staff or other detainees to request medical services.

## **D. The Facilities Fail to Track Detainees' Primary Language**

**None of the three facilities track detainee's primary language despite using ICE's Custody Classification Worksheet during intake, which has a place to indicate a detainee's primary and secondary languages. Indeed, in the review of detention files, Cal DOJ's corrections expert found that no detainee's Worksheet at any of the three facilities was completed with language information.** This information could easily be collected during intake, communicated to custody staff, and listed on detainees' identification cards.

Although the detainee handbooks indicate, and PBNDS policy requires, that detainees with limited English proficiency receive language assistance from the facility—including bilingual staff, professional interpretation, and translation services—in practice, detainees must largely make do without such assistance. Failure to overcome these language barriers results in detainees being unaware of critical information; staff misunderstanding detainees' concerns and positions; and staff having heightened difficulty managing emergency situations.

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<sup>69</sup> See ICE, PBNDS 2011, Part 6.3 Law Libraries and Legal Material, Appendix 6.3.A: List of Legal Reference Materials for Detention Facilities, pp. 429-433 (a list of all required legal material that shall be provided to detainees).

<sup>70</sup> ICE, PBNDS 2011, Part 6.4 Legal Rights Group Presentations, Part V, §D, p. 437.

# Comprehensive Facility Review: Adelanto ICE Processing Center

## 1. Background and Summary of Key Findings

The Adelanto ICE Processing Center, located in Adelanto, California, is owned and operated by GEO Group. In December 2019, ICE entered into a new direct contract with GEO Group running through 2024, with the option for two five-year extensions. The new contract expanded Adelanto's total bed capacity from 1,940 to 2,690 by adding as an annex, the former California prison, Desert View Modified Community Correctional Facility. In its fiscal year 2021 budget justification, ICE reported that it pays \$124.10 per bed per day for a guaranteed minimum of 1,455 beds, and \$44.18 for additional beds.<sup>71</sup> The 2011 PBNDS, with 2016 revisions, apply to Adelanto.

**Table 5. Key Data Points, Adelanto.**

<b>Facility:</b>	Adelanto ICE Processing Center
<b>Operator:</b>	The GEO Group, Inc.
<b>Housing Detainees Since:</b>	2011
<b>Bed Capacity:</b>	1,940 - Main Facility 750 - Desert View Annex
<b>Type(s) of Detainees:</b>	Male and Female Adults
<b>Snapshot of Detainees Housed at Adelanto on August 7, 2019</b>	
<b>No. of Countries of Origin:</b>	79
<b>No. of Detainees by Gender:</b>	Women: 219 Men: 1,464
<b>Average Length of Stay:</b>	120 days
<b>Longest Detainee Stay:</b>	1,378 days

<sup>71</sup> ICE, Dep't of Homeland Security, Budget Overview Fiscal Year 2021, Congressional Justification, p. 137, <[https://www.dhs.gov/sites/default/files/publications/u.s.\\_immigration\\_and\\_customs\\_enforcement.pdf](https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf)> (as of Oct. 29, 2020).

Cal DOJ faced challenges gaining the same level of access to Adelanto compared to other facilities it has reviewed. Nonetheless, Cal DOJ made the following key findings:

- Adelanto's staff fail to coordinate and communicate between different operational areas, with individuals carrying out their own tasks without an understanding or knowledge of what other staff does and therefore hindering its ability to deliver services to detainees. For example, it took three different interviews to get basic information about transportation; the chief of security could not speak about discipline because it was not his area; and the person responsible for discipline is not involved in security re-classification following release from restricted housing;
- The facility's compliance with PBNDS focuses more on meeting timelines and completing forms than on the underlying purpose and intent of the respective standard, which leads the facility to provide detainees with the bare minimum of services required by ICE's detention standards. For example, the facility offers some religious services but no leisure or educational programs;
- The facility's intake and security classification system fails to identify and address the health and safety needs of particularly vulnerable detainees. For example, the facility fails to acknowledge that it houses transgender detainees, thereby failing to provide for the safety and health needs of transgender detainees;
- Detainees face significant barriers to obtaining the materials and assistance they need for their immigration cases. For example, Adelanto fails to comply with the PBNDS requirement that facilities maintain up-to-date law library materials.<sup>72</sup> As of August 6, 2019, the legal materials found in the facility's law libraries were significantly outdated with the most recent materials dated November 2017. The failure to provide updated legal materials is particularly concerning because the majority of immigration detainees are not represented by counsel, and therefore, rely on resources available at the facility in order to represent themselves in immigration court;
- Cal DOJ found concerning issues during the curtailed review of Adelanto's healthcare system: (1) patient confidentiality is compromised by including medical and mental health history details in detainee custody detention files; (2) patient chronic care is managed by a registered nurse and not contained within the rest of the patient's medical records in the facility's electronic records system; and (3) while approximately 20 percent of the detainee population receives mental health services, the facility is understaffed, offers no meaningful therapy services, provides delayed care, and fails to adequately handle detainees placed in suicide watch, among other issues; and
- A significant number of detainees with a mental health condition are placed in restricted housing where their condition worsens.

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<sup>72</sup> ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §E(2), pp. 423-424.

## 2. Methodology and Limitations

Cal DOJ faced numerous obstacles conducting its review of Adelanto and was unable to complete its review, particularly with respect to detainees' access to medical care. Gaining access to the facility took almost two years. In late 2017, Cal DOJ requested a one-day site visit, which GEO Group declined based upon ICE's objection. In 2018, Cal DOJ requested a multi-day site visit and the opportunity to interview detainees. ICE, however, only allowed for a one-day visit on September 10, 2018, with no interviews. After extensive negotiations, Cal DOJ conducted a one-week site visit at Adelanto on August 5 through 9, 2019. Less than a week before the site visit was scheduled, GEO Group attempted to severely limit certain aspects of Cal DOJ's review, particularly regarding detainee interviews and access to healthcare files for review. GEO Group's counsel provided Cal DOJ with an 11-page document that governed, and limited, what Cal DOJ could do during its site visit. Negotiating deviations from the schedule took hours during the site visit and hindered Cal DOJ's substantive review.

Cal DOJ staff who attended the August 2019 site visit included five attorneys, two research assistants, a special agent, an analyst, and a law clerk, accompanied by a corrections expert, a medical expert, a nursing expert, and a mental health expert. Staff rotated their time on-site during the visit.

**Facility Tour.** The site visit commenced with a facility tour, on August 5, 2019, in which GEO Group attempted to limit Cal DOJ's access to housing units, the East side of the facility, and the kitchens. A tour of the East side of the facility occurred after the main tour concluded and only upon Cal DOJ's insistence. The team was denied a kitchen tour during the general facility tour, but it was later provided to Cal DOJ's correctional expert on August 7, 2019. GEO Group did not allow any interaction with detention officers, healthcare staff, or detainees during the tour. GEO Group did not allow Cal DOJ to take photos, but instead assigned a GEO Group staff to take photos. GEO Group only provided print copies of the photos. No other facility has limited Cal DOJ's initial tour in this manner.

**Staff Interviews.** Interviews of detention leadership and rank-and-file staff occurred from August 5 through 8, 2019, and healthcare leadership on August 5 through 6, 2019. Counsel for GEO Group and Wellpath Management, Inc., the facility's healthcare provider, were present at each interview. Most high level facility staff treated interviews as adversarial depositions, provided little substantive information, and generally reported no issues with the facility.

**Detainee Interviews.** Unlike other facilities, GEO Group limited detainee interviews to no more than three concurrent interviews at a time and only between 9:00 am-10:30 am and 1:00 pm-4:30 pm. Despite Cal DOJ providing detainee sign-up sheets 25 days prior to the visit, GEO Group did not post sign-up sheets for detainees to volunteer to speak with Cal DOJ until the evening of August 5, 2019. Despite previously having agreed to provide a detainee roster upon Cal DOJ's arrival, GEO Group did not do so until the evening of August 7, 2019, thereby limiting Cal DOJ's ability to interview a representative sample of the detainee population. Initially, Cal DOJ staff had to rely on documents previously produced by GEO Group, including a prior detainee roster and facility logs, to identify detainees to interview.

Cal DOJ staff and experts were only able to interview 53 detainees—10 females and 43 males. The corrections expert interviewed seven detainees; the mental health expert interviewed four detainees; and the medical and nursing experts conducted no detainee interviews. Cal DOJ staff interviewed 42 detainees, but given time limitations imposed by GEO Group, only asked priority questions.<sup>73</sup> Detainees interviewed came from 18 countries and spoke English (26), Spanish (18), Punjabi (6), Mandarin (2), and Farsi (1). On average detainees interviewed were 37 years old (ranging from 18 to 59 years of age), and had an average length of stay of 286 days (ranging from 5 days to 961 days).

**Detention File Review.** Cal DOJ gained access to many of GEO Group’s records only after serving an administrative subpoena in August 2018, pursuant to Government Code section 11180.<sup>74</sup> Thereafter, GEO Group produced additional documents without a subpoena. GEO Group specifically produced files, including facility logs, which Cal DOJ and experts analyzed prior to the visit. During its visit, Cal DOJ requested complete detainee files including any disciplinary, PREA, use of force, and grievance files, as applicable. Staff struggled to gather all the pertinent documentation, reporting that the facility does not maintain complete physical detainee files but instead maintains portions of detainee files in different locations. Ultimately, Cal DOJ’s expert reviewed 25 detainee files.

**Healthcare File Review.** GEO Group refused to provide Cal DOJ access to healthcare files without each individual detainee’s prior written consent (something that GEO Group does not require of other inspectors), severely limiting our medical expert’s ability to complete his review. Cal DOJ’s medical expert, and his nursing expert, were scheduled to complete their review between August 5 and 6, 2019, which, based on their prior experience, they determined would be sufficient for the size of the facility. On the afternoon of August 5, 2019, GEO Group instructed Wellpath to provide Cal DOJ’s healthcare experts with four logs with no names or substantive information. Without any substantive information, Cal DOJ’s medical and mental health experts were forced to randomly select entries from the logs, which Wellpath would then use to seek detainees’ written consent for file review. Wellpath, however, did not start attempting to obtain detainee consent until the morning of August 6, 2019. The consent process was aborted, midday on August 6, 2019, when ICE provided GEO Group with written consent to give Cal DOJ’s medical and mental health experts access to review healthcare files.

**Nursing Observations.** Observations by the nursing expert were severely limited. Initially, Wellpath refused to allow the nursing expert to observe nurses’ medical encounters with detainees inside the room, instead instructing him to observe through a window outside the room. When Wellpath and GEO Group finally agreed to ask detainees if they consented to the nursing expert’s observation, Wellpath’s counsel insisted on also being in the room and refused to allow the nursing expert to ask follow-up questions from nursing staff once the medical encounter was complete.

After the visit, Cal DOJ requested a follow-up visit so that the medical expert could complete his review. GEO Group declined the request.

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<sup>73</sup> See *Methodology*, p. 11. Out of the 72 questions prepared by Cal DOJ, only 21 priority questions were asked to detainees at Adelanto.

<sup>74</sup> Due to confidentiality limitations, this report does not discuss information and documents obtained pursuant to the subpoena.



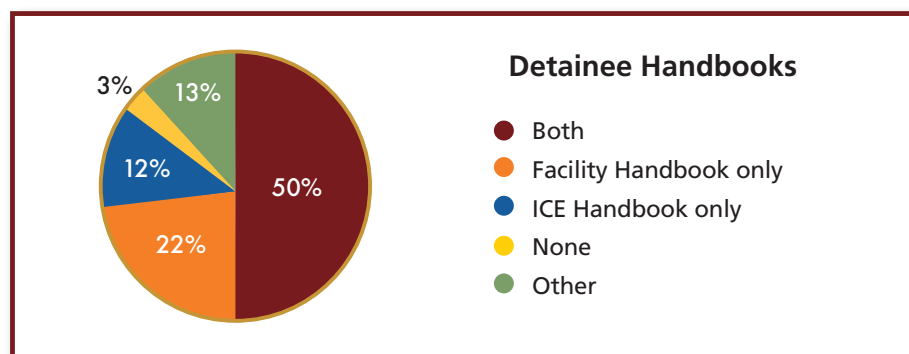
Some of Cal DOJ's findings are also informed by an attorney survey administered by Cal DOJ's Research Center. Thirty-three attorneys who had represented an estimated 195 clients at Adelanto between July 1, 2018 and June 30, 2019, responded to Cal DOJ's attorney survey.<sup>75</sup>

### 3. Conditions of Confinement at Adelanto

#### A. Intake and Orientation

Detainees entering and departing the facility, including for external appointments, are processed through the intake area. The facility maintains minimal staffing in intake and calls in off-duty intake staff upon notification of large groups of arriving and/or departing detainees. An orientation video plays in the holding cells but was barely audible during Cal DOJ's tour. Intake staff explained that the video mostly consists of slides in English and Spanish. Detainees interviewed by Cal DOJ staff were asked whether they had received the facility and ICE handbooks.<sup>76</sup> As illustrated in **Figure 14**, half of detainees (20 out of 40) reported receiving both handbooks, twenty-two percent (9) reported they only received the facility handbook, and twelve percent (5) indicated they only received the ICE handbook. Five detainees reported receiving an updated facility handbook a few days before Cal DOJ interviews. Detainees who do not speak English or Spanish reported not understanding the facility handbook. For example, Russian and Chinese speaking detainees requested ICE handbooks in Russian and Mandarin, respectively, but were told the facility did not have any. As detainees reported, the facility primarily relies on other detainees to orient new arrivals.

**Figure 14. Reported Handbooks Received by Interviewed Detainees, Adelanto.**<sup>77</sup>



<sup>75</sup> Please note, for each question included in the attorney survey, there were instances in which attorneys indicated questions were not applicable to them or in which they did not provide comments regarding their experience. In our discussion of this data, we will indicate the number of attorneys who provided comments for specific questions or topics in parentheses.

<sup>76</sup> Two out of the 42 detainees were not asked these questions due to time constraints.

<sup>77</sup> The 'Other' category refers to detainees who either did not recall if they received the handbooks (1 total) or who reported receiving either an Adelanto handbook or an ICE handbook, but were not asked whether they had received the other type of handbook (4 total). One detainee reported they did not receive either of the handbooks.

### **(i) Security Classification, Special Vulnerabilities and Management Concerns**

At intake, detainees are assigned a security classification level and are supposed to be screened for any special vulnerabilities or management concerns, which impacts housing assignments and movement around the facility. Cal DOJ found issues with Adelanto's security classification system, as discussed in *Systemic Issues, Section 1*.

**Transgender Individuals.** According to the facility, it does not house transgender detainees. Facility staff reported that if a detainee self-identifies as transgender, the detainee will be housed in the medical unit until ICE can transfer them to another facility. However, during its site visit, Cal DOJ met two transgender detainees and received reports of at least 15 more transgender detainees housed at Adelanto.

## **B. Housing Units**

### **(i) General Population**

In August 2019, Adelanto was comprised of two buildings—East and West. Women were housed in the East building and men were housed in both buildings. Each building has a kitchen, a library, a medical area, and immigration courtrooms.

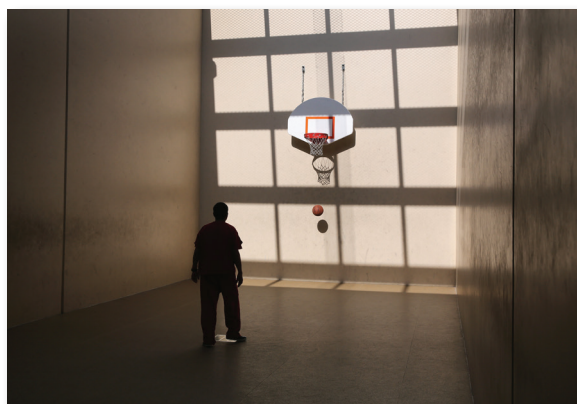
The East building is older. Its general population housing units are divided in four parts, two on each level, with 12 double bunks in each part. Each unit includes communal toilets and showers, and a dayroom. Women were housed in three low/medium-low security general population units and one mixed-use unit for restricted housing and medium-high/high security detainees. The remaining housing units in the East building housed low and medium-low security men in barracks-style general population units. Detainees in the East building eat their meals inside their housing units.

The newer West building's housing units have two- to eight-person cells, each of which has a toilet and sink. There are communal showers for each unit. Four of the West modules—divided into four units each—house men in the general population. Each module has two indoor recreation yards shared by the units. General population detainees in these modules rotate through one of four dining halls for their meals, three times a day. The fifth West module serves as restrictive housing for male detainees, and the sixth housing module is a medical unit that serves detainees from both the East and West buildings. One of the West general population units operates as a stepdown/in-between protective custody unit for some male detainees who were previously assigned to the restricted housing unit for disciplinary or administrative segregation, but do not want or are not able to return to general population. There were 31 medium-high/high detainees in that housing unit during the week of Cal DOJ's visit.

General population detainees' access to recreation yards varies by housing unit and gender. Facility schedules showed that: (1) in the West building, men have access to a small yard (**Figure 15**) six hours a day and a big yard four times a week for two hours; (2) men in the East building have access to a small yard 1.5-3 hours every day, and the large yard three times per week for two

hours; and (3) women have access to a small yard 1.5-3 hours, five days a week, and the large yard three times per week for two hours.

**Figure 15. Men’s Recreation Yard in West Building, Adelanto.**



Getty Images

Detainees are issued clothing, bedding, a plastic cup, and personal care items at intake. Cal DOJ was unable to inspect showers in each housing unit but received detainee complaints about the shower water being too hot in some of the housing units, and reports of mold and worms in the showers being eradicated just prior to Cal DOJ’s inspection.

**(ii) Restricted Housing Units**

Restricted housing for women consists of five administrative segregation cells and three disciplinary segregation cells that are separated by fencing. The men’s RHU has two-person cells and is divided into two separate units—a 64-bed disciplinary unit and a 48-bed administrative segregation unit. Depictions of the men’s RHU are illustrated in **Figures 16** and **17**.

**Figure 16. Use of Telephones at Men’s Restricted Housing Unit, Adelanto.**



Getty Images

**Figure 17. Men’s Restricted Housing Unit, Adelanto.**

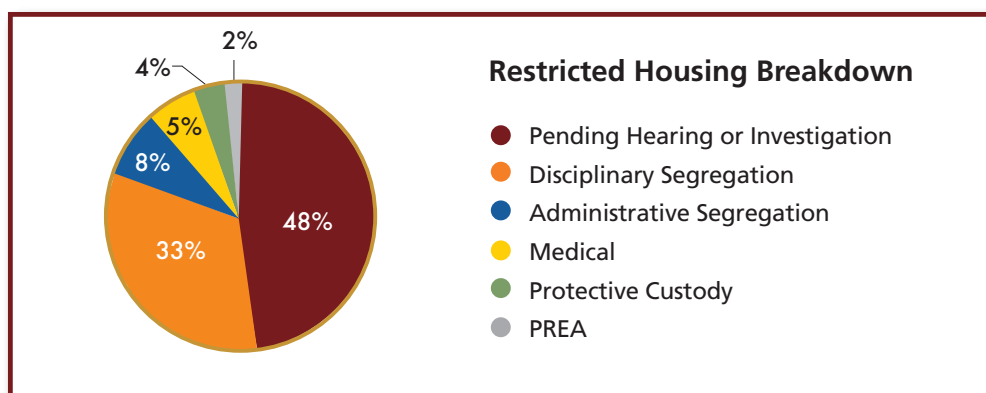


Getty Images

Detainees may be held in administrative segregation at Adelanto based on the detainee’s own request or at the facility’s initiation; based on voluntary or involuntary protective custody due to past or present gang affiliation or criminal history; pending a disciplinary investigation or hearing; pending a PREA investigation; for medical reasons including quarantine; or due to unavailability in general population housing. As of August 7, 2019, there were seven women in protective custody, 27 men in some form of administrative segregation, and nine men in disciplinary segregation.

Cal DOJ analyzed daily RHU logs from January 1, 2018, to June 20, 2019, which contained 1,101 separate RHU entries involving 569 detainees (**Figure 18**). On average, detainees spent 9 days in RHU, with the longest stay for disciplinary segregation being 58 days and then longest stay for protective custody being 283 days.

**Figure 18. Restricted Housing Breakdown by Segregation Status, Adelanto.**



As shown in **Table 6**, average length of stay varied by segregation status:

**Table 6. Segregation Status Summary based on Days in RHU, Adelanto.**<sup>78</sup>

Segregation Status	No. of Detainees	Average	Standard Deviation	Min-Max
Pending Hearing/ Investigation	527	3.47	2.12	0-12
Disciplinary Segregation	360	12.61	9.66	1-58
Administrative Segregation	94	12.80	31.78	1-276
Medical	58	12.09	10.20	0-37
Protective Custody	40	47.90	62.08	1-283
PREA	22	9.68	7.69	1-28
<b>Total</b>	<b>1,101</b>	<b>9.45</b>	<b>18.35</b>	<b>0-283</b>

<sup>78</sup> One disciplinary segregation case was not included in the calculations as it was unclear the amount of the sanction corresponding to the detainee’s disciplinary segregation or protective custody status.

Based on file review, Cal DOJ found that some detainees rotate through administrative and disciplinary segregation, such as one female detainee who was housed in RHU between early January and mid-August switching in status from protective custody, disciplinary segregation, and facility-initiated protective custody for being a security risk to self or others.

**Basis for Placement.** Disciplinary and detainee files contained little information from which to assess the basis for single or repeated placements in restricted housing. Disciplinary files lacked information identifying witnesses or describing evidence or investigative efforts. Documentation about protective custody assignments was similarly lacking. Adelanto did not appear to conduct reviews of RHU placements at the seven or fourteen day marks. cursory reviews every 30 days conducted by a “committee” of one did not document information about the basis for the placement in protective custody or rationales for its continuation. As noted above for all three facilities, Adelanto housed severely mentally ill detainees in restrictive housing and offered few liberties to detainees in administrative segregation beyond what is required for detainees in disciplinary segregation. See *Systematic Issues*, Section 2.

### C. Programming, Religious Practice, and Work Opportunities

**Programming.** Except for religious services and Zumba for women, Adelanto offers no programming to detainees. The Cal DOJ team observed Xbox game consoles and board games in some housing units but it was not clear how often they are available to detainees.

**Religious Practice.** Detainees observe their faith primarily by means of self-directed and group-led prayer, hair length and covering, religious texts, prayer rugs, religious objects (unless a specific item presents a security risk), and the religious diet. The facility also offers Christian, Catholic, and Jumah services, some in English, Spanish, and Mandarin. The facility’s chaplain recruits volunteers from the Roman Catholic, Christian, Sikh, Hindu, Muslim, and Jewish faith communities, and collects donations of religious materials.

Detainees can request religious diets. Kosher meals are available, but there is no halal menu. Muslim detainees who request a religious diet, and are approved, receive two Kosher meals and a vegetarian meal, daily. **For detainees requesting a religious diet, the chaplain conducts an interview to determinewhether a detainee has a “sincerely held belief” and tells detainees to re-interview in 30 days if he does not believe the detainee has a sincerely held belief.** There appeared to be no mechanism in place for a detainee to appeal or grieve a denial when the detainee failed “the integrity test.”

**Work Opportunities.** Detainees can volunteer to work in food service, dining hall, laundry, sanitation, as housing unit porters, and in general services, by submitting an application. High security detainees may only work in their housing units. The facility reported that detainees can have more than one position, but are only paid \$1 per day. The facility reported having 734 total positions and its May 2019 detainee payroll was \$12,499. If detainees are paid \$1 a day, that means an average of 403 detainees worked each day.

Cal DOJ interviewed 23 detainees who worked at the facility. Thirteen of these detainees reported issues with the work program. First, detainees reported their belief that unofficially, to be considered for paid work, detainees first have to volunteer for work without pay. For example, one detainee reported volunteering without pay for six months before getting a paid job. Second, at least five detainees reported working with or without pay for extra food. Third, nine detainees reported needing to submit “kites” (request forms) to get paid.

## D. Food and Nutrition

Detainees receive three meals a day, with detainees in the West building eating in dining halls (**Figure 19**). The West and East buildings each have a kitchen and prepare all the meals for their respective populations. The facility offers a multi-week, no-pork menu. **All food comes frozen, canned, or dried, and no fresh fruit or vegetables are served. Cheese is processed; eggs are powdered; and, except for chicken quarters offered once a week, all other proteins are ground or finely chopped.** The facility also provides a kosher diet, a vegetarian diet, and several medical diets. At the time of Cal DOJ’s visit, the food services manager estimated that 85 percent of the population received the regular meal. Of the fifteen detainees interviewed by Cal DOJ who reported requesting special diets, 12 received them, with turnaround times for approval taking up to two months.

Cal DOJ interviewed 31 detainees regarding the food served at Adelanto.<sup>79</sup> Twenty-eight detainees voiced concerns about the food served at the facility, with most reporting concerns about the lack of variety or restrictions (16), the quality (7), and the small portions (5) of the food served. Notably, those who reported concerns regarding the lack of variety or restrictions complained that beans are served frequently (5) and fresh fruits (6) and vegetables (3) are not served. Those concerned about the quality of the food mainly reported that the food is bland (5). The lack of fiber and solid proteins likely contributed to detainees’ complaints about always being hungry. At least three detainees reported supplementing their diets with items they purchased from the commissary when they could afford it.

**Figure 19. Dining Hall, Adelanto.**



Getty Images

<sup>79</sup> Eleven detainees were not asked this question due to time constraints.

Detainees interviewed reported they were cleaning the kitchen area through the night on Monday in preparation for Cal DOJ's kitchen tour. The kitchen tour occurred on Wednesday at 10:30 am and no food for that day's lunch was in sight. Detainees reported receiving a very late lunch on that day.

All food was raised off the floor, and food delivery and expiration dates were mostly visible. Food rotation, however, was uneven. Frozen foods with older expiration dates were found dispersed throughout the walk-in cooler and freezer. The shadow board containing all sharp-edged kitchen appliances, and corresponding logbook were in good order. The facility reported that it had created a position for a food compliance auditor.

## **E. Non-Legal Visitation, Telephone Calls, and Mail**

**Non-Legal Visitation.** Non-legal contact visitation is allowed for one hour, three times a week, with one of those times being on the weekend. This is appreciably less access than at many other detention facilities.

**Telephone Calls.** Each general population housing unit has phones in the common areas. Most phones tested during Cal DOJ's tour worked. The detainee handbook provides that telephone service is limited to the use of pre-paid accounts purchased through friends and family. Nine detainees reported, and detention officers confirmed, that phones are disabled when a large number of detainees are scheduled to be deported. General population women in the mixed restricted housing/general population unit reported that their phone use is restricted to times when females in restricted housing are not in the dayroom. Thirteen detainees reported disconnected lines or otherwise complained about the quality of the phone lines. Detention officers confirmed that sometimes the detainees' assigned PIN number does not work or they encounter other technical problems impeding their ability to place their calls.

**Mail.** All non-legal mail is delivered by a mail clerk on Monday through Friday and opened in front of the detainee. The detainee handbook provides that detainees may obtain paper and writing materials from the programs department and envelopes from the mail room. Indigent detainees with less than \$15 in their accounts can receive free stamps from the mailroom; however, at least one detention officer interviewed was unaware of any accommodations for indigent detainees. Mailroom staff reported that personal mail for detainees who are on the Security Threat Group's (STG) watch list is routed to STG for review prior to giving to the detainee, and, if it is a package, it is not delivered to the detainee but stored in the detainee's property.

## **F. Sexual Harassment and Abuse Prevention and Investigations**

The facility has a PREA Coordinator and a PREA Investigator. Those individuals maintain copies of the PREA Risk Assessment administered at intake, conduct detainee PREA re-assessments every 90 days, conduct pre-service and annual staff trainings, and investigate PREA allegations. PREA allegations are also investigated by the San Bernardino County Sheriff's Department.

Adelanto maintains two PREA risk lists of detainees. PREA staff reported monitoring individuals who are identified as having PREA-related special vulnerabilities. At the time of Cal DOJ's visit, 200 detainees were included in that list in order to monitor the appropriateness of housing assignments. The facility keeps a second list of detainees who identify as lesbian, gay, or bisexual and who the facility identifies at intake as being at risk of abusiveness or victimization. At the time of Cal DOJ's visit, the list included 57 individuals, none of whom was identified as transgender.

The facility's PREA Risk Assessment form administered at intake scores a detainee's risk for either abusiveness or victimization. Only those detainees with high enough scores are added to the risk lists maintained by PREA staff. For example, one self-identified LGBT detainee who identified as a victim of a prior sexual assault and as having a history of being subjected to domestic violence was not added to the PREA risk lists because the score on the assessment form was not high enough. The facility explained that the detainee was omitted from the facility's PREA lesbian, gay, or bisexual list because being LGBT does not automatically mean a detainee needs to be tracked for PREA purposes and, the lesbian, gay, or bisexual list itself is not required by PBNDS.

Cal DOJ reviewed PREA logs that included incidents reported from January 7, 2018, to June 11, 2019. The logs contained 30 incidents reported by 29 detainees. The majority of cases involved detainee-on-detainee allegations (23 out of 30), while seven cases involved staff-on-detainee allegations. None of the cases included in the log were substantiated and six cases had pending investigations at the time the logs were provided to Cal DOJ.

Cal DOJ's corrections expert reviewed six PREA files on-site. She noted that some investigations took a long time to complete. For example, facility staff reported that sometimes the Sheriff's Department takes from six months to a year to complete an investigation. Upon the conclusion of the investigation, detainees reportedly receive a form notifying them of the finding and sign an acknowledgement of receipt. The facility does not give detainees a copy of the Sheriff Department's report and only provides detainees with the report number so the detainee can request a copy.

## **G. Staff and Detainee Relations**

### **(i) Staffing, Overtime, and Training**

The facility's custodial workforce consists of: the facility administrator, deputy/assistant facility administrators, a chief of security, a captain, lieutenants, sergeants, and full time (40 hours) and part-time (32 hours) detention officers. The facility reported that detention staff receive three



weeks of pre-service training and one to two weeks of on-the-job training. One detention officer is assigned per shift to each general population housing unit regardless of those detainees' custody level. Most custodial assignments are fixed, not rotating. Sergeants are usually the most senior officer on-site during the second and third shifts, and on holidays and weekends. Cal DOJ's corrections expert found that senior and mid-level management and supervisory ranks were lean.

During staff interviews, Cal DOJ consistently noted that the custodial staff's knowledge about facility operations appeared to be very limited, focusing only on their areas of responsibility, without knowledge of other areas. For example, the facility has three areas responsible for transporting detainees: GEO Transport, Inc. (GTI) provides transportation to off-site immigration courthouses; the facility's intake unit provides transportation for scheduled off-site healthcare appointments and other, non-emergency healthcare needs; and the shift commander with detention officers provide transportation for unscheduled non-emergency and emergency medical transportation. They do not communicate with each other—this became clear when Cal DOJ had to interview individuals from all three areas of responsibility to obtain basic information about transportation because no one person was able to provide a full picture of how detainee transportation functions at the facility. Thus, while there is a pool of GTI vehicles, including vans and buses of various sizes, there is no centralized transportation coordination. The lack of coordination sometimes results in no vehicle availability, or the wrong type of vehicle available, for both anticipated or unanticipated trips. Cal DOJ also observed that staff seemed focused on meeting PBNDS timelines and ticking all the boxes rather than considering the purpose and intent of the PBNDS' requirements. For example, during interviews, frequent responses from management staff were, *"that is all that is required by PBNDS"* or *"that is not required by PBNDS."*

Supervisory staff would not discuss how frequently overtime is mandated or how many hours, on average, detention officers work per pay period. Detention officers, however, generally reported working long hours and feeling overwhelmed. The facility has few limitations on overtime, and custodial staff is routinely expected to work more than 40 hours a week. Some detention officers did report that the need to work overtime was decreasing.

## **(ii) Bunk and Cell Searches**

Detainees' bunks and cells are subject to random searches. The facility reported that shift supervisors select random cells/bunks to be searched and assign them to detention staff during shift briefings. The STG unit also conducts targeted searches if they have suspicions about specific detainees. The facility reported that personnel remove items if they do not fit in the detainee's property box, if the detainee has too much commissary, or if the facility perceives items as dangerous contraband. Twenty-eight detainees interviewed by Cal DOJ reported being subjected to bunk/cell searches, with seven of those reporting that officers moved or tossed their belongings without putting them back.

### **(iii) Use of Force**

Detention officers reported that no force is used on detainees without supervisor approval, unless there is an imminent threat to safety and a need for a “reactive” use of force as in the case of a suicide attempt. Cell extractions are performed by a Correctional Emergency Response Team (CERT), and only CERT members and supervisors are issued pepper spray. The facility does not use tasers. When confronted with detainee fights, detention officers reported calling the CERT team to respond.

Cal DOJ reviewed Adelanto’s use of force logs for incidents occurring from January 1, 2018, through May 6, 2019. The logs contained 52 separate incidents involving 46 different detainees, but did not include substantive information about what occurred, which staff members were involved, and/or whether any restraints were used. Six of those incidents were recorded as “calculated uses of force.”<sup>80</sup> Three incidents indicated that pepper spray was used during the incident.

*One detainee attempted to hang himself while on suicide watch and officers used pepper spray to contain him. Cal DOJ’s mental health expert identified a total of 7 use of force incidents out of 37 that involved detainees in mental health crisis.*

When asked about physical use of force, most (29 out of 33) interviewed detainees reported that detention staff had not physically abused them, however, four detainees did indicate that they had been physically harmed by staff. Of the detainees who were asked to specifically comment about their observations of the use of force (15), the majority (13 out of 15) reported witnessing staff physically hurting other detainees. Additionally, three detainees reported incidents where staff used pepper spray. Further, when asked about insults by staff, the majority (21 out of 36) of interviewed detainees reported that they had been insulted or yelled at by staff. Of those who were asked whether they had observed staff insulting or yelling at other detainees (11), the majority (10) reported that they had observed this behavior.

### **(iv) Discipline and Control**

Detainees may be disciplined for prohibited acts as outlined in the detainee handbook and PBNDS. The facility’s disciplinary files consisted primarily of forms with boilerplate language and checkboxes, with little information specific to the incidents and detainees involved. Facility leadership reported that there is no separate “investigation file” because it is not required by PBNDS. The few lines of explanation on each discipline form is the extent of any investigation statement maintained by the facility.

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<sup>80</sup> Per PBNDS policy, use of force is categorized as either calculated or immediate. Calculated use of force “requires supervisor pre-authorization and consultation with medical staff to determine if the detainee has medical issues requiring specific precautions.” (ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, §B(15), p. 202.)

Cal DOJ's on-site file review revealed that when a detainee is found guilty of a rule violation, the facility's tendency is to assign that detainee to disciplinary segregation—usually in increments of 30 days and coupled with 30-day losses of both visiting and commissary privileges, sometimes consecutively with one or more additional 30-day penalties. When disciplinary charges are not sustained, the documentation is not maintained in the detainee file.

*Cal DOJ found instances where detainees were disciplined when they attempted to commit suicide by hanging. One was written up for destruction of facility property for tearing a sheet to fashion a noose, and the other for assaulting a detention officer when he struggled as he was cut down.*

Between January 1, 2018, and June 20, 2019, there were 527 instances of detainees being placed in restricted housing pending a hearing. Most of those detainees were charged with fighting (274), misconduct against staff (99), or "conduct that disrupts or interferes with security of facility" (35). Detention staff reported that cursing at an officer will result in four to five days in segregation and more minor offenses will result in a three-day stint in restricted housing, pending investigation.

#### **(v) Requests and Grievances**

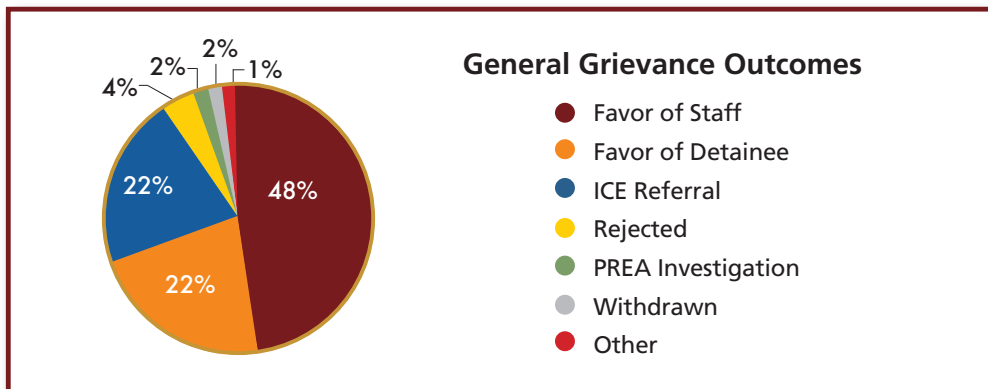
Adelanto uses a detainee request form (known as "kite"), which detainees can submit to the facility. It also accepts handwritten notes from detainees. The detainee handbook provides that the facility should respond within three days. The majority of kites reviewed by Cal DOJ during the site visit concerned lack of payment for days detainees worked; requests to replace worn articles of clothing; and lost clothing items the detainee purchased from commissary, usually when it was sent to the laundry to be washed. There were also quite a few requests for a work assignment, special diets, and reassignment to a different housing unit. The facility does not maintain a log of requests received or of replies provided.

Detainees can file informal and formal grievances. Detainees are not required to exhaust the informal process before submitting a formal grievance in writing using the facility's grievance form. Many detainees preferred conveying their complaint to staff with a "kite," mentioned above, to which they reported receiving an answer much sooner than to grievances. There is a grievance coordinator who tracks grievance information, but actual grievances are assigned to the head of the department for which the grievance pertains for resolution (medical grievances are discussed in the *Healthcare* section below). Per the detainee handbook, a response should be provided within five working days, but eight detainees interviewed by Cal DOJ reported they did not receive a response or their grievance was never resolved.

Between August 29, 2018, and June 17, 2019, Adelanto documented 208 formal grievances, submitted by 134 different detainees. Cal DOJ categorized the grievances in order to analyze them. The top five categories of grievances involved: allegations of staff misconduct (52), ICE-related complaints or requests<sup>81</sup> (41), property or detainee funds (20), general facility conditions (17), and food (15). As shown in **Figure 20**, 48 percent (100 out of 208) of detainee grievances were resolved in favor of staff; 22 percent (45 of 208) were resolved in favor of the detainee; 22 percent were referred to ICE (45 of 208); four percent were rejected; two percent were forwarded for PREA investigation; two percent were withdrawn; and one percent included other outcomes.

*Nine of the 52 grievances alleging staff misconduct were resolved in favor of the detainee. One of those grievances alleged that as an officer cuffed the detainee, a lieutenant pulled out a can of pepper spray, pulled the pin, and threatened to spray the detainee. The grievance was sustained.*

**Figure 20. Outcomes for Filed Grievances, Adelanto.**<sup>82</sup>



## H. Hunger Strikes

Cal DOJ cannot address hunger strikes at Adelanto because the facility did not provide sufficient information and the facility reported that it does not maintain a hunger strike log.

<sup>81</sup> These include complaints regarding detainees’ immigration cases, deportation requests, requests for release from detention, facility transfer requests, missing property or funds upon transfer from another facility, and requests for copies of specific legal documents (e.g., passports, birth certificates).

<sup>82</sup> The ‘Other’ category involved one instance in which a detainee was released from custody before conclusion of grievance and one case in which the outcome was unclear.

## 4. Due Process

Although the facility is not responsible for detainees' immigration cases, it must give detainees access to legal materials, legal calls, and mail, and the ability to access legal services and representation; facilitate detainees' attendance to court; and provide detainees access to personal property related to their case.

### A. Ability to Access Legal Services and Representation

#### (i) Legal Orientation Opportunities

The Esperanza Immigrant Rights Project conducts group legal orientation presentations (LOP) at the facility on most Monday, Wednesday, and Friday mornings in English and Spanish only, which are followed by some one-on-one sessions with detainees.<sup>83</sup> Out of 38 detainees asked about LOP during Cal DOJ interviews, 28 indicated that they had attended an LOP presentation. Due to GEO Group imposed limits on detainee interviews, Cal DOJ was not able to explore why some detainees did not attend or whether detainees found the presentations helpful.

#### (ii) Access to Legal Counsel

Fifty-eight percent (23 out of 40) of detainees who were asked about legal representation indicated that they were currently represented by an attorney. This is likely not representative of the entire detainee population, but rather, a reflection of the group of detainees who felt more comfortable speaking with Cal DOJ. There are eight attorney contact visit rooms in the West and two in the East. Each room is equipped with a phone that attorneys can use to have their own interpreter by phone. The facility handbook provides, “[d]etainee access to counsel is ensured 7 days a week and at least 8 hours a day.”

Attorneys surveyed by Cal DOJ reported that when visiting clients, they can bring cell phones (24 out of 30) and laptops (21 out of 30). While 10 attorneys reported that the facility has an appointment system to schedule client meetings, most attorneys (8) reported that the system is unreliable, and they still have to wait up to an hour before seeing their client. Most attorneys (16 out of 21) reported that there is no system to make copies of client files at the facility. Consequently, attorneys have to either: take files out of the facility to copy and then return originals to their clients at a later time; rely on client family members to send copies; or take pictures of documents with their phones. Most attorneys (27 out of 32) reported that the conditions under which they are able to communicate with their clients limited their ability to represent clients at Adelanto. Because of the conditions limiting communication, the majority of attorneys reported that the conditions led them to limit the number of clients they represent (12) or led them to both limit the number of clients and to not initiate further representation in that facility (10).

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<sup>83</sup> Throughout the United States, the Executive Office of Immigration Review (EOIR) manages the Legal Orientation Program (LOP) through a contract with the Vera Institute of Justice. Through LOP, legal services organizations provide comprehensive explanations about immigration court and basic legal information to large groups of detained individuals. The program normally includes a group presentation, individual orientations—where unrepresented individuals can briefly discuss their cases with LOP providers, self-help workshops, and referrals to pro bono legal services. (U.S. Dept. of Justice, Executive Office of Immigration Review, Legal Orientation Program, <<https://www.justice.gov/eoir/legal-orientation-program>> [as of Oct. 29, 2020]; Esperanza Immigrant Rights Project, Community Education for Detained Adults, <<https://www.esperanza-la.org/programs-ce-detained-adults>> [as of Oct. 29, 2020].)

## B. Access to Materials Needed for Immigration Case

**Legal Calls.** Detainees interviewed during Cal DOJ's site visit (2) and attorneys who responded to the attorney survey (10) reported they had experienced difficulties obtaining or setting up confidential calls. Calls from phones in the housing units are normally monitored, and require that the call recipient press a button to accept the call. The phones are also very close to each other, impeding confidentiality. While the facility posted signs on the same wall where the phones are located to inform detainees (in English only) about the option to request a legal call that is not recorded or monitored by staff, some detention staff reported this system was rarely used. Of the attorneys who commented on their experience setting up legal calls (10), the majority (6) noted the service was either not provided or they were unaware of this service being provided at the facility.

In April 2020, after Cal DOJ's visit, a district court in the class action lawsuit *Torres v. U.S. Department of Homeland Security* entered a preliminary injunction allowing detainees and attorneys to request, among other things: (1) that detainee calls to counsel phone numbers allow detainees to leave voice mail messages; (2) that calls between counsel and detainees are confidential and not monitored; and (3) that counsel's phone numbers be set to unmonitored, unrecorded, and free status from the housing unit phones.<sup>84</sup> While this alleviates some barriers to the due process rights of those detainees who are represented by counsel, barriers remain for those who are trying to retain counsel, or who must rely on family and friends to gather the necessary information to present their case before immigration court.

**Legal Mail.** Legal mail is opened in front of detainees as required by PBNDS. Most attorneys surveyed (17 out of 25) reported delays with their clients detained at Adelanto receiving the mail sent to them.

**Law Library.** Adelanto has three law libraries, one in the East and two in the West. All housing units, including segregated housing, are also equipped with at least one law library computer and some leisure reading materials. The libraries have computers for legal research and a limited selection of fiction and non-fiction books, the majority of which are in English. Library hours are Monday through Friday 7:00 a.m. to 3:00 p.m. and detainees can sign-up to visit the library for one hour on weekdays.

LexisNexis research materials are only available in English. During its visit, Cal DOJ reviewed the materials available in one of the East law library computers. While the facility represented that the computers had the latest version (v. 28) of the LexisNexis software supplied by ICE, our review revealed that the legal materials were outdated. As of August 7, 2019, the latest materials, including court cases, found in the LexisNexis software were dated from November 2017. In contrast, during our June 2019 visit to the Imperial facility, the LexisNexis software had materials dated up to June 2018.

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<sup>84</sup> ICE, Legal Notices 2020, *Torres, et al. v. DHS, et al.* (Apr. 11, 2020), <<https://www.ice.gov/legal-notice>> (as of Oct. 29, 2020); *Torres v. United States Dep't of Homeland Sec.*, (C.D. Cal., Apr. 24, 2020, No. 5:18-cv-2604-JGBSHKx) 2020 WL 3124305, at \*1.

Detainees indicated that facility staff do not provide assistance with legal research or how to use the LexisNexis software. Detainees also reported difficulty getting any printed copies quickly for legal filings and they could not get copies of any filings that were not in English. Per the detainee handbook, there is a 72-hour turnaround time for copies.

### **C. Access to Court**

Detainees at Adelanto attend live, in-person immigration court hearings. The facility has seven courtrooms— five in the West building for detained men’s hearings and two in the East building for detained women’s hearings. Designated custodial staff serve as bailiffs—one for each of the courtrooms—to supervise the detainees during the proceedings. Detainees also appear in person at off-site locations.

## **5. Healthcare**

### **A. Medical Care**

Pursuant to PBNDS, detainees must “have access to appropriate and necessary medical, dental and mental health care, including emergency services.”<sup>85</sup> GEO Group contracts with Wellpath Management, Inc. (formerly Correct Care Solutions) to provide healthcare services at Adelanto. Cal DOJ’s assessment of medical services at Adelanto was curtailed by GEO Group’s refusal to provide access to medical files on the same terms Cal DOJ has obtained for every other comprehensive review of a facility. Consequently, Cal DOJ’s medical expert was unable to fully assess the level and quality of medical care at the facility. GEO Group declined Cal DOJ’s request for a follow-up visit.

At the time of Cal DOJ’s visit, the facility had an acting health services administrator, a transitioning clinical director, a director of nursing, and a mental health director. Medical staff reported that nursing staff consisted of 16.75 RNs, 23 LVNs, six per diem RNs, and three per diem LVNs. The staffing was lean for the size of the facility. Healthcare staff reported that daily nursing staff consists of three RNs (one in the infirmary, one in the West building and one in the East building), and three LVNs in the West building and two in the East building. Additionally, there is an on-call physician.

Detainees may request medical and mental health assistance by completing a medical request form and placing it in a box. Requests are paper triaged and routed to RNs. Wellpath RNs conduct sick call every day by following over 50 nursing protocols, unless the issue is not covered by a protocol, in which case a healthcare clinician<sup>86</sup> is consulted. According to Wellpath staff, sick call takes place within 24 hours, but wait times for medical care can take up to seven days for routine, non-urgent matters.

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<sup>85</sup> ICE, PBNDS 2011, Part 4.3 Medical Care, Part I, p. 322.

<sup>86</sup> For the purposes of this section, a healthcare clinician refers to a physician, nurse practitioner, or physician’s assistant.

LVNs administer pill call two times a day, seven days a week, in each housing unit. LVNs do not use a language line during pill call. Wellpath staff reported having difficulties dealing with an international population, where language and cultural barriers can sometimes make it hard to diagnose medical conditions. It also takes a long time for ICE to clear new staff to work at the facility, which leads to long wait times to fill vacancies. Detainees reported that the facility offers tooth extractions but no root canals or tooth fillings.

The medical facilities in the intake area were not in use at the time of our tour, but appeared to be adequate for the patient volume. Facility staff reported that the Adelanto facility processes intake for about 600 detainees every month. The medical housing unit consists of two mental health rooms, six negative pressure rooms, and two medical observation rooms. Only a few patients were housed in this unit at the time of Cal DOJ's tour.

RNs and LVNs have different scopes of practice as authorized by statute. For the purposes of this report, the most significant difference in their scopes of practice is that RNs may perform nursing assessments (observing signs and symptoms of illness, reactions to treatment, general physical condition) and arrive at basic nursing diagnoses (such as fever, stomach pains, etc.). While LVNs may take patients' vital signs, they may neither perform comprehensive nursing assessments nor make nursing diagnoses. RNs are also prohibited from delegating these functions to an LVN. Both RNs and LVNs may administer medications under the supervision of a physician or surgeon.<sup>87</sup>

#### **(i) Medical Care Concerns Identified by Cal DOJ Experts**

A limited review of healthcare information provided brief glimpses of medical care at Adelanto and allowed for the following observations:

##### **a. Incomplete Electronic Health Care Records**

Wellpath uses an electronic health records system, however, Cal DOJ's medical expert observed that the chronic diseases being managed are frequently not recorded in the electronic record system's medical problem list, which precludes the ability to run reports based on diagnoses in the problem list. The facility's February 2019 National Commission on Correctional Health Care (NCCHC) accreditation audit had the same finding, but the issue was not yet addressed by the time of Cal DOJ's visit in August 2019. Wellpath indicated that it manages chronic care through a nurse who maintains her own records. This is problematic for two reasons. First, keeping two different records systems can produce discordant information. Second, nurses are not adequately trained to manage the complexities of chronic disease and a nursing model that oversees chronic healthcare patients long-term is not in accordance with good medical practice.

Additionally, the blood glucose levels for diabetic patients were not recorded in the electronic health records. Cal DOJ's medical expert was told that this information resides in the

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<sup>87</sup> Bus. & Prof. Code, § 2725 et seq. & § 2859 et seq.



medication administration record only. Therefore, the medical expert was unable to look at the connection between insulin dosing and blood glucose levels over time to determine if insulin dosing is adequate.

#### **b. Inadequate Medical Care for Detainees with Chronic Illnesses**

During Cal DOJ's visit, Wellpath, at GEO Group's direction, provided a list of patients receiving chronic care. The detainees' care for their chronic diseases was up-to-date and followed the prevailing standard of care for the respective diseases. However, it was evident that much of the care had been scheduled in the same general time window, which suggests that a staff member previewed those patients and checked the charts to make sure that all of the care was up to standards. The revisions reflect that at least the person who reviewed these charts is aware of the standard of care and able to orchestrate the care in accordance with that standard. However, it is difficult to determine whether this level of care is in place throughout the institution over a sustained timeline or whether it was done in preparation of Cal DOJ's visit.

The limited records reviewed by Cal DOJ's medical expert raised some concerns about the adequacy of medical care being provided at Adelanto for chronic care patients:

- A patient was on antihypertensive medications, but hypertension was not listed on the patient's problem list in the electronic health records system. The patient was also a diabetic, but the medication Lisinopril (for renal protection) was discontinued for no identifiable reason.
- A patient appeared on the external chronic care tracking form for hepatitis C, but that diagnosis was not included in the electronic health records problem list.
- Another patient was diagnosed with hypothyroidism but had not been prescribed any thyroid replacement medication.
- A patient with gout was given a shot of Toradol and started on indomethacin at the same time that he was taking ibuprofen, amounting to a triple prescription of a nonsteroidal anti-inflammatory drug (NSAID), which is very dangerous and not in accordance with the standard of care.

#### **c. Delayed Care and Inadequate Continuity of Care**

Limited medical chart review revealed examples of delayed care and lack of continuity of care for detainees with serious medical concerns. With respect to delays in medical care, one file reviewed showed a detainee who was referred to a medical doctor by the psychiatrist in January due to ovarian pain; however, in August after submitting three sick call requests, the detainee had only been seen by a nurse, who gave her Pepto-Bismol, then Mylanta. With respect to lack of continuity of care, another detainee was involved in a fight that resulted in a nose injury. The detainee was sent to a hospital but, upon return, facility medical staff failed to follow up on the missing work-up results from the emergency room, and the

detainee never received treatment for the acute non-displaced fracture of bilateral nasal bones. This fracture was not even listed on the electronic healthcare system's problem list.

#### **d. Inadequate Restricted Housing Nursing Rounds**

Cal DOJ requested, but was not allowed, to review video footage of nursing staff rounds in RHU. Records, however, revealed concerns about the adequacy of RHU rounds by nursing staff.

*For one detainee, nurses noted no issues with the detainee during RHU rounds for 20 days in a row. However, a mental health clinician noted the detainee was angry and irritable; expressed hopelessness and helplessness; reported having thoughts of harming others and self; and threatened a hunger strike during this time. During the same period, the detainee was extracted from the cell, pepper sprayed, and sent to a psychiatric hospital. The nurse's daily assessment was not accurate, particularly during the five days when the detainee was in a hospital and not in RHU.*

#### **(ii) Concerns Identified by Prior Inspections**

The facility's February 2019 NCCHC accreditation audit found that at intake, detainees with major diagnoses were not adequately processed, resulting in nursing staff failing to take follow-up baseline blood sugar levels for two diabetic detainees. The same audit found that, while policy requires that a healthcare clinician referral be made after a detainee is seen by a nurse three times for the same complaint, the policy was not consistently followed. The audit also found that the facility had a practice of sharing test results with detainees only when the findings were positive. Cal DOJ was unable to assess whether these issues had been addressed.

#### **(iii) Concerns Reported by Detainees During Cal DOJ Interviews**

Detainee interviews revealed a series of allegations related to access to and quality of medical care offered at Adelanto, as well as significant delays obtaining adequate and timely medication. Although Cal DOJ was unable to verify these allegations given the limited medical file review that the facility permitted, they are included in this report given their similarity to findings in other reports about Adelanto's medical care. A September 2020 U.S. House of Representatives report cites to findings by DHS' Office for Civil Rights and Civil Liberties outlining "systemic issues related to the medical care of detainees that resulted in 'medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees.'"<sup>88</sup> A second U.S. House of Representatives' September 2020 report, cites to GEO Group's own

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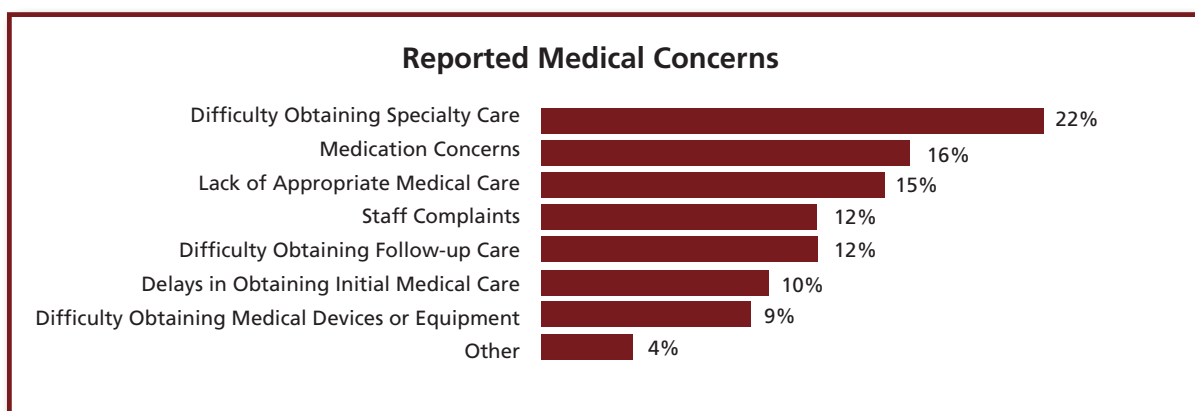
<sup>88</sup> U.S. House of Representatives, Committee on Homeland Security Majority Staff Report, ICE Detention Facilities Failing to Meet Basic Standards of Care (Sept. 21, 2020), pp. 8, 10-12, 14 <<https://homeland.house.gov/download/staff-report-ice-detention-facilities&download=1>> (as of Oct. 29, 2020); Dreisbach, Despite Findings Of 'Negligent' Care, ICE To Expand Troubled Calif. Detention Center, NPR (Jan. 15, 2020), <<https://www.npr.org/2020/01/15/794660949/despite-findings-of-negligent-care-ice-to-expand-troubled-calif-detention-center>> (as of Oct. 29, 2020) (the report, dated December 2017, found that "[o]verall the medical care at the Adelanto facility is inadequate and does not meet the 2011 Performance Based National Detention Standards (PBNDs)," and that many issues remain from a similar 2015 inspection by the same CRCL expert. See Corrections Expert's Report on Adelanto Correctional Facility (Nov. 17, 2017) <<https://www.documentcloud.org/documents/6278922-HQ-Part2-Copy.html>> [as of Oct. 29, 2020]).

2019 audit of healthcare services at Adelanto, which found “that women at Adelanto were not receiving appropriate medical care, detainees with mental health concerns were not being monitored by medical staff, some medications on hand were expired, and chronically ill patients were not being routinely seen by medical staff.”<sup>89</sup>

Ninety-five percent of detainees (38 out of 40) interviewed stated that they had required medical care while at the facility. Of these, eighteen commented on the turnaround time for medical services, with detainees reporting they could be seen within a day (2); within the same week (7); between one to two weeks (7), once a month (1), or up to four months (1).

**In response to the question, “Have you had any problems with medical care at the facility?” 91 percent (30 out of 33) of detainees mentioned they had encountered problems. Figure 21 illustrates all categories derived from the comments provided by the 30 respondents and their corresponding percentages.**

**Figure 21. Medical Problems Encountered by Detainees, Adelanto.**<sup>90</sup>



**The majority of concerns reported by detainees resulted from difficulties obtaining specialty care (15);<sup>91</sup> medication (11); lack of appropriate medical care (10);<sup>92</sup> and staff complaints (8).** Five detainees reported they had experienced difficulties obtaining medical devices or equipment. Specifically, four detainees stated they encountered difficulties obtaining wheelchairs; one reported difficulty obtaining a metal sling; and another reportedly requested but did not receive a hearing aid.

<sup>89</sup> U.S. House of Representatives, Staff Report Committee on Oversight and Reform and Subcommittee on Civil Rights and Civil Liberties, The Trump Administration’s Mistreatment of Detained Immigrants: Deaths and Deficient Medical Care by For-Profit Detention Contractors (Sept. 2020), pp. 19-20 <<https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-09-24.%20Staff%20Report%20on%20ICE%20Contractors.pdf>> (as of Oct. 29, 2020).

<sup>90</sup> Percentages were calculated based on the number of unique concerns derived from the interviews.

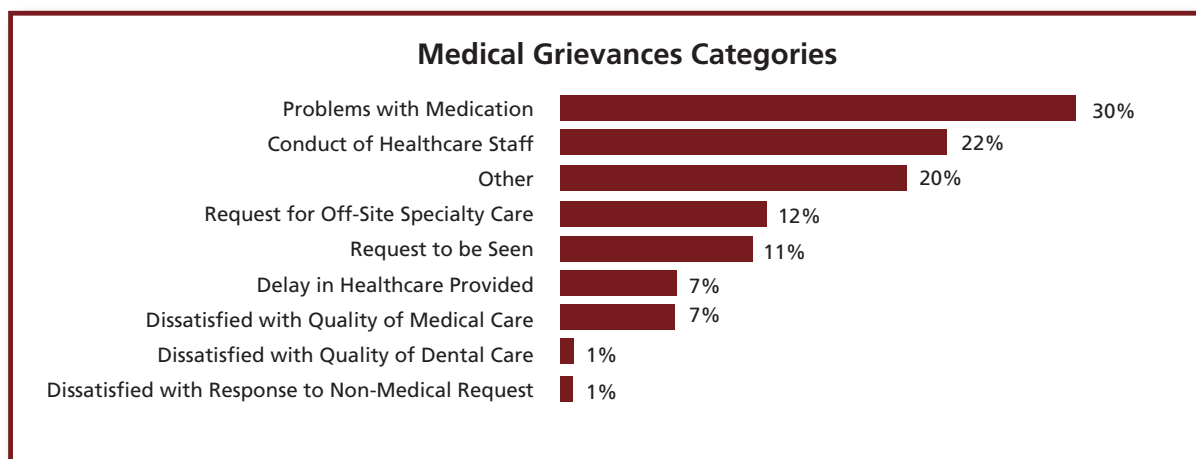
<sup>91</sup> Referring to medical care from specialized medical professionals, including medical staff external to the facility and/or medical staff who did not routinely provide care to detainees until they had spent a designated amount of time housed at the facility (e.g., dental or vision care).

<sup>92</sup> Referring to instances in which detainees perceived that they or other detainees had not received appropriate medical care from staff within the facility (e.g., nurses, doctors, or other medical support staff within the facility) and/or disagreed with the course of treatment.

#### (iv) Concerns Identified through Medical Grievances

Cal DOJ reviewed logs for medical grievances submitted by detainees between September 3, 2018, to June 13, 2019. While the data provided included 555 grievances submitted by 306 detainees, 421 were deemed “Withdrawn.”<sup>93</sup> A total of 134 grievances filed by 100 detainees received a formal grievance number. **Figure 22** provides a breakdown of the categories included within them.<sup>94</sup>

**Figure 22. Medical Grievances Filed by Detainees, Adelanto.**<sup>95</sup>



The majority of healthcare grievances involved problems with medication (40 out of 134)—most of which concerned delays in receiving medication (12), denied or discontinued medication (5), and medication requests (5); allegations regarding the conduct of healthcare staff (30 out of 134); and Other concerns (27 out of 134).<sup>96</sup> The majority of grievances categorized as Other involved medical item requests (e.g., a leg brace, a therapeutic stress ball, an ace bandage, shoes, a mattress, a chair for exercises, a CPAP [continuous positive airway pressure machine], and a hernia belt) or complaints regarding items that had not been received (7 out of 27); and requests for special diets (i.e., morning or night snacks or sack lunches; 4 out of 27).<sup>97</sup>

**Figure 23** illustrates the general grievance outcomes. Overall, 60 percent of grievances (81 out of 134) were categorized as Unfounded; 36 percent (48 out of 134) were categorized as Founded, and 4 percent (5 out of 134) received Other outcomes.<sup>98</sup> **Sixteen of the founded grievances involved problems with medication, including delays in medication and one patient who went three days without medication.**

<sup>93</sup> The majority of grievances categorized as Withdrawn did not contain details regarding the nature of the grievance.

<sup>94</sup> A total of 150 categories were included within the 134 filed grievances (16 grievances included two categories/concerns each).

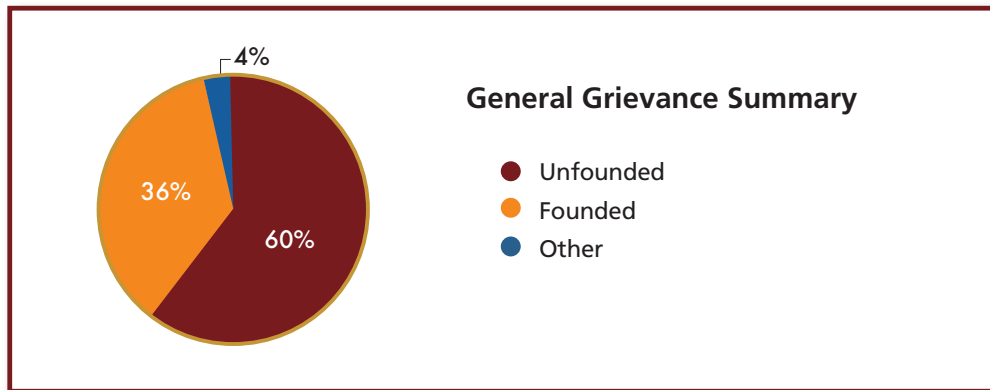
<sup>95</sup> Please note this figure only contains grievances that received a formal grievance number and were not characterized as Withdrawn.

<sup>96</sup> Note, seven cases involved allegations of staff mistreatment or disrespect and only one was categorized as Founded.

<sup>97</sup> Nine entries corresponding to 2019 did not include information.

<sup>98</sup> We manually coded outcomes as Other when no code was provided (3) or an unknown code was provided (2) under the ‘\*\*\*G’ or Grounds column.

**Figure 23. Outcomes of Grievances Filed by Detainees, Adelanto.**



## **B. Mental Health Care**

Mental health services at Adelanto consist of a mental health screening upon arrival at the facility, daily sick call triages, emergency crisis intervention, on-call services, some individual therapy, and medication evaluations and management. There are no therapy groups available. For a higher level of care, a detainee may be transported to Anaheim Global Medical Center, with ICE approval.

At the time of Cal DOJ’s visit, the facility had three full-time psychologists (one also acting as the mental health director); two full-time psychiatrists who live out-of-state; and a vacant psychiatric RN position. One of the psychiatrists interviewed reported being on-site once a month for 10 hours.

At the time of Cal DOJ’s visit, 387 detainees were receiving mental health services and 222 were on psychiatric medications. Of the detainees on the mental health roster, 25 percent were diagnosed with psychotic disorders, 23 percent were diagnosed with adjustment disorder, 15 percent had a deferred or “to be determined” diagnosis or one that only ruled out incorrect diagnoses, 10 percent were diagnosed with some form of anxiety disorder, 8 percent had a history of suicidal ideation, and the rest had a mix of other diagnoses. On average, each psychologist managed 129 cases, in addition to attending to referrals, new evaluations, crisis interventions, and sick calls.

Cal DOJ’s mental health expert reviewed 21 clinical charts to formulate the following findings, which highlight deficiencies in staffing levels, mental health screenings, continuity of care, timely care, treatment plans, and suicide risk assessments:

### **(i) Intake Assessments, Evaluations, and Diagnoses**

**Intake.** Four of the charts reviewed by Cal DOJ’s mental health expert contained incomplete, inaccurate, or inconsistent mental health information based on intake screenings, such as marking “No” for psychiatric medications, mental health condition, and prior mental health treatment for a detainee who arrived with psychiatric medications.

**Referrals.** Four of the charts reviewed showed that the referrals to mental health services at intake were not completed within the 72 hours as required by PBNDS 4.3.O.3. In one case, an arriving detainee received a mental health referral on Thursday. The facility did not conduct its initial mental health evaluation within 72 hours, and by the following Monday, he required psychiatric hospitalization.

**Failure to Conduct Suicide Risk Assessments.** Adelanto has two suicide watch rooms that are not appropriate for suicide watch because they have fissures that a detainee could use to hang themselves. Chart review revealed one detainee who attempted to hang himself while on suicide watch. GEO Group's internal May 2019 audit noted that observation logs showed that suicide watch rounds were not staggered, as required, and nursing staff failed to complete the required vitals and assessments every eight hours. While mental health staff conduct an initial evaluation within 24 hours of a suicide watch referral, of the 21 charts reviewed, none of the patients who were on suicide watch obtained a quality suicide risk assessment, a safety plan, or a subsequent modified treatment plan upon discharge from suicide watch. PBNDS 4.6.V.D. and E., however, require a treatment plan and that suicide watch be terminated only "after a current suicide risk assessment."

#### **(ii) Failure to Follow Standards of Care for Mental Health Treatment**

**Delays in Care.** Adelanto's detainee population faces significant delays in receiving mental health care. One of the facility's tele-psychiatrists expressed concerns about the shortage of off-site psychiatric hospital beds for transfer of acute patients. One detainee with an acute mental illness had been in one of the facility's medical observation rooms for over 30 days despite very concerning notes by mental health providers demonstrating the need for outside psychiatric care. Another detainee was seen by a psychologist who determined that no mental health follow up was needed. The detainee, however, worsened and was subsequently diagnosed with schizophrenia.

**Underdiagnosing.** Seven of the charts reviewed contained sufficient information to suggest a diagnosis more serious than the one given or failure to explore and document other issues to properly exclude another diagnosis. For example, one detainee reported a history of physical abuse with head injury at intake. At the mental health evaluation, the psychologist wrote that the patient had "insomnia, anhedonia, poor concentration, anergia [abnormal lack of energy], low appetite, worry, increased arousal, restlessness," and diagnosed the patient with "Other Reactions to Severe Stress," recommending exposure therapy with follow up in three to four weeks. Documentation did not reveal exploration of symptoms that could be related to trauma so as to advance the diagnosis to PTSD. Although the patient subsequently reported nightmares, the chart failed to document any questioning as to the cause of the nightmares. The patient eventually requested to see the psychiatrist, who wrote "consider" PTSD, and started a PTSD medication. No real therapy was provided even though it was part of the treatment plan.

**Insufficient Therapy.** Therapy is limited to 15-minute sessions with a psychologist every four to six weeks. With no other therapy offerings, detainees and clinical notes revealed that the limited sessions create more anxiety and stress on detainees who have a history of trauma. At least nine patient charts reviewed revealed detainees with significant trauma who did not receive adequate therapy services.

**Mental Health Orders Not Followed.** In five of the 21 clinical charts reviewed, the mental health provider's written orders were not followed. In three instances, the psychiatrist increased the patient's psychiatric medication doses, but nursing staff did not follow the orders. In another instance, medication was to be immediately discontinued, but three days later, the detainee was still receiving it. In a case involving severe paranoid delusions, there were no records reflecting compliance with the doctor's order that the detainee's food intake and output and daily weight be checked.

**Issues with Treatment Plans.** From the 21 clinical charts reviewed, the treatment plans were either not consistently done; not sufficiently detailed or complete; not modified when detainee's circumstances changed, or not finalized for months after treatment commenced. The interventions were mostly the same for all, regardless of diagnosis or problems. Everyone was ordered to receive "psychotherapy, exercise, controlled breathing, faith based coping skills." Those treatment plans that were done did not always detail specific symptoms to be addressed, the way the symptoms were impairing functioning, or how progress would be measured. The plans also failed to include strategies to prevent decompensation, including after a detainee had been placed on suicide watch.

**Fragmented Continuity of Care.** Thirteen of the 21 clinical charts reviewed revealed deficiencies in continuity of care. Tele-psychiatrists failed to recognize the psychiatric hospital's diagnoses following a hospital discharge. Although seven detainees arrived with psychiatric medications and/or a reported history of mental health treatment, at intake, the screener failed to obtain the detainees' permission to request outside records. At least two detainees were released with insufficient medication for their conditions. GEO Group's own internal May 2019 audit also found a number of problems with continuity of care.

**Lack of Confidentiality.** Cal DOJ's mental health expert found various patient confidentiality violations. For example, during pill call, nurses announce medications by medical condition (i.e. "all diabetics come"). Some medical encounters also occur at cell front or in day rooms. Detainees also reported tele-psychiatrist appointments conducted with open doors. Some mental health information is also contained in detention files.

**Tele-psychiatry.** The facility started using tele-psychiatry as its main delivery method of psychiatric services 1.5-2 years before Cal DOJ's visit, but had no written policy relating to tele-mental health services. A draft policy was shared with our mental health expert on the last day of Cal DOJ's visit. Further, none of the medical charts reviewed documented the patient's consent prior to delivering mental health care via tele-psychiatry. A major issue identified by the mental

health providers is poor sound quality when using a language line to communicate with the patient—a service utilized for at least 25 percent of the patients.

### **(iii) Concerns Related to Isolation of Detainees with Mental Health Needs**

Thirteen of the 21 charts reviewed by Cal DOJ's mental health expert revealed instances where segregation was used to house detainees with mental health conditions. Two of those detainees spent over 75 days in RHU and two others over 200 days. Mental health staff failed to advocate for alternative, less harmful housing for these detainees and poorly monitored those who were housed in RHU. **Mental health staff reported that administrative segregation is “better” for those with mental health conditions because they “get the best of both worlds. It is less stressful and more safe” given that the facility “does not have a step down program.” However, when asked, neither custodial nor mental health staff could tell Cal DOJ how many detainees currently in RHU had a mental health condition.**

Documentation showed a variety of reasons for placing detainees in protective custody in RHU, including: “fear for his safety in general population due to medical condition,” “due to mental status,” “[s]elf [protective custody]/due to his sexual preference,” “[f]ears for his safety because of his mental capacity,” “prior acts of self harm,” “[f]ears for his safety in [general population] due to mental illness,” “[s]elf protective custody/afraid of hurting someone or himself,” “wants to be alone, not around people,” or “[f]ears for his safety in [general population] does not program well.” A detainee diagnosed with schizophrenia was in RHU because he “does not like to deal with dorm politics.”

Medical charts showed that detainees with mental health conditions deteriorated during their placement in RHU. Notations in detainees' files included:

- “[H]aving suicidal thoughts since placed in the RHU;”
- Detainee did not want to go back to RHU because “‘make me suicidal,’ says he can’t tolerate the small locked rooms;”
- “[R]eports struggling in segregation with increased auditory hallucinations and suicidal ideation with reportedly at least one attempt by hanging;” and
- “His prolonged segregation (albeit technically by his choice) approaching 11 months means he has lost a sense of relatedness to the larger environment and worldviews. Any perceived slight or grievance is distorted as a major issue and his reactions will be disproportionate.”



#### **(iv) Barriers Limiting Access to Mental Health Services**

**Understaffing.** Inadequate staffing is a barrier to accessing to mental health services. From May 1, 2019, to August 5, 2019, there were 18 days without any mental health staff on-site, 17 days without any psychiatrist scheduled, and 28 days when only one psychologist was on-site. Further, mental health professionals may see too many patients in one day. The number of patients seen by a psychologist in one day ranged from 1 to 21, and patients seen by a tele-psychiatrist ranged from 1 to 19. Wellpath staff acknowledged that understaffing is a concern.

**Language Barriers.** Orientation, detainee handbooks, and sick call forms are only available in English and Spanish. Mental health staff do not always use a language line to communicate with detainees, limiting the efficacy of the mental health services offered. See also *Systematic Issues*, Section 3.

**Costs.** When Cal DOJ visited Adelanto in September 2018, the form that detainees must use to request healthcare services stated, "I understand and agree that a clinic fee may be charged to my account for this visit." At that time ICE representatives indicated that the form would be revised. The language, however, was still present on the medical request forms during Cal DOJ's August 2019 visit. Although detainees are not charged for healthcare services, as stated in the detainee handbook, this language can cause confusion among detainees, and particularly for those who do not receive a handbook in a language that they understand.



# Comprehensive Facility Review: Imperial Regional Detention Facility

## 1. Background and Summary of Key Findings

The Imperial Regional Detention Facility (Imperial), located in Calexico, is owned by the City of Holtville and operated by the Management and Training Corporation (MTC). In December 2019, ICE entered into a new direct contract with MTC for three five-year terms, totaling 15 years. In its fiscal year 2021 budget justification, ICE reported that it pays \$143.14 per bed per day for a guaranteed minimum of 640 beds, and \$96.43 for any additional beds.<sup>99</sup> The facility has a maximum bed capacity of 704. The 2011 PBNDS and 2016 addendum apply to this facility.

**Table 7. Key Data Points, Imperial.**

<b>Facility:</b>	Imperial
<b>Operator:</b>	Management and Training Corporation
<b>Housing Detainees Since:</b>	2014
<b>Bed Capacity:</b>	704
<b>Type(s) of Detainees:</b>	Male and Female Adults
<b>Snapshot of Detainees Housed at Imperial on June 3, 2019</b>	
<b>No. of Countries of Origin:</b>	38
<b>No. of Detainees by Gender including Transgender Detainees:</b>	Females: 64 Men: 616 Transgender: 6 (included in numbers above)
<b>Average Age:</b>	30
<b>Average Length of Stay:</b>	103 days
<b>Longest Detainee Stay:</b>	962

<sup>99</sup> U.S. Immigration and Customs Enforcement, Dept. of Homeland Security, Budget Overview Fiscal Year 2021 Congressional Justification, p. 137 <[https://www.dhs.gov/sites/default/files/publications/u.s.\\_immigration\\_and\\_customs\\_enforcement.pdf](https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf)> (as of Oct. 29, 2020).

During the comprehensive review, Imperial management was forthcoming, open to issues raised, transparent in their activities, and afforded Cal DOJ more access than other facilities, including shift briefings, file review, and interviewing detainees within housing units. Imperial is one of two facilities in California where ICE has implemented the use of tablets in housing units.<sup>100</sup> Tablets are the primary means for detainees to submit requests and grievances to the facility.

Cal DOJ made the following key findings:

- Staff foster positive relationships with detainees, and detainees reported being treated humanely at this facility;
- The facility appears to make a concerted effort to accommodate LGBT detainees' preferences during the intake process;
- Detainees enjoy access to a robust offering of programs and activities beyond what is required by federal detention standards;
- Detainees who are housed in administrative segregation experience extremely restrictive conditions, nearly identical to those facing disciplinary segregation (isolation) as a punishment for misconduct;
- The facility has a clear protocol for responding to allegations of sexual abuse and harassment;
- Due to the isolated geographic location of the facility, there is a lack of access to counsel which causes detainees to face impediments to due process; and
- The facility sees patients in need of medical care in a timely manner, but maintains poor health care records and lacks adequate mental health services.

## 2. Methodology

Cal DOJ held a pre-site visit meeting with Imperial operational staff in February 2019. Cal DOJ then conducted a multiday comprehensive site visit to Imperial from June 3 through 6, 2019. MTC staff were very cooperative with Cal DOJ's review of the facility. As part of the comprehensive site visit, Cal DOJ toured the facility; attended shift briefings; observed detention staff working in their assignments; and interviewed executive staff, operational managers and department heads, supervisors and rank and file detention staff, and detainees. Cal DOJ's medical expert also observed clinical encounters in the medical unit. In addition to interviews with detainees and staff, Cal DOJ's corrections expert reviewed 49 detention files; Cal DOJ's medical expert reviewed 37 healthcare records; and Cal DOJ's mental health expert reviewed 40 healthcare records. Information about detainee demographics at the time of Cal DOJ's site visit can be found in the *Detainee Demographics Snapshot* Section of this report.

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<sup>100</sup> The Mesa Verde ICE Processing Center also has tablets available for detainee use in its housing units.

Cal DOJ interviewed 88 unique detainees in individual<sup>101</sup> and group settings on a variety of topics, including medical and mental health-focused interviews by Cal DOJ's experts in those fields. All detainee interviews were conducted in the detainees' preferred language. Cal DOJ selected detainees to interview from over 160 detainees who volunteered, giving preference to those individuals who had been in the facility the longest, and attempting to speak to detainees from a broad range of countries. Detainees with whom Cal DOJ spoke came from 16 countries<sup>102</sup> of origin and spoke six different languages.<sup>103</sup> The majority of detainees interviewed were from India (32), Honduras (14), Mexico (9), and Guatemala (6). Six attorneys who had represented 40 clients at Imperial between July 1, 2018 and June 30, 2019, also responded to Cal DOJ's attorney survey.

### 3. Conditions of Confinement at Imperial

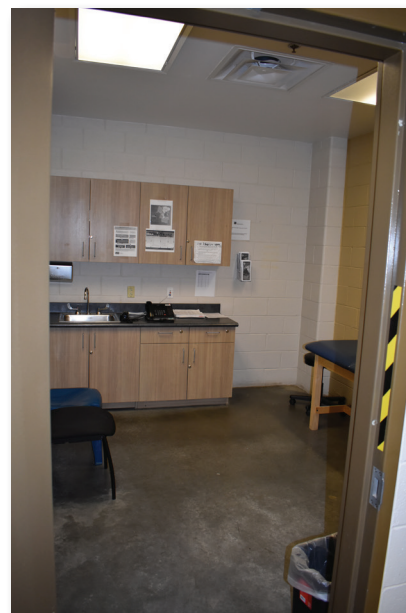
#### A. Intake and Orientation

Individuals housed at Imperial are first processed through a Receiving and Discharge (R&D) area for intake and orientation to the facility (**Figures 24 and 25**). Intake consists of a medical evaluation; checking in personal property and funds to the facility (for which a detainee will receive an itemized receipt); a shower; the provision of clean facility uniforms, shoes, bedding, and toiletries; and security classification. Individuals are also given an opportunity to make a free, five-minute phone call.

**Figure 24. Intake Area, Showing Property Bins, Imperial.**



**Figure 25. Intake Area, Medical Screening Room, Imperial.**



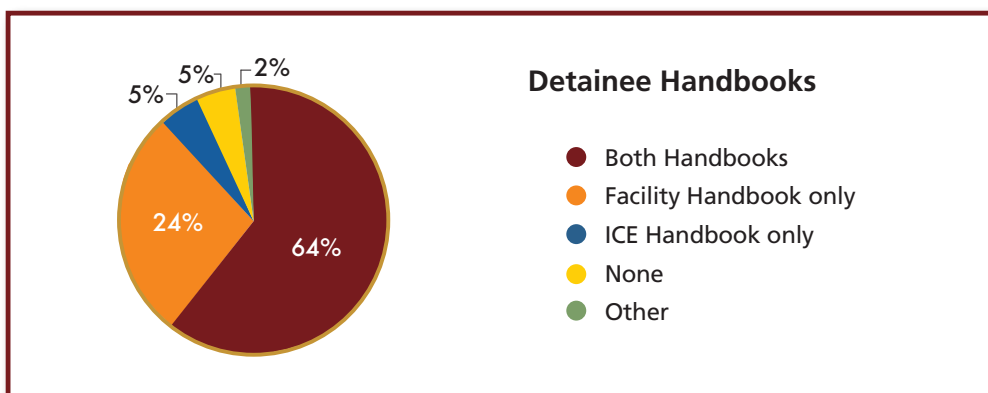
<sup>101</sup> Cal DOJ conducted 44 individual, standardized interviews.

<sup>102</sup> Cal DOJ also interviewed individuals from El Salvador, Eritrea, Cuba, Pakistan, Nicaragua, Venezuela, Ecuador, China, Kyrgyzstan, Brazil, Fiji, and Nigeria.

<sup>103</sup> Forty-two interviews were conducted in Spanish, 30 in Punjabi, 12 in English, two in Tigrinya (language spoken by people of Eritrea), one in Mandarin, and one in Portuguese.

During intake, the facility plays an orientation video and distributes the ICE National Detainee Handbook and the MTC facility handbook, as outlined by PBNDS.<sup>104</sup> As illustrated in **Figure 26**, most detainees interviewed by Cal DOJ staff reported receiving both handbooks (27 out of 42), though 24 percent (10 out of the 42 detainees) noted they only received the MTC facility handbook; two reported receiving an ICE handbook only; and two indicated they did not receive either handbook. Detainees reported receiving MTC handbooks in English and Spanish, and ICE handbooks in English, Spanish, Hindi, and Chinese. Imperial also plays a facility-specific orientation video and the American Bar Association’s “Know Your Rights” video on loop in a holding cell in R&D. Both videos play in English and Spanish. While most detainees reported seeing the video, 15 reported that they could not hear the video, or could not otherwise understand the content. The handbooks and videos are detainees’ primary means of understanding their rights and responsibilities within the facility; not receiving this information in one’s primary language deprives the detainee of this understanding. The majority of detainees reported learning facility rules and procedures from other detainees. Relatedly, detainees (and detention officers) received no training on how to use the tablets, and detainees rely on each other to learn how to use the tablets and fill out forms.

**Figure 26. Reported Handbooks Received by Interviewed Detainees, Imperial.**<sup>105</sup>



**(i) Security Classification, Special Vulnerabilities and Management Concerns**

At intake, R&D staff conduct a security classification of each detainee during which where they are supposed to screen for any special vulnerabilities or management concerns. This screening impacts housing assignments and movement around the facility. Cal DOJ found issues with Imperial’s security classification system, as discussed in *Systematic Issues*, Section 1.

**Transgender Individuals.** At the time of Cal DOJ’s visit, Imperial housed six transgender detainees identified by the facility. Cal DOJ spoke with two of them. Both detainees had positive feedback

<sup>104</sup> ICE, PBNDS 2011, Part 2.1 Admissions and Release, Part V, §§ F & G, pp. 55-57.

<sup>105</sup> The ‘Other’ category refers to one detainee who reported receiving an MTC handbook but was not asked whether they had received an ICE handbook.

about the PREA coordinator's accommodation of their needs. The PREA coordinator is routinely in the intake area to help identify LGBT individuals and guide them through the intake process. The coordinator also administers a facility-specific form that includes identification of LGBT individuals soon after detainees are admitted. If an individual self-identifies as transgender or is identified as transgender at intake, Imperial accommodates the individual's preferred corresponding toilet and shower area in R&D, and the individual is placed in the medical unit before being assigned to a housing unit. Within 72 hours, the facility's transgender care committee meets to determine whether to house the detainee in female or male housing. The committee, comprised of custody, healthcare, and ICE representatives, oversees housing assignments and related accommodations for transgender detainees throughout their detention. The facility generally assigns identified transgender individuals to dorm-style housing units, rather than cells, and to the second tier of the housing unit to ensure greater privacy and access to individual showers. Whether a transgender individual self-identifies at intake or thereafter, the facility reports that it accommodates the individual's preferred gender for purposes of housing, preferred name, and clothing. However, the two transgender detainees with whom Cal DOJ spoke identify as female but were housed in male housing units.

## B. Housing Units

### (i) General Population

All of the 11 general population housing units have two stories. Eight are dorm-style for men; one is dorm-style for women; and two are cell-style for men. The dorm-style units consist of 16 separate, open-air "rooms," each with two double bunks. Cell-style units house two detainees per cell, and cell doors remain unlocked. One of the cell-style units houses high security detainees; the other houses low to medium security detainees.

Communal toilets, sinks, and showers are available downstairs and upstairs in each unit (**Figure 27**). All units have a day room with several tables and a small outdoor recreation area that detainees may access at any time, except during count and at night (**Figures 28 and 29**). Detainees may also

**Figure 27. Sinks and Showers in General Population Housing Unit, Imperial.**



**Figure 28. Day Room in General Population Housing Unit, Imperial.**



**Figure 29. Small Recreation Area in General Population Housing Unit, Imperial.**



**Figure 30. Outdoor Recreation Yard, Imperial.**



**Figure 31. Multipurpose Room in General Population Housing Unit, Imperial.**



access recreation in a large outdoor area each day, for about two hours (**Figure 30**). In all housing units, soccer and volleyballs are provided for use, as well as a boom box. The female housing unit additionally has access to exercise mats. Each housing unit has an enclosed multipurpose room used for prayer, programming, meetings, and legal orientation presentations by outside organizations (**Figure 31**).

Detainees receive toothpaste, a toothbrush, and soap/shampoo upon arrival at the facility. Feminine hygiene items are available as needed in the female housing unit. However, seven detainees reported that they buy their own soap and shampoo from the commissary because they either do not receive shampoo, or the liquid they are instructed to use as shampoo is a multipurpose soap/shampoo.

Five detainees reported that the shower temperature is very hot and that the facility did not make changes in response to their formal and informal complaints.



## (ii) Restricted Housing Unit

Imperial has one RHU that houses both men and women for disciplinary and administrative segregation purposes, with the women's cells separated by fencing (**Figures 32 and 33**). RHU cells can house two detainees and include two bunk-style beds, a toilet, and a shower. Cells remain locked at all times in this housing unit. Detention staff reported that they conduct safety checks on each cell approximately every 30 minutes, and detainees may call out from their cells to request use of the phone or tablet.

**Figure 32.**  
Cells in Restricted  
Housing, Imperial.



**Figure 33.**  
Inside cell in Restricted  
Housing, Imperial.



**Figure 34. Recreating  
pens in Restricted  
Housing, Imperial.**



Detainees in RHU have access to a small recreation yard consisting of secure cages adjacent to the unit, for one hour each day (**Figure 34**). Some detainees in protective custody are offered about one hour in the large recreation yard each day, but it is unclear what criteria the facility uses to grant a detainee in administrative segregation access to that yard.

Cal DOJ analyzed lengths of placement in restricted housing from a log provided by the facility.<sup>106</sup> The most common reason for placement in RHU was for administrative segregation pending an investigation (180 of 592 cases), for which detainees spent an average of three days in RHU. The average consecutive days for disciplinary segregation was 16.96 days; 44.43 days for protective custody; and 36.7 days for security risk.

<sup>106</sup> The RHU log included detainees with release dates from January 1, 2018, to May 20, 2019, and contained a total of 592 cases involving 381 detainees.

<sup>107</sup> Imperial designates detainees as security risks for administrative segregation if the detainee presents a propensity for violence. Typically, this characteristic is considered for classification purposes and would not result in a restricted housing placement.

At the time of Cal DOJ's site visit, a total of 17 detainees were housed in RHU. Fifteen were designated as protective custody—a combination of people who had been placed there voluntarily and involuntarily. One was in administrative segregation based on the facility's assessment of security risk, and the other was in disciplinary segregation.<sup>107</sup>

Cal DOJ's file review showed that detainees in protective custody may be held in RHU indefinitely, either voluntarily or because the facility declines to return a detainee who chose protective custody to general population upon the detainee's request. **At the time of our visit, one detainee had been segregated in protective custody for 253 days, another for 302 days, and three detainees who began in voluntary protective custody reported their requests to be returned to general population had been denied without explanation.**

Imperial also houses current and former gang members in administrative segregation. At the time of Cal DOJ visit, a former Norteño was housed in RHU at the same time as an active Sureño.<sup>108</sup>

As noted in Systemic Issues, Section 2, like the other facilities, Imperial treats detainees in administrative segregation as restrictively as those in disciplinary segregation, submitting detainees in protective custody to harsh and isolating conditions. See *Systemic Issues*, Section 2. While Imperial holds weekly RHU meetings, the meeting Cal DOJ observed did not include a meaningful discussion of each detainee's status or plan for release.

*Improper Use of RHU as "Overflow" for Women.* Based on Cal DOJ's review of RHU logs, there were a total of 101 women placed in RHU between January 1, 2018, to March 8, 2019. Of those women, 88 were placed in RHU for an average of two days as "overflow" because the female housing unit was full, rather than because of disciplinary or administrative segregation. These 88 women were subjected to the overly restrictive conditions in RHU, despite being cleared to be placed in general population, in violation of the PBNDS.<sup>109</sup>

## C. Programming, Religious Practice, and Work Opportunities

**Programming.** Imperial has a robust offering of programs for detainees, including an English as a Second Language online course, INEA (Instituto Nacional para la Educación de los Adultos),<sup>110</sup> computer classes, beauty classes for women, Zumba, barbershop (**Figure 35**), religious services, and organized sports tournaments. Outside volunteer groups offer group classes on anger management, parenting, and Alcoholics Anonymous/Narcotics Anonymous. Detainees sign up for classes on a first come, first served basis. Detainees may also pay three to five cents per minute to access music, games, and movies as well as use the phone feature on the tablets.

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<sup>108</sup> Norteños are a gang based in Northern California; Sureños are based in Southern California. The two gangs have a history of rivalry.

<sup>109</sup> PBNDS requires that "[d]etainees shall be assigned to the least restrictive housing unit consistent with facility safety and security." ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § A, p. 62.

<sup>110</sup> INEA is a GED-like course and credits earned can be transferred to Mexico.

**Figure 35. Barbershop, Imperial.**



Despite the number of programs offered and consistent reports of program access, eight of the detained men Cal DOJ interviewed reported they do not attend—either because programs are not offered in their primary language or because they simply have no interest in that activity. Women reported to Cal DOJ that they more consistently participate in programming. One man and one woman detainee reported that while they would like to attend English classes, they do not do so because the classes are computer-based and they are unfamiliar with using a computer.

Under the PBNDS, detainees in administrative segregation should have equal access to programming as general population detainees.<sup>111</sup> However, RHU detainees may only attend programming with approval, and are restricted by classification status.

Detainees in general population may visit the library daily. Those who accessed the library reported that they generally check out books for leisure reading or prayer. No detainees reported having issues accessing the library. However, reading material is available primarily in English. The Cal DOJ team toured the library and observed that there were limited books available in languages other than English and Spanish, and current newspapers and periodicals were not available in any non-English language.

**Religious Practice.** Imperial facilitates the practice of several faiths through chaplain and volunteer-led services and programs. There are services offered for Sikhs, Catholics, and Christians. At the time of Cal DOJ's visit, there were also detainee-led Eritrean Orthodox services, and one on-call rabbi. The chaplain also collects donations of religious materials including prayer rugs, headwear, religious texts, and prayer books. Detainees are generally allowed to keep religious items unless they pose a security risk. Unlike many other detention and correctional facilities, Imperial appears to approve hair length, facial hair, and religious objects. Religious diets are generally approved without an interview or test to ascertain whether the detainee has a "sincerely-held belief." During Cal DOJ's visit, the facility hosted an Eid celebratory dinner to mark the end of Ramadan.

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<sup>111</sup> ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, § L, p. 181.

**Detainee Work Program.** Imperial facilitates ICE’s detainee work program, and demonstrates initiative to create work assignments for male and female detainees. The assignments are intended to provide skill-building, reduce idleness, and create income. Approximately half of the detainees who participated in individual standardized interviews with Cal DOJ reported they had a paid work assignment at the facility. Job opportunities include the laundry, cleaning crews, serving meals in housing units, and kitchen assignments. Detainees with a high security classification generally cannot work outside the housing unit. Detainees who wish to work submit a request and must receive security and medical clearance (for kitchen). Although some detainees noted the turnaround time for receiving work assignments was timely, three indicated they had been waiting between two to five months for their assignments.

Detainees are generally paid \$1 per day for their work, though kitchen and laundry workers are paid \$1.25. Most who provided comments regarding their work compensation reported that they are duly compensated for their work. However, three detainees from the same housing unit reported they were not compensated for the duties they performed. Two of these detainees reported they were assigned to daily clean-up duty of the common areas in their housing unit, while the other indicated he assisted with meal service, but was not paid. All three were unaware of why they had not been paid.

## D. Food and Nutrition

Imperial serves three hot meals a day, on a five-week menu cycle. Meals are cooked on-site (**Figure 36**). The menu contains no pork, beef, or nuts. Imperial also accommodates several special diets, including a religious diet, vegetarian diet, and medical diet. At the time of Cal DOJ’s visit, 201 detainees—accounting for 29 percent of the population—received a special diet. Detainees reported no obstacles or significant delays in receiving special diets, including religious diets.

Cal DOJ interviewed 43 detainees regarding the food served at Imperial.<sup>112</sup> Twenty-three of these voiced concerns about the food served at the facility, with most reporting concerns regarding small

**Figure 36. Kitchen, Imperial.**



<sup>112</sup> One interviewee was not asked this question.

portion sizes (9), too many hours between dinner service and lights out, bland food, too much processed food, and undercooked poultry (6). At least five detainees reported that they supplement meals with items from the commissary if they can afford to do so. The food menu is reviewed annually by a consultant dietician for nutritional and caloric adequacy. In the 2018 review, the dietician consultant noted that some meals may have potentially low caloric amounts.

During Cal DOJ's visit, the team observed that the kitchen facility was clean and orderly.

## E. Non-Legal Visitation, Telephone Calls and Videoconferencing, and Mail

**Non-Legal Visitation.** The facility has both non-contact and contact visitation areas, and the latter includes a children's play area (**Figure 37**). In-person visitation occurs Wednesday to Sunday from 1:00 pm to 9:00 pm and is scheduled by classification and gender. Male and female detainees never mix during visitation unless they can prove they are married. Personal visits are limited to two hours and most, if not all, visits are contact visits.

**Telephone Calls and Videoconferencing.** ICE contracts with Talton Communications to provide phone service at Imperial. There are seven phones in each general population housing unit (**Figure 38**). All phones are located in the dayroom and detainees are afforded no guaranteed privacy when making calls. There are two mobile telephones that can be wheeled to detainees' cell doors in RHU. Detainees may use the telephones from wake up to lights out.

**Figure 37.**  
**Visitation Area, Imperial.**



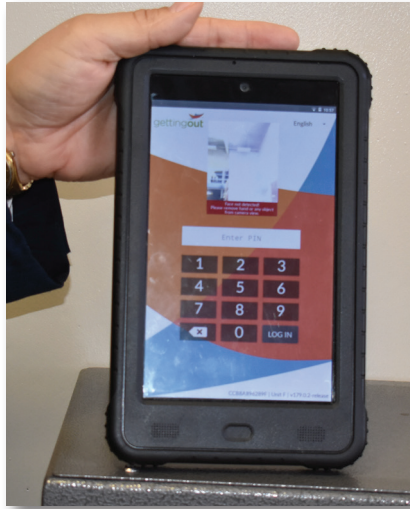
**Figure 38. Phones in General  
Population Housing Unit, Imperial.**



Local calls cost seven cents per minute and international calls cost 15-35 cents per minute. Detention staff reported that if there is an emergency, if a detainee is indigent (has less than a specified amount in their account),<sup>113</sup> or if a detainee wants to make a confidential legal call, the detainee can request a free call in R&D. However, the facility does not actively inform detainees that this option is available via the ICE or the facility handbooks, or otherwise.

<sup>113</sup> Per PBNDs, detainees with less than \$15 in their account are indigent. ICE, PBNDs 2011, Part 5.1 Correspondence and Mail, Part V, § B, p. 358.

**Figure 39.**  
**Tablet Used at Imperial.**



Family members or others may call and leave messages, which facility staff relay to detainees.

Videoconferencing is available on the tablets for a cost of 20 cents per minute and is subject to monitoring and recording (**Figure 39**).

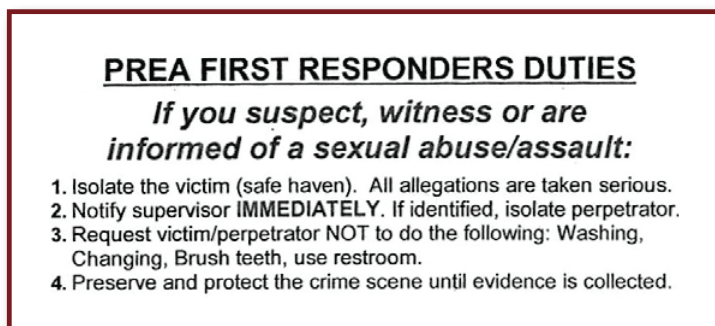
**Mail.** Detainees who reported sending or receiving personal mail at Imperial generally had no complaints about mail service. Unlike other facilities where only legal mail is opened in front of detainees, at Imperial, detention officers open all mail in front of the detainee in the housing unit, search for contraband, and then give the mail to the detainee.

Based on the corrections expert's interviews with detainees, it appears some detainees are unaware that indigent detainees can receive weekly, limited postage and envelopes to correspond with family or friends, although this opportunity is listed in the facility handbook.

## **F. Sexual Harassment and Abuse and Abuse Prevention and Investigations**

Imperial's PREA protocols, covering allegations of sexual assault or harassment, are more expansive than those at other facilities that Cal DOJ has visited and appear to be effective. At intake, the PREA coordinator personally administers an in-person PREA orientation in English or Spanish to each detainee to explain the rules regarding touching and sexual misconduct at the facility, what to do as a victim, and the consequences of being a perpetrator. The PREA coordinator uses illustrative cards, translated to Mandarin, Punjabi, Hindi, Russian, Urdu, and Tamil, as needed, to conduct the orientation. If a detainee is flagged at intake as having a special vulnerability or a history of sexual assault, mental health clinicians and the PREA coordinator are alerted.

**Figure 40. Snapshot of PREA First Responder Duties, Imperial.**



Detention staff carry a PREA step-by-step response card on their person at all times and are trained on how to respond to a PREA incident at onboarding and during refresher trainings (**Figure 40**). If a sexual misconduct allegation involves a detainee-on-detainee incident, protocol requires detention officers to separate and isolate the individuals and contact the shift supervisor. If the allegation involves a staff-on-detainee incident, the officer calls Human Resources to report the incident. For both incident types, medical staff and the PREA coordinator are contacted. All PREA related incidents are reported to ICE. If the alleged perpetrator is staff, a volunteer, or a contractor at the facility, the incident is classified as criminal in nature and is referred to the local Sheriff's Department for investigation. The facility PREA coordinator investigates a staff-detainee PREA incident after the criminal investigation is completed and only if required by ICE.

The PREA coordinator maintains extensive records of detainee orientations, individualized screenings for risk of victimization, correspondence with facilities that a detainee is transferred to or from, and investigation files.

Imperial recorded eight alleged PREA reports from March 14, 2018, to March 8, 2019. Of the eight allegations, four were determined to fall under PREA, and all were determined to be "unfounded" or "unsubstantiated."<sup>114</sup>

## **G. Staff and Detainee Relations**

### **(i) Staffing, Overtime, and Training**

Facility management invests considerable time and effort into hiring optimal detention staff. At the time of Cal DOJ's visit, the facility's detention workforce consisted of the Warden, Deputy Warden, Chief of Security, six lieutenants, seven sergeants, and 133 custodial staff. The facility provides the same training to both full-time and part-time, civilian and custodial personnel, in accordance with best practice. Training includes an 80-hour pre-service, 40-hour on-the-job, and an annual 40-hour in-service refresher program. Mental health staff provide annual suicide prevention and cultural competence trainings to all staff. PREA training is provided to all volunteers and contractors at the facility.

<sup>114</sup> Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities, 79 Fed. Reg. 13100 (Mar. 7, 2014).

Most detention staff rotate through assignments, which allows them to gain knowledge about the entire population and decreases the possibility of complacency and forming special relationships with specific detainees. The Cal DOJ corrections expert found that while this practice is beneficial, it also increases the likelihood of not following through with detainee-specific issues that may arise during that shift.

Cal DOJ's corrections expert also found that facility staffing levels were insufficient to provide minimum coverage without overtime, which is often required of detention staff. Staff reported low salaries, lack of raises, and frequent overtime as factors contributing to turnover. **A group of detention staff anonymously wrote a letter to Cal DOJ during the course of the visit raising concerns regarding overtime, lack of pay raises, inadequate healthcare, and unhealthy food served.**

### **(ii) Demeanor of Detention Staff**

Detention staff are knowledgeable about their work assignments, duties, and detainees. Staff appear to share a common mission, to conduct themselves professionally, and ensure the facility operates safely.

Regarding detainee interaction with staff, the vast majority of detainees reported that they feel safe at Imperial and that if they need help, they could ask detention officers. Although most detainees reported that detention officers do not insult or verbally (29 out of 43) or physically (41 out of 42) abuse them, 14 detainees reported that detention staff yell at them for various reasons, such as not knowing the rules, or not cleaning; and three detainees reported that staff has used disrespectful language or insults towards them. Detainees reported that staff treat them humanely at Imperial, which was not generally the case for detainees' reports from other facilities.

### **(iii) Bunk and Cell Searches**

Detention officers conduct assigned bunk and cell searches twice a day. Detainees reported that detention officers are generally respectful of their property, including religious texts, and allow detainees to be present during the search. Nine detainees complained that, for health and safety reasons, detention officers confiscate food they have not consumed after the meal service has concluded. Detainees reported commissary items are left intact.

Detainees are subject to pat down searches when returning to their housing unit from the large recreation yard, library, or kitchen. Random pat down searches are generally not conducted. Strip searches are rarely done and require reasonable suspicion and Warden approval.

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<sup>115</sup> ICE, PBND 2011, Part 2.15 Use of Force and Restraints, Part I.



#### **(iv) Use of Force**

PBNDS policy on use of force adopted by Imperial, allows detention staff to “use necessary and reasonable force after all reasonable efforts to otherwise resolve a situation have failed.”<sup>115</sup> Cal DOJ’s corrections expert found that, as required by PBNDS policy, detention staff primarily manage behavior through verbally engaging with detainees, including addressing detainees as Sir or Miss, and maintaining a conversational voice and eye contact. The facility does not issue tasers or chemical agents, such as pepper spray, to detention staff.

When use of force is planned, the facility utilizes its “Disturbance Control Team,” which undergoes training once a month on use of force. Immediate use of force may be required to prevent an immediate threat to a detainee(s), staff, or the security of the facility. When verbal efforts fail, and an unplanned use of force is necessary, detention officers activate the Incident Command System—which triggers a specialized team and medical response—and wait for back up if at all possible. PBNDS and facility policy requires videotaping both planned and unplanned uses of force.

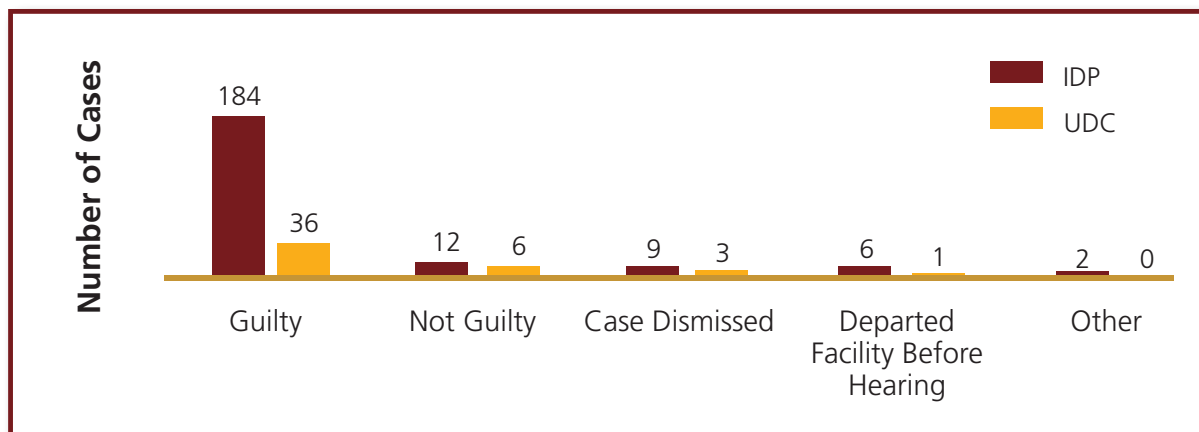
Imperial maintains a use of force log and provided Cal DOJ with a log containing a total of 20 cases from March 20, 2018, to March 20, 2019. Ninety percent (18 out of 20 cases) of incidents reported in this log were categorized as “Unplanned,” or immediate, uses of force; ten percent (2 out of 20) were “Planned,” or calculated. None of the 20 cases reported the usage of intermediate force weapons or firearms. Two of the 20 use of force incidents resulted in detainee injuries, both of which occurred during unplanned uses of force.

#### **(v) Discipline and Control**

Detention staff reported that detainees may be subject to disciplinary action for a variety of behaviors, including refusing to help with cleaning; refusing to go to bed or interfering with count; fighting; showing disrespect; stealing; destroying property; lying to an officer; or touching other detainees. Detainees reported being disciplined for arguing with officers, and fighting, kissing, pushing, and arguing with other detainees. Per the PBNDS and facility policy, detainees appear before the Unit Disciplinary Committee (UDC) for minor violations—insolence, misuse of phone, petty theft, refusal to clean up—or the Institution Disciplinary Panel (IDP) for more serious violations, such as fighting. Detainees reported that they have little opportunity to speak and be heard at the hearings. Per the detainee handbook, detainees may request an advocate at the hearing. However, many detainees (and staff) interviewed were unaware of this option, or did not avail themselves of it. Once the disciplinary panel is held, the Warden has the final approval authority.

Based upon Cal DOJ’s review of Imperial’s disciplinary log dated from January 4, 2018, to May 24, 2019, 82 percent (213 out of 259) of incidents were in the more serious IDP category, whereas 17.76 percent (46 out of 259) were in the UDC category. Eighty-five percent (220 out of 259) of all the cases received a Guilty outcome (**Figure 41**).

**Figure 41. Outcomes by Disciplinary Hearing Type, Imperial.**<sup>116</sup>



*Note. Other includes case dispositions of Diagnosed Incompetent by Mental Health and Detainee was Bonded.*

Of the 220 cases that received a Guilty outcome, 80 percent (175 out of 220) of detainees were placed in disciplinary segregation;<sup>117</sup> 12 percent (26 out of 220) received a loss of privilege sanction;<sup>118</sup> and seven percent (15 out of 220) received a reprimand or warning.<sup>119</sup> The particular sanctions and number of days sanctioned for the most frequent offenses varied for each unique offense combination. For instance, for a high-level fighting offense, detainees received sanctions including some type of segregation—disciplinary segregation with or without loss of privileges. For a low-level offense of “conduct that disrupts,” most detainees received lost privileges, for a length of time ranging from 1-30 days, or multiple sanction ranges were specified. For example, one detainee lost recreation privileges for 10 days and commissary privileges for 15 days. The wide variety of possible disciplinary actions for any given violation suggests there is little consistency in disciplining detainees.

**Figure 42** illustrates the types of sanctions based on guilty outcomes as well as the sanction ranges for these outcomes in 10-day increments.

Based on Cal DOJ’s review of disciplinary logs, disciplinary segregation sanctions ranged from 1-30 days. Ninety-three percent (149 out of 160) of detainees sentenced to disciplinary segregation were released prior to or within the time specified by their sanction; three percent

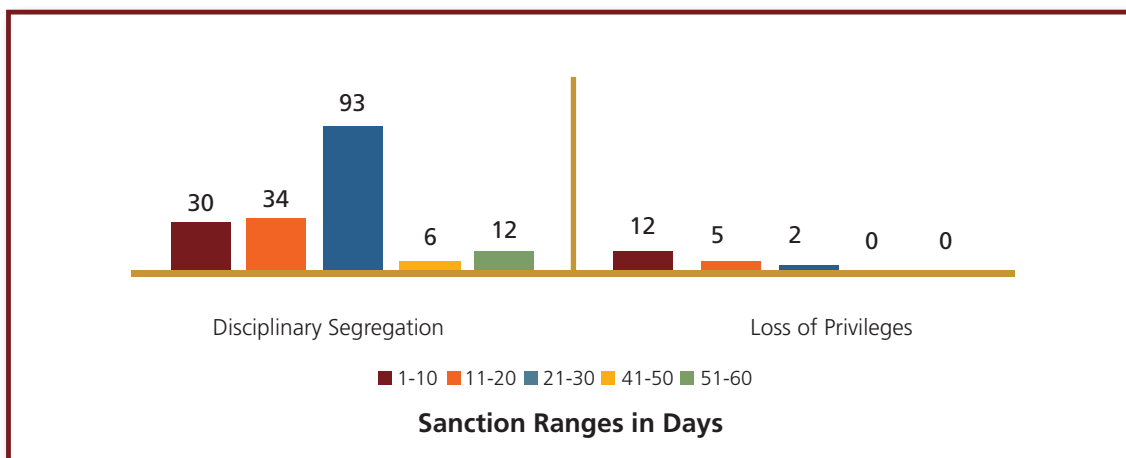
<sup>116</sup> The ‘Case Dismissed’ outcome included the following reasons for dismissal: Due process violation, incompetent at time of incident, lack of evidence, and time constraints.

<sup>117</sup> Twelve detainees placed in disciplinary segregation additionally received loss of privileges sanctions. For those who received a Disciplinary Segregation and Loss of Privilege sanction, only three entries included information on the loss of privilege. For these detainees, the loss of privilege included a loss of job or commissary and/or their personal property was impounded by the facility.

<sup>118</sup> According to staff and detainees, lost privileges may include TV or microwave privileges and restrictions on recreation, programming or commissary. Other possible sanctions include changing a detainee’s housing unit and sending a detainee to anger management with the facility chaplain. Minor violations, such as interfering with count or refusing to obey a staff member may beget a verbal warning or write up. Violations, such as fighting, boxing, or wrestling, typically result in RHU placement.

<sup>119</sup> One percent (3 out of 220) were placed in quarantine due to a medical outbreak; and for 0.45 percent (1 out of 220) no sanction was indicated.

**Figure 42. Guilty Outcomes Sanctions and Sanction Ranges, Imperial.<sup>120</sup>**



(4 out of 160) exceeded their original sanction; and four percent (7 out of 160) of the cases did not specify the length of sanction. A total of five detainees received a consecutive sanction following the completion of their original sanction, and two additional detainees remained in RHU after completing their original sanction due to unavailability of other beds.

At the time of Cal DOJ’s visit, only one of 17 detainees was in RHU for disciplinary reasons.

**(vi) Requests and Grievances**

Detainees may submit requests and grievances through the tablets located in each housing unit.

Detainee requests submitted via tablet are routed through the Chief of Security and sent to the pertinent department at the facility to resolve. Detainees may submit requests for numerous reasons, including medical attention, food accommodations, and work applications.

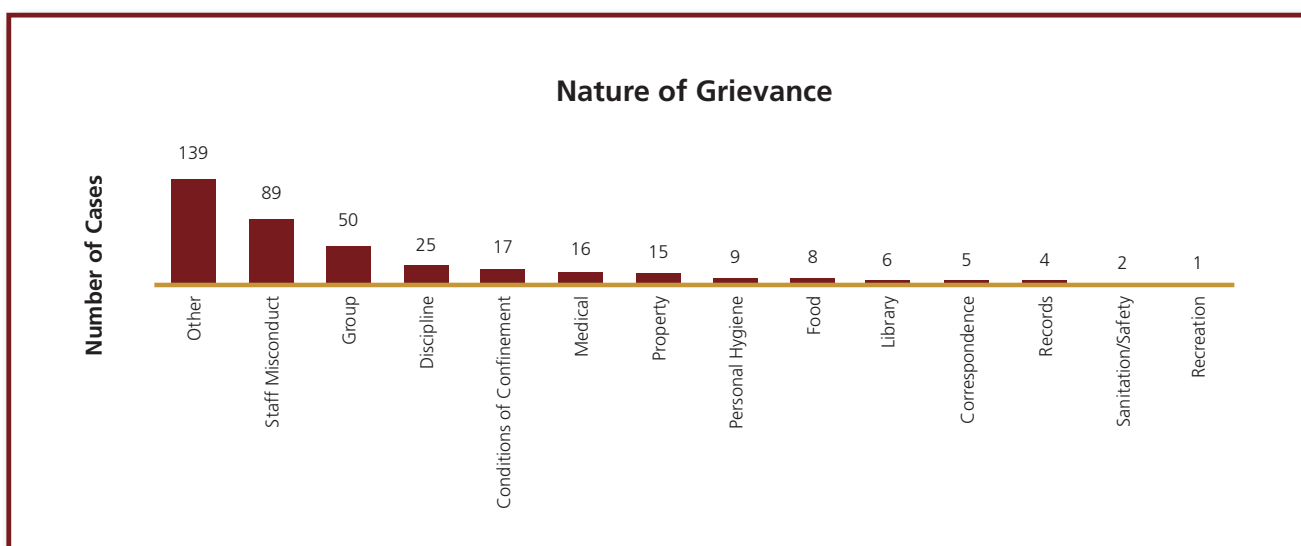
Detainees may file informal grievances verbally, or they may file formal grievances and receive responses and file appeals via tablet. There are three review levels for filed grievances: uninvolved detention officer, Chief of Security, and then Warden for final resolution.

Detention officers reported that detainees most frequently file informal, verbal grievances regarding their court hearing being changed or rescheduled without their knowledge, length of stay, food portions and taste, lack of TV programming in some detainees’ primary language, and cultural differences with other detainees.

<sup>120</sup> Ten cases are not included in this figure. Four of these cases correspond to the loss of privileges sanction and involve cases that received separate sanctions for different aspects of their loss of privilege (e.g., 10-day loss of recreation and 15-day loss of commissary). Three cases received a loss of privileges sanction but the number of days was not specified. The remaining two cases involve two detainees who were placed in medical or dorm segregation given their prior quarantine status.

The Cal DOJ team received a grievance log containing a total of 386 cases dated from January 4, 2018, to April 10, 2019. Imperial categorizes grievances as: Formal, Informal, Emergency, and Medical. Based on our review of the grievance log, grievances are further categorized based on 14 general categories, the majority of which are named in **Figure 43** below.<sup>121</sup> The Other category included issues related to and referred to ICE; facility repair requests (e.g., toilets, telephones); laundry requests; and hygiene, among others. The Group category included grievances filed by an entire housing unit, or two or more detainees. Group grievances were generally related to complaints against other detainees.

**Figure 43. Nature of Grievances filed at Step 1: Grievance Officer Review, Imperial.**



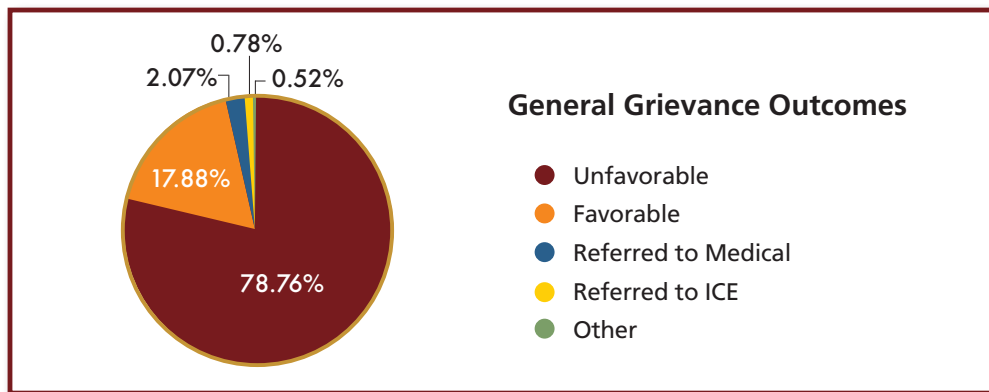
Our review of the grievance log uncovered that when detainees file grievances, the outcomes are rarely in their favor (**Figure 44**). Further, although the housing units have video surveillance, detainees expressed concerns that their requests for review of what they believed to be vindicating video went unanswered. It may be that their requests were received past the video retention timeframe or that the cameras did not cover the areas in question, but staff’s written responses to grievances did not indicate whether they had attempted to review video and were unable to do so.

## H. Hunger Strikes

Per PBNDS and facility policy, a detainee is considered officially on a hunger strike if they miss nine meals or self-declare.<sup>123</sup> According to logs produced, there were two official hunger strikes at Imperial between January 2, 2018, to March 6, 2019.

<sup>121</sup> Both the Other and Group categories concern a number of different issues, some of which overlap with the other major grievance categories. For some cases, however, the narrative does not provide enough information to extract the specific nature of the grievance.

**Figure 44. Outcomes for Filed Grievances, Imperial.**<sup>122</sup>



## 4. Due Process

Perhaps the most significant challenge for detainees at Imperial is pursuing their immigration cases from within a geographically isolated detention facility. Imperial is located approximately 130 miles from San Diego, and 235 miles from Los Angeles—the nearest metropolitan cities—making consistent access to counsel difficult. While Imperial has no legal responsibility with respect to assisting detainees with the litigation of the merits of their underlying immigration cases, Imperial must give them access to legal materials, legal calls, and mail, and the ability to access legal services and representation; facilitate detainees’ attendance in court, whether inside the facility or outside; and provide detainees access to personal property related to their case.<sup>124</sup> Unfortunately, language barriers limit detainees’ awareness and ability to use the limited resources available at Imperial to support them in their immigration cases.

### A. Ability to Access Legal Services and Representation

#### (i) Legal Orientation Opportunities

The American Civil Liberties Union (ACLU) offers a legal presentation once a month in rotating housing units. The program includes a presentation about the immigration legal system and individual meetings with detainees to help them identify claims and defenses, fill out paperwork, and make referrals for legal representation. Because of the limited schedule and the short average length of stay for detainees at Imperial, 33 out of 41 detainees asked reported that they have not attended the presentation or did not know about the presentation.

<sup>122</sup> The Other category represents two cases that were filed close to the date in which the facility provided the Cal DOJ team with the facility logs and thus did not include outcome information.

<sup>123</sup> PBNDS requires that detainees who have not eaten in 72 hours (equivalent to nine meals) to be referred for a medical and mental health evaluation and possible treatment. ICE, PBNDS 2011, Part 4.2 Hunger Strikes, Part II (1), p. 253.

<sup>124</sup> ICE, PBNDS 2011, Part 6.3 Law Libraries and Legal Material, Part V, pp. 422-28.

A representative from the ACLU who Cal DOJ was able to informally interview on-site reported that the facility is accommodating of their program, does not subject ACLU representatives to a time limit to conduct their presentation, and does not require officers to directly supervise the program.

### **(ii) Access to Legal Counsel**

Of the 44 detainees whom Cal DOJ interviewed individually, only 15 were currently represented by counsel, and many by the same attorney. The facility is located in a relatively remote geographic location, there are few legal organizations offering immigration representation in the Callexico area.

Twenty-six of 41 detainees reported that they received a list of phone numbers they could call free-of-charge to seek pro bono legal services. Cal DOJ staff observed that ICE had posted this list in some housing units, but it was outdated. Eight of the 16 detainees who reported that they attempted to call reported that either no one answers, or they were told that the detainee was outside the organization's service area.

Of the 15 detainees who were represented, 11 reported that their attorneys visited them at Imperial, although three of the six attorneys who responded to the Cal DOJ Attorney Survey cited the distance to the facility as an obstacle to visitation. Attorneys may visit in-person seven days a week, at any time, and have no time limit. There are three private contact rooms, two private non-contact rooms, and the large common visitation area that may be used for legal visits. Staff, detainees, and at least one lawyer reported that non-contact rooms are only used during a facility quarantine or if a detainee is ill. At least one lawyer reported that the phones in the non-contact rooms are not always in working order. Further, while there are three contact visit rooms, those rooms are often used by asylum officers to conduct credible fear interviews and are thus unavailable for attorney use during those times. Two detainees who reported they had representation indicated that they meet with their attorneys in the main common area.

Five of the six attorneys who responded to the Cal DOJ Attorney Survey reported no problems delivering legal documents to their clients at Imperial.

## **B. Access to Materials Needed for Immigration Cases**

**Legal Calls, Mail, Property.** Most detainees make calls related to their case in the public dayroom in their housing unit because they are unaware of the option to request confidential legal calls. While attorneys may leave messages for their clients, and facility staff reported routinely delivering messages, three of the six attorneys who responded to the attorney survey and represent clients at Imperial reported difficulties with getting messages to clients. One respondent commented that the facility would not take messages, and another indicated that message delivery was unreliable.

Attorneys who responded to the Cal DOJ Attorney Survey reported some difficulty receiving calls from clients, with three out of six reporting difficulties with the phone system, noting that calls have been dropped, would not go through, and phones have been out of service.

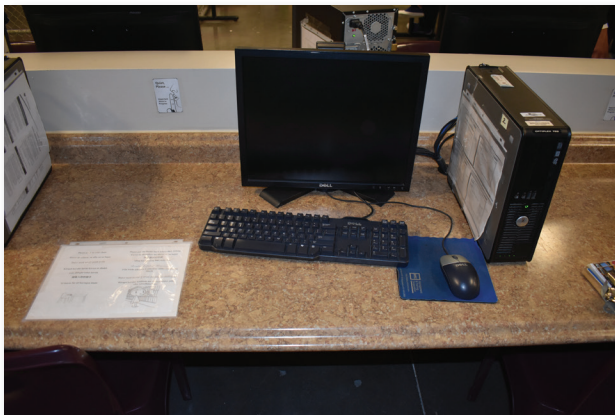
Regarding access to legal materials via mail, detention officers open legal mail in front of the detainee in the housing unit and thereafter give the mail to the detainee. Both staff and detainees uniformly reported that detention officers do not read legal mail.

Facility staff reported that detainees may retrieve photos and numbers off their cell phones when needed for their legal case.

**Law Library and Legal Research Terminals Throughout Facility.** Detainees may frequent the law library on a daily basis, on a rotating schedule according to their housing unit and classification (**Figures 45 and 46**). Computers are uploaded with LexisNexis software, which is ICE’s case law database and should be updated quarterly. Detainees in RHU have access to a caged computer within the unit. The facility reported that detainees are given USB drives so detainees can save their work, but Cal DOJ was unable to confirm this.

The majority of detainees reported visiting the law library at some point, but noted several issues with the resources, including that LexisNexis is outdated, many materials are available only in English, and that no one is available to assist with navigating the database. At the time of our visit, the facility did not have the most recent software update, reporting that ICE had sent them the wrong version, and therefore the case law available was not current. Further, ICE’s formatting of the software is difficult to navigate, and the LexisNexis research material is only provided in English and some in Spanish. Only two of the nine Punjabi-speaking detainees Cal DOJ interviewed individually reported that they had used the computer for legal case work, one to file for asylum and one to draft a letter; neither used LexisNexis. Apart from the computers, the law library has very little hard copy legal research material, and Cal DOJ observed such material only in English and Spanish.<sup>125</sup> The law librarian and detention officers who supervise the library may assist with making copies and locating items if a detainee asks, but are not required to assist detainees with navigating books or LexisNexis.

**Figure 45.**  
**Law Library Computer, Imperial.**



**Figure 46.**  
**Law Library, Imperial.**



<sup>125</sup> PBNDs lists that the only material required in a language other than English is the legal dictionary. ICE, PBNDs 2011, Part 6.3 Law Libraries and Legal Materials, Appendix 6.3.A: List of Legal Reference Materials for Detention Facilities, p. 432.

## C. Access to Court

The facility employs two bailiffs who are responsible for coordinating detainees' attendance at credible fear interviews and court hearings. Detainees attend most court hearings via video conference in one of the two video courtrooms located at Imperial. Some detainees reported periodic connection issues with the video conferencing system, sometimes resulting in the cancellation of a court hearing. Detainees are escorted off-site to the Imperial courthouse for merits hearings. All six attorneys who responded to the Cal DOJ Attorney Survey reported that their clients often do appear in person for court. While the facility used to receive a court calendar seven days in advance, at the time of Cal DOJ's visit, it received additions overnight, making it more difficult for the facility to coordinate court appearances.

# 5. Healthcare

## A. Medical Care

MTC provides medical, mental health, and dental care on-site.

Healthcare is overseen by a Health Services Administrator (HSA) and the Director of Nursing (DON). At the time of the Cal DOJ visit, the medical care service was staffed by one physician, two nurse practitioners, eight LVNs, nine RNs, and as-needed nurses. Two RNs and two LVNs are on-site at any given time. The nurse practitioners and physician work full time, five days per week, and are on call thereafter. There is one licensed dentist and one certified dental hygienist who work full time, five days per week.

The intake health screening occurs within 12 hours of a detainee's arrival at the facility. This process includes an initial visual assessment by a nurse to observe detainees for signs of distress, itching, or rash; a chest x-ray to screen for tuberculosis; a medical and mental health questionnaire evaluation; a physical exam; and obtaining a consent form for treatment. The female medical intake process additionally includes assessment of gynecologic history, need for referral to breast and cervical cancer screening, and need for sexually transmitted infection testing. At any point in this process, the nurse may transfer the individual to the medical unit for observation, a valuable practice to prioritize care for new arrivals who may be sick.

Detainees may submit a formal medical request through the tablets located in the housing units. Detainees reported that they are seen by the medical staff within one day, a meaningful improvement from the two- to three-day turnaround time that the facility reported when medical requests were submitted by paper. Detainees may also approach detention officers for immediate medical issues.

All sick calls and walk-in care visits are assessed by RNs and may be referred to a nurse practitioner or the physician (**Figure 47**). Female detainees are only seen by the female nurse practitioner. Chronic care patients are assigned to one of the three clinicians for ongoing care. Patients who require treatment for tuberculosis are referred to a visit with a local infectious disease specialist after



one month. On-site dental services include extractions, fillings, bite-wing films, and dental cleaning after one year at the facility. Dental referrals are made as needed from intake or nurse visits.

In RHU, a RN conducts and logs daily wellness checks on all detainees. The interaction with the detainee is brief, occurs through a closed cell door, and usually takes place in the morning.

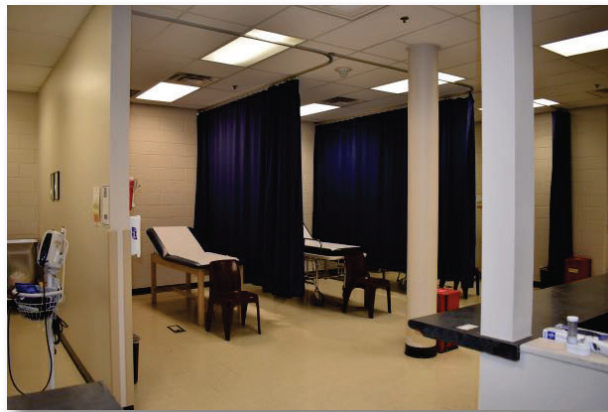
Imperial does not have an on-site pharmacy. Pharmacy orders are filled by an out-of-state contractor and sent overnight. Supplies for urgent dosing are procured from the local Rite Aid. The interviewed detainees who had arrived to the facility with medication did not report issues with continuity of care. Some medications are issued in self-carry supply, and small packets of over the counter medications may be ordered from commissary.

There are seven negative pressure cells, an accessible cell for use by detainees with disabilities, and a suicide watch cell in the medical unit.

If detainees require medical or mental health attention beyond what is provided by the facility, they are taken to El Centro Medical Center for medical emergencies; the Alvarado Pathway Institute for mental health needs; or transferred to Otay Mesa Detention Center for in-custody care. Non-emergency off-site referrals must be approved by ICE. When detainees are transported off-site for medical purposes, the transport vehicles use dividers so that both males and females, or high and low security classification detainees, may be transported simultaneously. Three officers serve as escorts per vehicle, and two are armed.

Cal DOJ's medical expert reviewed 37 medical charts, and her findings are informed by the National Commission on Correctional Health Care (NCCCHC), the American Correctional Association, the 2011 PBNDS, and Title 15 of the California Code of Regulations.

**Figure 47.**  
**Medical Exam Area, Imperial.**



## **(i) Medical Care Concerns**

Although most detainees did not report concerns with the timeliness and adequacy of healthcare at Imperial, Cal DOJ's medical expert identified several concerning practices and areas for improvement.

### **a. Overreliance on Nursing Protocols**

When a detainee sees a nurse in the medical unit, visits are most often resolved by following printed assessment protocols sourced from MTC corporate headquarters. Over 50 assessment protocols are kept on file, addressing anything from toothaches and headaches to abdominal pain and unconsciousness. Most uses of protocols were appropriate, but some nursing assessments raised concerns. A few examples are:

- One patient was seen by a RN for "pain to left leg and swelling" they had been experiencing for one year, with bruising noted to the shins. The RN provided Tylenol, and advice to return to clinic if the pain worsened. This incident warranted elevation to a healthcare clinician due to the possibility of asymmetric leg swelling indicating deep vein thrombosis, a life-threatening condition.
- One detainee was assessed for abdominal pain with the same nursing protocol four times within two months, with the RN providing a 3-day supply of antacids each time. Only on the final visit was the patient referred to a healthcare clinician. Abdominal pain can have life-threatening causes and should not be assessed without clinician involvement. Likewise, recurrent clinic visits for the same complaint cannot safely be managed with repeated nursing assessments, without clinician involvement.

Nursing protocols may be appropriately utilized by nurses to collect information and assess specific complaints. However, as a general practice, nurses at Imperial over-relied on protocols when patients presented particularly severe or repeated symptoms, without consultation with clinicians, thereby potentially overlooking and failing to treat possibly life-threatening conditions. Lowering the threshold of when to involve a clinician in a treatment decision or plan would significantly resolve this issue.

### **b. Communicable Disease Protocols**

At the time of our visit, Imperial did not have written protocols to manage the outbreak of communicable diseases. Imperial had faced at least nine outbreaks of chicken pox or mumps in the six months prior to Cal DOJ's visit (information on Imperial's management of COVID-19 is discussed separately in the *COVID-19 at Immigration Detention Facilities in California* section). To address the situation, the physician and HSA researched the control of outbreaks in correctional facilities, worked with the county health department and ICE epidemiology unit, and implemented testing and vaccination plans.

Despite the diligent effort, Imperial was unable to address problems in real time. For instance, the varicella (chicken pox) vaccine is best offered within three to five days of exposure to rash in order to provide best protection.<sup>126</sup> Cal DOJ's medical expert chart review indicated a wait time to administer vaccination until corporate staff's approval. Delayed administration of vaccines can reduce their effectiveness. One detainee submitted a grievance during a varicella quarantine, expressing concern that he might miss an upcoming court appointment. One week later, he had still not been given a vaccine. This report raised concern that there is insufficient planning and communication to address outbreaks, including contact tracing or otherwise assessing exposure risks and immunity status of individual detainees.

Further, rather than administering varicella vaccines as a matter of course, the facility locked down entire housing units where one patient from that unit had contracted chicken pox or mumps. These lockdowns occurred in different housing units, at different times, and significantly affected daily operations and detainees' freedom of movement. Detainees were unable to visit the library or attend some programming, and workers with jobs outside the housing unit could not report to work.

The lack of protocols regarding quarantines also affected detainees' ability to attend court. When quarantines first began, detainees could attend their court appearances if they were immune and cleared by medical. Then, Imperial staff reported that ICE instructed the facility not to take detainees to court if they were under quarantine, even to attend video hearings. Detainees' immigration cases were needlessly postponed due to the potentially unnecessary quarantine of entire housing units. One detainee and one attorney with a client at Imperial reported that court dates were rescheduled to later dates due to the lockdowns.

### **c. Language Barriers in Healthcare**

At the time of our visit, all nursing staff were bilingual in Spanish and English; one was multi-lingual. Staff sometimes, but not always, used the language line to speak with detainees who do not speak either language. Cal DOJ's medical expert spoke to a Punjabi-speaking detainee who reportedly declined a gynecology exam on the day of arrival. However, this care was described to her as a "total body check" by a male medical staff who "had learned some Punjabi," suggesting that the staff member may not have accurately conveyed the purpose of the exam. Providers "getting by" with acquired language skills in medical encounters with patients who have limited English or Spanish proficiency is a potential source of medical error.

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<sup>126</sup> Centers for Disease Control and Prevention, Strategies for the Control and Investigation of Varicella Outbreaks Manual, 2008 (2008) <<https://www.cdc.gov/chickenpox/outbreaks/manual.html#ref49>> (as of October 27, 2020).

Cal DOJ personnel also observed potential miscommunication with regard to medication dispersal during pill call in the housing unit. Some Punjabi-speaking detainees had questions regarding their medication, and though the nurse conducting pill call attempted to communicate through hand gestures, she did not have immediate access to a language line in the housing unit. As a result, she was unable to provide simple information regarding medication administered, for example, for an as-needed medication dose. However, the Cal DOJ team observed that the nurse wrote down the detainees' names and followed up with them later.

#### **d. Manual Recording System Allows for Error**

The Offender Data System (ODS), which Imperial uses to schedule off-site appointments, allows for lapses in off-site medical appointments. One medical records staff member is responsible for scheduling off-site medical appointments and retrieving reports and recommendations from off-site care. During chart review, Cal DOJ's medical expert found indications of lapses in coordination of off-site care, which can lead to delay in care or worsening of medical issues. Examples of failure to properly coordinate off-site care and potential consequences include the following:

- In one instance, the scheduling staff member called for a report from an off-site provider and was told that the patient had not shown up for the test, indicating a possible lapse in communication with transport staff.
- One patient's injury worsened due to lack of communication and a failure to record missed appointments. Records indicated that the patient arrived at Imperial in a splint, on crutches, with hospital imaging detailing a leg fracture. The physician ordered an urgent referral to the local orthopedist, which was scheduled for approximately two weeks later. However, the patient was not seen until almost a month after arriving at the facility, and even then, the patient was sent to the orthopedist without the necessary imaging or x-ray. Despite follow-ups being scheduled by the orthopedist, the patient was not taken to the provider on scheduled dates at least twice. These missed appointments were not noted in the patient's record. By the time the patient was taken to a specialist, a CT scan revealed a severe fracture with fragment malalignment, ankle joint deformity, and severe bone loss. By the time the facility provided access to orthopedic follow up, the detainee required referral to a more specialized trauma surgeon due to fracture complications.

#### **e. Nurse Decisions**

In reviewing intake forms, our medical expert found that LVNs were completing and signing forms which include the disposition of patients, such as "general population" or "without restrictions," indicating that a detainee is medically cleared to be placed in a housing unit. Relatedly, in reviewing RHU files, it appeared that LVNs were approving detainees' placement

in RHU. Designating dispositions for detainees constitutes development of a care plan, which is outside the legal scope of LVN practice.<sup>127</sup>

#### **f. Care in Restricted Housings**

Cal DOJ's medical expert observed that some RHU patients refuse sick call even after submitting an electronic request. One individual in the RHU who submitted an electronic sick call request for stomach pain one night declined sick call the next morning. While the medical chart noted that the patient declined to go to the clinic, the refusal form failed to provide any explanation for the refusal. Counseling patients on the risks of declining care, and eliciting a patient's reasons for refusal are important components of informed decision-making. Further, clinicians should be notified and investigate patient refusals to go to the clinic.

Checking on detainees in front of the cell door, as is routinely done in RHU, does not allow for confidential, meaningful interactions between detainee and nurse, given that others are within earshot of any conversation, in potential violation of the Health Insurance Portability and Accountability Act (HIPAA).<sup>128</sup> The rounds take place early in the morning, sometimes when detainees are sleeping. Shifting medical rounds to a schedule when patients tend to already be alert and awake, such as after a meal, could encourage communication with nursing staff during rounds.

The restrictions inherent to indefinite or disciplinary isolation create a barrier to movement to the medical clinic, impede the development of a therapeutic rapport between patient and clinical staff, and potentially interrupt the access to medical services.

#### **g. Continuous Quality Improvement**

Monitoring the provision of medical care through "Continuous Quality Improvement (CQI)" allows for the identification and improvement of healthcare operations. Each month, the HSA randomly reviews up to 10 medical charts to evaluate certain medical subject areas, such as diabetes, asthma, and emergencies. The physician also randomly selects 10 charts to review each month for performance of each nurse practitioner. While these internal practices are commendable, they do not target identification and improvement of potentially deficient practices.

Meaningful CQI would identify and correct deficient practices that could improve patient care and safety, such as missed or delayed off-site consults, nursing triage visits that were not discussed in real time with a clinician, or repeated patient visits for the same complaint.

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<sup>127</sup> See e.g. Cal. Code Regs., tit. 16, § 2518.5.

<sup>128</sup> HIPAA provides that an individual's protected health information may not be disclosed without valid authorization by the individual.

#### **h. Detainees with Disabilities**

At intake, medical staff assess detainees for any visible disabilities, or detainees may request disability accommodations. The facility provides crutches and wheelchairs. For detainees who have low vision, the facility assigns the detainees to a lower bunk on the first floor, nearer to the detention officer, for safety reasons.

Imperial has an ADA<sup>129</sup> committee comprised of the HSA, the DON, a medical provider, the Warden, the Deputy Warden, the Chief of Security, and the Classification Manager, which reviews disability accommodations after 30 days, and then after 90 days.

The HSA and DON stated that no policies or practices are in place to identify, evaluate, and accommodate detainees with limited intellectual functioning, or impairments requiring accommodation by braille or ASL.

#### **i. Lack of Vision Exams**

A cursory vision screening takes place at intake. While most detainees reported healthy vision, at least four shared that they do have vision issues, but have not been examined, let alone provided glasses. Impaired vision coupled with language barriers is likely to further impede effective communication.

## **B. Mental Health Care**

Mental health services at Imperial consist of a mental health screening at intake, crisis intervention, on-call services, individual therapy, and medication evaluations and management. No inpatient psychiatric unit exists on-site.

At the time of our visit, mental health staff included one full-time licensed social worker (LCSW), one full-time licensed marriage and family therapist (LMFT) who had joined Imperial just the week prior to CalDOJ's visit, and one part-time board certified psychiatrist who worked approximately 16 hours per week and was only on-site on weekends. The LCSW and LMFT were bilingual in English and Spanish.

Detainees can access mental health services by electronically submitting a sick call request via tablet, or by being referred to mental health services by other medical or custodial staff.

At the time of Cal DOJ's visit, the Warden reported that approximately 80 percent of the population at Imperial was seeking political asylum. Many asylum seekers have witnessed or experienced a variety of traumatic events and tend to have higher rates of mental health conditions, which are further negatively affected by detention.<sup>130</sup> Yet, based on the mental health roster at the time of Cal

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<sup>129</sup> Shorthand for Americans with Disabilities Act.

DOJ's visit, only 26 of 685 detainees were receiving mental health services (4%), and, of those, 20 were prescribed psychotropic medication (3%).

Cal DOJ's mental health expert reviewed 40 clinical charts. Her findings below are informed by PBNDS, Title 15, NCCHC, and best practices in the field.

**(i) Intake Assessments, Evaluations, and Diagnoses**

**Intake.** Based on a review of records, Cal DOJ's mental health expert found that intake forms fail to reflect mental health concerns for incoming detainees. In general, intake forms are marked "negative" for mental health issues, and referrals to mental health are not noted, even if they occur. In one case, a patient arrived with medical records from a prior facility that stated that he had "panic attacks and has claustrophobia secondary to childhood trauma and panic disorder." Imperial mental health intake records noted nothing about these conditions, even though the intake RN referred this patient to mental health. Chart review also revealed at least one inappropriate mental health referral, where the intake nurse referred a patient to mental health based only on the individual's identity as "gender non-conforming."

**Psychotropic Medication.** Based on Cal DOJ's mental health expert's review of the charts of detainees on psychotropic medication, mental health staff fail to complete—or at least document—thorough evaluations of patients' mental health while on medication. Half of the psychiatric medication evaluations in these charts consisted of only a short paragraph, often failing to include allergy or historical information, current medications, a clinical formulation (analysis of the mental health problems presented), or the results of the practitioner's examination of the patient's mental status.<sup>131</sup> The psychiatrist rarely noted any medical condition that could be contributing to mental health symptoms, and charts showed deferred diagnoses or noted that certain diagnoses were "ruled out" without providing a definitive diagnosis.<sup>132</sup> At least five patients were prescribed psychotropic medication without a mental health diagnosis, contrary to standard practice. Further, the prescribed dosages of psychiatric medications were sometimes missing from patients' charts.

Due to limited inquiry during mental health evaluations, patients at Imperial are often not diagnosed, or are potentially misdiagnosed or underdiagnosed, resulting in the denial of mental health services and medication tailored to the patient's individual diagnosis.

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<sup>130</sup> See Robjant, et al., *Mental Health Implications of Detaining Asylum Seekers: Systematic Review* British J. of Psychiatry (2009) p. 309 (Clinically significant levels of depression, anxiety and post-traumatic stress disorder (PTSD) were found in a high proportion of detainees in the sample (86%, 77%, and 50% respectively)); Filges, et al., *The Impact of Detention on the Health of Asylum Seekers: a Systematic Review*, Social Work Practice, Vol. 28 (May 2018) p. 399-414, n4.

<sup>131</sup> A mental status exam assesses a patient's mood, behavior, thinking process, and speech.

<sup>132</sup> A deferred or rule out diagnosis occurs when a mental health provider cannot reach a diagnosis, and thus the patient may not receive targeted treatment.

- At intake, one patient was appropriately referred to mental health. The detainee reported a history of trauma, had been diagnosed with depression and schizophrenia paranoia, had attempted suicide, and had been on psychiatric medications until three months prior. However, when a therapist followed up with the patient the next day, a timely response, mental health records indicated that there was minimal inquiry into any of these subject areas; and, despite the patient's history, the therapist declared the patient had no mental illness.
- Another patient was sent to the Alvarado Pathway Institute for elevated mental health care. There, the patient was diagnosed with schizophrenia. Yet, when the patient returned to Imperial, the therapist offered no diagnosis and marked the box on the patient's chart that stated "No serious mental illness."

Even when properly diagnosed, Cal DOJ's record review revealed instances of inaccurate or internally inconsistent recordkeeping, such as failing to update the roster of mental health patients with new diagnoses. Accurate record keeping enables any provider treating the patient to know the patient's background, problems, and prior treatments so that mental health care can be tailored to that patient's needs.

#### **(ii) Failure to Follow Standards of Care for Mental Health Treatment**

**Treatment Plans.** Compounding the inadequacy of evaluations and diagnoses are the incomplete or non-existent treatment plans. Treatment plans (in the charts that included them) lacked detail about specific symptoms to be addressed, how symptoms were impairing functioning, how progress would be measured, or patients' inclusion in the development of treatment plans, as recommended by NCCHC. The plans also failed to include strategies to prevent relapse.

**Continuity of Care.** Continuity of care—maintaining previously provided treatment upon a patient's arrival or return to the facility—is not consistently provided at Imperial. One patient returned to Imperial from Alvarado Parkway Institute with three prescriptions from the off-site facility: one psychiatric medication, and two medications "as needed." At Imperial, the two "as needed" medications were dropped from the patient's records with no recorded discussion or note about why they were no longer necessary. This decision or oversight is particularly dangerous because the patient had been sent for off-site care due in part to catatonic symptoms, which can be fatal.

Further, at least two detainees reported that mental health staff do not follow up on care provided. For example, one patient saw the psychiatrist on a Saturday several weeks prior to our visit. During that encounter, the psychiatrist told the patient that a therapist would see the patient within two weeks. This did not happen. The patient—who was struggling with depression and bullying related to being transgender—attempted to place a sick call request for mental health services via the tablet, but reported receiving a message that the appointment had been cancelled.



**Lack of Proper Psychiatric Medication Monitoring.** Review of the charts of patients on psychotropic medication also revealed that Imperial’s mental health staff are failing to appropriately monitor dangerous side effects from certain psychiatric medications. For example, while patients’ records indicated that the Abnormal Involuntary Movement Scale (AIMS) test was administered to determine whether a patient has Tardive Dyskinesia (a side effect from antipsychotic medications, which can cause uncontrollable jerking movements in the face and body), the absence of psychiatrist notes suggested that mental health clinicians (who are not medical doctors) were administering the test, rather than the psychiatrist. Proper administration of the AIMS test requires that the provider is medically trained to distinguish between different types of tremors associated with psychiatric medication. In addition to administering a test beyond their expertise, those mental health clinicians who are administering the AIMS test are administering the AIMS on all patients taking any type of psychiatric medication, rather than just those on antipsychotics for whom it is needed.

Patients on antipsychotics also require monitoring via blood tests before and during administration of the medication, per standard of care, but records did not reflect that such monitoring took place at Imperial.

**Consent for Medication.** Cal DOJ’s mental health expert’s review revealed that patient files lacked documentation evidencing that Imperial is properly obtaining patient consent for administering psychiatric medication.

For example, one patient was sent to Alvarado Parkway Institute and returned to Imperial on three psychiatric medications. Although the Imperial psychiatrist was not on-site to obtain the informed consent necessary to continue the detainee’s medication, the medication consent form was signed and medication was administered.

### **(iii) Concerns Related to Isolation of Detainees with Mental Health Needs**

**Isolation Instead of Treatment for Suicidal Detainees.** Per mental health logs, there were 59 incidents of suicide ideation or self-harm related incidents that took place between January 1, 2018, and June 5, 2019. Four of the incidents were suicide attempts.

Cal DOJ’s mental health expert reviewed files related to attempted suicide and self-harm and found that the facility’s response is inadequate to address the needs of suicidal detainees. For example, one patient was placed in RHU and tried to hang himself less than one week later. The patient was placed on suicide watch and was seen by the psychiatrist the next day. Despite the suicide attempt, the psychiatrist provided no diagnosis, offered no medication, and failed to conduct a suicide risk assessment or implement a safety plan. Two days later, a therapist determined that the detainee’s suicide risk was low (but did not document why), released the patient from observation, and cleared his return to RHU. When asked about the incident, the psychiatrist said that the patient’s suicide attempt was “a ploy to get out of punishment.” The

detainee reported that placement in RHU and suicide watch had triggered past trauma and brought feelings of helplessness and loneliness.

Suicide watch takes place in a dry cell on the medical unit (**Figure 48**). The cell is barren with only a mattress on the floor, a rectangular fluorescent bar light, and a drain in the middle of the floor. There is no toilet, shower, or sink. Meals are eaten in the cell. If the detainee needs to use the restroom, wash their hands, or shower, they are escorted to another area where they will be monitored as discreetly as possible. Isolation under such conditions does not, by itself, constitute adequate treatment.

**Figure 48.**  
**Safety Cell in Medical Unit, Imperial.**



Relatedly, “cut-down” equipment—utilized to cut down a person trying to harm themselves by hanging—is not issued to staff or made available within housing units. Instead, staff is directed to call for assistance and must attempt to lift the detainee to minimize harm while waiting for a supervisor to respond with a cut down device. This protocol is inefficient and dangerous because time is of the essence and many staff are not able to raise a detainee who is hanging from a noose until help arrives.

Imperial would benefit from revising its practices to address suicide and self-harm, ensure compliance with time-sensitive medical consultations, implement minimum requirements for routine mental health rounds in RHU, and issue cut-down equipment.

**Potential Overreliance on Use of the Safety Cell.** The cell used for suicide watch is also used for any detainee who poses a danger to themselves or to others. Any facility staff can place a detainee in the observation cell if there is a safety concern. Within 24 hours of placement, mental health staff is expected to do an initial evaluation to document level or risk, decide what property the detainee may keep in their cell, determine the level of supervision needed, and whether the detainee needs a high level of care.<sup>133</sup> This evaluation was not consistently being done within the required timeframe. Moreover, examples showed the safety cell was being used to manage detainees' crises or serious symptoms, even when they posed no danger to themselves or others:

- One patient was recorded as “talking to self...odd behavior, disorganized, frightened, could not answer questions.” The patient was referred to medical and mental health staff and immediately admitted to the observation cell, without an initial evaluation to determine the levels of risk posed, or supervision or care needed. Further, in contravention of MTC, ACA, and NCCHC policy and standards, the patient was not evaluated on the date of admission, but rather, two days later.
- One detainee was placed in observation for “shouting religious statements in dorm.” There was no documented threat to self or anyone else that justified isolation.

#### **(iv) Insufficient Mental Health Assessments for Detainees in Restricted Housing**

As noted in *Systemic Issues*, Section 2.B, Imperial fails to ensure mental health approval of restricted housing placements.<sup>134</sup> Between January 1, 2018, and April 5, 2019, 18 detainees were listed on both the facility's suicide history and RHU logs. One detainee was placed in RHU without a suicide risk assessment after a routine cell search revealed contraband. Within four days, the detainee attempted suicide, was placed in the safety cell for suicide watch for four days, and was then returned to RHU, again with no suicide risk assessment. He was not seen by a therapist in RHU for almost one month, despite his prior suicide attempt.

Records of wellness checks for RHU detainees at Imperial failed to flag concerns that were revealed through mental health referrals and treatment, suggesting that wellness checks are inadequate.

#### **(v) Barriers Limiting Access to Mental Health Services**

Many of the barriers to care discussed in “Medical Care” above apply to mental health services as well, including language access and related lack of privacy afforded by the tablets. Below are barriers unique to mental health services.

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<sup>133</sup> ICE, PBNDs 2011, Part 4.6 Significant Self-harm and Suicide Prevention and Intervention, Part V, §§ C-D, pp. 333-34.

<sup>134</sup> Per NCCHC Policy, this evaluation must be done by a mental health professional, not just a medical professional who may only have minimal mental health training.

**Lack of Notice of Mental Health Services.** Imperial does not widely advertise or explain mental health services offered. The detainee handbook, only offered in Spanish and English, mentions mental health in passing, as part of the healthcare services offered at the facility, and does not mention suicide prevention. Although some medical care postings—in English and Spanish only—mention suicide, the Cal DOJ team did not observe postings in any language about mental health care services provided by facility staff or classes provided by outside volunteer agencies.

**Cultural Barriers and Trauma-Informed Practices.** Our mental health expert found that mental health providers at Imperial do little to discuss or document cultural factors that may influence a detainee’s mental health. Distinguishing delusions from religious or cultural beliefs or distinguishing hallucinations from culturally sanctioned experiences is important. Charts do not contextualize symptoms within a cultural context or identity and lack in-depth discussion of how cultural elements may be understood and may or may not influence diagnosis and care.

Further, key healthcare providers are unaware of the term “trauma-informed practices.” Trauma-informed practices would assist mental health staff, as well as detention staff and even volunteers, with being more attune to the ways in which traumatic past experiences—which are potentially compounded by being in detention—as well as culture differences may inform current symptoms.<sup>135</sup>

**Inadequate Staffing.** Per records reviewed, access to mental health providers is severely limited, which compromises Imperial’s ability to see patients within timeframes required by MTC policy and standard of care.

Of particular concern is that access to the psychiatrist is generally limited to one weekend day. Review of the psychiatrist appointment log from January 1, 2019, to June 5, 2019, indicated that the psychiatrist was on-site for both weekend days only five out of 22 weekends. Additionally, the psychiatrist is located 200 miles away from the facility, and thus cannot be on-site for any emergency. Industry standard of care requires that a provider on call be available on-site within an hour, if clinically needed. There is no alternative on-site psychiatric coverage.

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<sup>135</sup> Adams, et al., *Trauma-Informed and Evidence-Based Practices and Programs to Address Trauma in Correctional Settings*, ICJIA Research Hub (July 25, 2017) <<http://www.icjia.state.il.us/publications/trauma-informed-and-evidence-based-practices-and-programs-to-address-trauma-in-correctional-settings>> (as of Oct. 27, 2020).

# Comprehensive Facility Review: Otay Mesa Detention Center

## 1. Background and Summary of Key Findings

The Otay Mesa Detention Center (Otay Mesa) is a non-dedicated (shared use) contract detention facility owned and operated by CoreCivic (formerly Corrections Corporation of America) in San Diego, California.<sup>136</sup> Otay Mesa houses detainees in the custody of ICE and prisoners in the custody of the U.S. Marshals Service.

The facility was built in 2015 with a capacity for 1,482 detainees. A recent expansion to the building added four dorms, increasing its capacity by 512 additional beds, for a total capacity of 1,994. At the time of Cal DOJ's review, the facility had not fully implemented the expansion. In December 2019, ICE granted a contract extension in the amount up to \$2.1 billion to CoreCivic for a period of five years:<sup>137</sup> five years, with two optional five-years extensions, for a total of 15 years. ICE reports that it pays a flat monthly fee of \$2,814,791.55 for a guaranteed minimum of 600 beds, at a rate of \$154.24 per bed, and \$138.29 for any additional beds.<sup>138</sup> Otay Mesa operates under the 2011 PBNDS (rev. 2016), with several waivers granted by ICE related to strip searches, use of chemical agents, and safety cells.<sup>139</sup>

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<sup>136</sup> "Contract detention facility" is the term used for facilities owned and operated by a private entity and with which ICE contracts directly for immigration detention services. ICE, Facility Inspections, Over-72-Hour ICE Detention Facilities <<https://www.ice.gov/facility-inspections>> (as of Oct. 27, 2020).

<sup>137</sup> *US Awards Immigration Detention Contracts In California*, KPBS (Dec. 24, 2019) <<https://www.kpbs.org/news/2019/dec/24/us-awards-immigration-detention-contracts-californ/>> (as of Oct. 27, 2020); ICE, Detention Services Contract Requirement B for California Solicitation 70CDCR20R00000002 (2019) <<https://beta.sam.gov/opp/6e5581f4a56248c0b2497d6b6f80e8af/view>> (as of Oct. 27, 2020); Plevin, *ICE signs long-term contracts worth billions for private detention centers, dodging new state law*, Desert Sun (Dec. 22, 2019) <<https://www.desertsun.com/story/news/2019/12/20/ice-signs-long-term-contracts-private-detention-centers-two-weeks-ahead-state-law/2713910001/>> (as of Oct. 27, 2020).

<sup>138</sup> DHS, ICE, Budget Overview Fiscal Year 2021 Congressional Justification, p. 137 <[https://www.dhs.gov/sites/default/files/publications/u.s.\\_immigration\\_and\\_customs\\_enforcement.pdf](https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf)> (as of Oct. 27, 2020).

<sup>139</sup> Otay Mesa's waivers allow the facility to: conduct strip searches following visitation, even without reasonable suspicion of contraband, which is inconsistent with PBNDS 2.10; use chemical agents other than pepper spray, which is inconsistent with PBNDS 2.15; and use safety cells as holding pens for non-compliant immigration detainees and U.S. Marshals Service prisoners as these are the only cells with floor drains in the facility. ICE, PBNDS 2011, Part 2.10 Strip Searches, Part V, § D(2)(b), p. 121 ("Staff may conduct a strip search where there is reasonable suspicion that contraband may be concealed on the person.") and Part 2.15 Use of Force and Restraints, Part V, § C(4)-(5).

**Table 8. Key Data Points, Otay Mesa.**

<b>Facility:</b>	Otay Mesa Detention Center
<b>Operator:</b>	CoreCivic
<b>Housing Detainees Since:</b>	2015
<b>Bed Capacity:</b>	1,994
<b>Type(s) of Detainees:</b>	Male and Female Adults
<b>Snapshot of ICE Detainees Housed at Otay Mesa on December 9, 2019</b>	
<b>No. of Countries of Origin:</b>	60
<b>No. of Detainees by Gender<sup>140</sup></b>	Females: 114 Males: 751
<b>Average Age:</b>	34
<b>Average Length of Stay</b>	126 days
<b>Longest Detainee Stay</b>	1,515 days

Cal DOJ made the following key findings:

- The facility employs a progressive “unit management” approach, assigning day shift detention counselors and case managers to run programs and respond to detainee requests while detention officers focus on other aspects of operations. Despite the opportunities presented by this system, Otay Mesa has a higher rate of grievances than the two other facilities comprehensively reviewed in this report.
- The layout of the facility—combined with diverse categories of detainees who cannot intermingle due to gender, classification, and custody status—presents significant obstacles to timely and adequate delivery of healthcare and other services.
- Staffing shortages and insufficient physical space for medical and mental health services and protective custody housing negatively impact the standard of care provided at Otay Mesa.
- Provision of mental health services below the community standard of care results in self-harm, psychiatric hospitalizations, and the prolonged isolation and suffering of some of Otay Mesa’s most vulnerable detainees.
- The facility experienced a 284 percent increase in reports of sexual abuse and harassment under the Prison Rape Elimination Act (PREA) from 2017 to 2019, including an increase in substantiated reports. Cal DOJ observed that PREA concerns chilled healthcare assessments and treatment and identified areas where the facility could improve its PREA prevention practices without compromising access to healthcare.

<sup>140</sup> Otay Mesa assigns gender according to the detainees’ assigned gender at birth and did not provide Cal DOJ with the number of transgender detainees.

- ICE granted several PBNDS waivers to Otay Mesa, including one that permits the use of chemical agents other than pepper spray. While some detention centers do not use pepper spray at all, Otay Mesa used chemical agents in at least 18 incidents over a 19-month period.<sup>141</sup> Based on records from 2018, Otay Mesa has a rate of using force more than double the other two facilities reviewed in this report, with a rate of 43.5 uses of force per 1,000 detainees compared to 21.3 (Imperial) and 21.1 (Adelanto).
- As in most immigration detention facilities, language barriers are a serious obstacle to detainees realizing their rights and opportunities in detention and in the immigration legal system.

## 2. Methodology

Cal DOJ held a pre-site visit meeting with Otay Mesa operational staff in June 2019 and conducted a multi-day comprehensive site visit from December 9 through 12, 2019. Although Cal DOJ was not able to view all housing units and certain files were incomplete, CoreCivic and IHSC staff were generally very cooperative with Cal DOJ's review of the facility. The site visit commenced with a tour of the facility. It included interviews with detention and healthcare leadership and nine rank-and-file detention officers and unit management staff; observations of shift change, pill call, intake, nurse visits in the medical unit, and other aspects of operations; review of video footage of several use of force incidents and nursing rounds in the men's restricted housing unit; and document review including medical charts, detainee files, and logs of grievances, use of force, and discipline. CoreCivic counsel participated in all detention staff interviews. Otay Mesa's food services provider, Trinity Services Group, declined Cal DOJ's request to interview the food services manager at Otay Mesa and provided an interview with a Trinity regional manager instead.

Cal DOJ interviewed 100 detainees, 67 who participated in individual standardized interviews and 36 who participated in individual or group interviews with one or more of Cal DOJ's experts.<sup>142</sup> Detainees with whom Cal DOJ spoke came from 25 countries of origin and spoke 12 different languages including English (48), Spanish (32), Mandarin (10), and Punjabi (3), among other languages.<sup>143</sup> Detainees interviewed were on average 35 years old (ranging from 18 to 58 years of age), and had an average length of stay of 232 days (ranging from 2 days to 1,240 days). In addition to interviews with detainees and staff, Cal DOJ's corrections expert reviewed 22 detention files; Cal DOJ's medical expert reviewed over 30 healthcare records; and Cal DOJ's mental health expert reviewed 16 patient charts.

Finally, ten attorneys who had represented an estimated 154 clients at Otay Mesa between July 1, 2018, and June 30, 2019, responded to Cal DOJ's attorney survey. The responses obtained from this survey are integrated in the discussion of detainee due process.

Information about detainee demographics at the time of Cal DOJ's site visit can be found in the *Detainee Demographics Snapshot* section.

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<sup>141</sup> The Use of Force Log provided by Otay Mesa also included nineteen entries with conflicting information about the use of chemical agents beyond the eighteen clear cases.

<sup>142</sup> Three detainees completed both standard and expert interviews.

<sup>143</sup> Interviews were also conducted in Russian, Bangla, Pulaar, Arabic, Armenian, Farsi, and French.

### 3. Conditions of Confinement at Otay Mesa

#### A. Intake and Orientation

When detainees arrive at Otay Mesa, they are initially screened in a sallyport outside the facility. Although a medical screening prior to entry is an important procedure to prevent entry of individuals with communicable diseases, there is no privacy or interpretation service available for this initial medical screening, and it can be delayed due to a shortage of nurses on-site. Once inside, detainees are placed in holding cells (**Figure 49**) where they are physically separated based on gender and whether they are in ICE or U.S. Marshals Service custody. They are questioned for classification and housing assignment purposes, given information about the facility, are provided a free three-minute phone call from a non-private area, and are given a phone card with a five-minute credit to use in the housing unit. Detainees relinquish their clothing and property, take a shower, and are issued facility clothing color-coded by security classification, bedding, and hygiene items. They undergo a further medical screening, which consists of a three-page list of questions and an assessment of vital signs. Detainees that are determined to be suicidal or have severe mental health problems are placed in a safety cell for observation and a mental health evaluation. Nurses can refer detainees for an evaluation by a healthcare clinician within two days or place a patient in the Medical Housing Unit for 24-hour observation prior to being transferred to a housing unit in the event of abnormal findings.

**Figure 49. Holding Cells in Intake Area, Otay Mesa.**

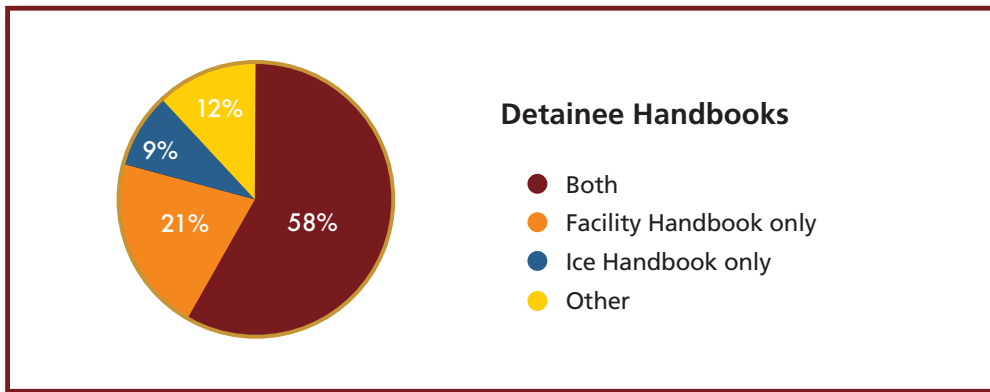


According to facility staff and leadership, detainees are provided a facility handbook and the ICE National Detainee Handbook, are shown orientation videos, and receive an orientation in their housing units to learn about their rights and the rules at Otay Mesa. As illustrated in **Figure 50**, most detainees interviewed by Cal DOJ staff reported receiving both handbooks (39 out of 67), though 21 percent (14 out of the 67 detainees) reported they only received the facility handbook, and nine percent (6 out of 67) indicated they only received the ICE handbook. Language barriers prevent many detainees from reading the handbooks. See *Systemic Issues*, Section 3. Two detainees reported having requested and not received translations of the ICE handbook (Chinese and French) from Otay Mesa. Detainees who read the handbooks found them helpful.



Only one detainee out of nine whom Cal DOJ questioned about orientation videos had seen one, and no detainees cited a housing unit orientation as a source of information about the facility. Nearly half the detainees interviewed by Cal DOJ (24 out of 51) reported learning the rules from fellow detainees rather than other sources.

**Figure 50. Reported Handbooks Received by Interviewed Detainees, Otay Mesa.**<sup>144</sup>



**(i) Security Classification, Special Vulnerabilities, and Management Concerns**

At intake, R&D staff conduct a security classification for each detainee and detainees are screened for any special vulnerabilities or management concerns, which impacts housing assignments and movement around the facility. Cal DOJ found issues with Otay Mesa’s security classification system, as discussed in *Systemic Issues*, Section 1.

**Transgender Individuals.** Otay Mesa houses transgender detainees according to their assigned gender at birth, unless they have undergone a full surgical transition to the gender with which they identify or request protective custody in administrative segregation. Cal DOJ spoke with one transgender detainee who was housed in a male dorm with three other transgender females. She was accommodated with feminine undergarments, but her request for hormone therapy—which she had been prescribed prior to being detained—was denied.

The decision to house strictly by gender at birth is not required by healthcare or other policies and may not always be in the detainee’s best interest. Transgender detainees should have the same opportunity as all others to be housed with detainees with whom they are compatible, and safe alternatives that are less restrictive than the conditions present in administrative segregation at Otay Mesa should be considered.

<sup>144</sup> The Other category refers to detainees (8 total) who reported receiving either an Otay Mesa handbook or an ICE handbook, but were not asked whether they had received the other type of handbook.

## B. Housing Units

At the time of Cal DOJ’s visit, Otay Mesa had nine housing units for ICE detainees in general population settings. In addition, there was one segregation unit each for men and women, and a medical housing unit, all of which housed both ICE detainees and U.S. Marshals prisoners.

### (i) General Population

Two of the general population housing units—one housing low security men and the other low security women—had 16 open sleeping bays with five bunk beds in each bay and separate toilets and showers, with stalls and curtains for privacy (**Figures 51 and 52**). The remaining units have cells with a toilet, a sink, and a door that locks, each accommodating two or four detainees (**Figure 53**).<sup>145</sup> The celled units, which included four newly constructed housing units, housed groups of either low/medium-low or high/medium-high men (**Figures 54-56**). Although facility staff said that they have the option not to lock cell doors in these units, both staff and low security classification detainees in celled units reported that the cells are locked at night and during count. The men’s and low security women’s general population units are free to be outside of their sleeping quarters during daytime hours—from 5:00 a.m. to 10:00 p.m.—except during facility count times. The general population unit for women with medium-high and high security classifications was shared with U.S. Marshals detainees, resulting in restricted dayroom and recreation time compared to other general population units because the two populations cannot comingle in the dayroom or recreation areas.

**Figure 51. Sleeping Bay Behind Phone in Open Bay Dormitory, Otay Mesa.**



**Figure 52. Tables and Bathroom Facilities in Open Bay Dormitory, Otay Mesa.**



**Figure 53. General Population Unit with Locking Cells, Otay Mesa.**



<sup>145</sup> There was one housing unit that Cal DOJ did not enter and view during its tour of the facility, and therefore could not confirm whether it was an open bay dormitory or celled style unit.

**Figure 54. Toilet and Sink  
High Custody Women’s Cell,  
Otay Mesa.**



**Figure 55. Beds in High  
Custody Women’s Cell,  
Otay Mesa.**



**Figure 56. Outside View of  
High Custody Women’s Cell,  
Otay Mesa.**



Each of the housing units has an adjacent outdoor recreation area, to which detainees have access for two or three two-hour periods each day, absent an emergency and weather and staffing permitting (**Figures 57 and 58**).

**Figure 57. Exercise Equipment in Men’s General  
Population Recreation Area, Otay Mesa.**



**Figure 58. Men’s General  
Population Recreation Area, Otay Mesa.**



Upon intake, the facility issues each detainee a bar of soap, a roll of toilet paper, a toothbrush, toothpaste, a comb, denture adhesive if appropriate, and feminine products, if appropriate. Two detainees reported that water in the showers is so hot it burns their skin, which Cal DOJ was not able to confirm. Cal DOJ observed that there was no soap provided at the toilets and sinks in the gym.

Detainees expressed significant discomfort with cold temperatures throughout housing units and during long waits for court and medical appointments, and reported that they are unable to obtain warmer clothing or extra blankets upon request. Staff noted clothing and blankets are frequently requested items. Three detainees reported that the facility beds caused them pain, and eight detainees expressed fears about falling from the top bunks, including two who received medical attention after falling.<sup>146</sup> At the time of Cal DOJ's visit, the bunks had not been equipped with safety rails.

### **(ii) Restricted Housing Units (RHU)**

Otay Mesa has one male (**Figures 59 and 60**) and one female RHU, each of which house both ICE and U.S. Marshals detainees in disciplinary segregation or administrative segregation—including detainees in protective custody who are separated from general population for their own safety. Detainees are housed alone or with one other person in cells with toilets, and the cells remain locked at all times.

The women's RHU is connected to and within a general population unit for women in ICE and U.S. Marshals Service custody who have been classified as high security. A metal cage extending into the dayroom separates the general population housing unit from those assigned to RHU cells.

**Figure 59. Fenced-off Portion of Men's RHU Day Room, Otay Mesa.**



**Figure 60. Men's RHU Recreation Pens, Otay Mesa.**



<sup>146</sup> PBNDS requires the facility to make reasonable accommodations for persons with handicapping conditions. ICE, PBNDS 2011, Part 4.8, Part I, p. 344. Assignments to the lower bunk bed or the lower tier are among the most frequent accommodations detention facilities make.

ICE detainees in administrative segregation have shower access five days a week; those in disciplinary segregation have shower access three days a week. Meals are delivered through food ports in the cell doors, and sick call takes place from 4:00 a.m. to 5:00 a.m. Detainees in RHU may access a computer terminal in the multipurpose room for legal research needs.

As described above for all facilities, all segregated detainees—whether in disciplinary or administrative segregation—spend nearly all their time in their cells, allowed outdoor recreation for one hour a day in a small recreation pen, either alone or with their cellmate, if they have one (**Figure 60**). See *Systemic Issues*, Section 2. Detainees in administrative segregation are allowed dayroom time, which takes place in an interior fenced area or in the multipurpose room. At the time of Cal DOJ’s visit, there were two women and eight male immigration detainees in the respective RHUs. One woman was in involuntary protective custody and the other was in voluntary segregation.

### (iii) Medical Housing Unit

ICE detainees and U.S. Marshals prisoners in need of inpatient healthcare are assigned to the Medical Housing Unit (MHU), which houses all genders and classifications. This unit has two large rooms able to hold nine patients each, a single room used for detainees transitioning from higher acuity to the general population or RHU, a safety cell (for a suicidal detainee), several additional single cells, and a negative pressure room (**Figures 61-63**). There is also a recreation area and a medical detention officer on duty at all times. See Section 5 (*Healthcare*).

**Figure 61. Medical Housing Unit Cell, Day Room, Otay Mesa.**



**Figure 62. Medical Housing Unit Cell, Outside View, Otay Mesa.**



**Figure 63. Medical Housing Unit Cell, Toilet and Sink, Otay Mesa.**



## C. Programming, Religious Practice, and Work Opportunities

**Programming.** Unit management staff for each housing unit have discretion to offer anger management, parenting, communications skills, and other programs in the housing units. These are offered only in English and sometimes Spanish, and thus exclude the many detainees who do not understand these languages. Arts and crafts materials are also available. A recreation coordinator runs monthly bingo and other games and tournaments. Detainees facilitate Alcoholics Anonymous/Narcotics Anonymous programs in some housing units. GED classes are only available to U.S. Marshals prisoners. Detainees in restricted and medical housing cannot participate in group activities but may request workbooks and colored pencils.

Each housing unit has a multipurpose room where programs and religious services may be held. In restricted housing, the multipurpose room holds a television and law library computer terminal. Detainees in administrative segregation may use it to watch movies during their out-of-cell time, provided the computer is not in use.<sup>147</sup>

Detainees in general population may use the library each weekday; however, they may only check books out once a week. Moreover, reading material is available primarily in English and Spanish.

In addition to daily access to the small recreation area adjacent to the housing units, detainees in general population may use the facility's gym for one hour, twice a week. Sports equipment for badminton, volleyball, and basketball may be made available. Zumba is offered to women who have access to the gym and yoga is offered once a month in the low security women's dorm.

Cal DOJ commends Otay Mesa for providing programs beyond what is required by PBNDS. However, programming is at the unit management staff's discretion. Also, because programming does not accommodate language minorities and is not available for detainees in restricted housing, it fails to meet PBNDS's mandates to provide language access and equal access to programming for detainees in administrative segregation.<sup>148</sup>

**Religious Practice.** Otay Mesa employs two chaplains, both of Christian faiths. They provide 10 non-denominational chapel services weekly, which detainees attend on a rotational basis. The chaplains recruit volunteers to run programs in particular denominations and confer with a Rabbi and Imam, as needed.

In interviews with Cal DOJ, non-Christian detainees and language minorities reported obstacles to religious practice. A Sikh detainee reported that her requests for a turban and a Sikh prayer book were denied. Another detainee reported that the Torah is not made available to Jewish detainees

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<sup>147</sup> Cal DOJ did not verify that such access is available to women in the restricted housing unit.

<sup>148</sup> See ICE, PBNDS 2011, Part 4.8 Disability Identification, Assessment, and Accommodation, Part II Expected Outcomes, § 8 p. 345 and Part 2.12 Special Management Units, Part V, §A(1)(c)(9), p. 175.

on the same basis that the Christian Bible is provided, and reported that Jewish services are not available. A Muslim detainee shared that Muslim services are available less frequently than Christian ones. Another detainee who speaks and understands only Russian reported that he is not able to participate in services or access a religious text in Russian.

**Detainees requesting religious diets are subject to lengthy questionnaires, and detainees have encountered delays in obtaining a religious diet, including one detainee who received the questionnaire in English, which he was not able to read. Three detainees indicated it took them one to two months to receive kosher meals, and facility records show 10 grievances related to religious diets over 19 months. Revocations of religious diets may also occur when a detainee behaves in a manner the chaplain believes is inconsistent with the tenets of that detainee's faith. For example, according to facility staff, a kosher diet could be revoked if a detainee took food items from the dining hall, contrary to the Eighth Commandment, which forbids stealing. These practices raise concerns regarding the facility's accommodation of detainees' religious practices, including implementation of PBNS expectations for religious diet accommodations.**<sup>149</sup>

**Work Opportunities.** Detainees at Otay Mesa may volunteer to work in the kitchen, the laundry, the commissary, and as porters in the housing units and other areas of the facility. In the kitchen, detainee workers are supervised by an employee of Trinity Services Group, the food services provider. Detainees are paid \$1 per day for their work, except that food service workers receive \$1.25 per day. Fifteen out of 23 detainees who commented about payment reported that payment was sometimes delayed or that they sometimes had to remind the facility to pay them for their work.

## D. Food and Nutrition

Otay Mesa has a 5-week, no pork, rotating menu. All foodstuff comes frozen, canned, or dried. Cheese is processed and eggs are powdered. The facility provides two religious diets—kosher and halal—a vegetarian diet, and several medical diets. Detainees in general population must be escorted to one of the two dining halls to eat (**Figure 64**). Logistical challenges related to moving diverse custody classifications and genders that cannot comingle sometimes led to significant delays for lunch and dinner. Seven detainees interviewed reported delays, reporting that they may have lunch as early as 10:00 a.m. and as late as 3:00 p.m., whereas dinner can be served anytime between 4:30 and 9:00 p.m.

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<sup>149</sup> Although religious accommodations are only required for detainees with sincerely held beliefs, “the fact that a person does not adhere steadfastly to every tenet of his faith does not mark him as insincere.” *Reed v. Faulkner* (7th Cir. 1988) 842 F.2d 960, 963 (professed Rastafarian’s eating of meat and shaving of his beard was not conclusive proof of insincerity). See ICE, PBNS 2011, Part 5.5 Religious Practices, Part V, § G(1) (“While each request for religious diet accommodation is to be determined on a case-by-case basis, ICE anticipates that facilities will grant these requests unless an articulable reason exists to disqualify someone for religious accommodation or the detainee’s practice poses a significant threat to the secure and orderly operation of the facility.”).

Eighty-four percent (52 out of 62) of detainees interviewed by Cal DOJ voiced concerns about food served at the facility, with most reporting concerns regarding the quantity (19 out of 52), the lack of variety or restrictions of food served (19 out of 52), and the quality of the food served (13 out of 52). Detainees complained about not receiving enough food, that beans, rice, and pasta are served frequently but chicken is only served once a month, that fresh fruits and vegetables are not served, and that food sometimes is not fresh, is bland, or lacks nutritional value. Other reported concerns involved religious or medical diets (4 out of 52) and medical complaints (11 out of 52). For instance, two detainees on the Kosher diet reported that they are only given two hot Kosher meals per week excluding breakfast porridge. Those who reported medical concerns, reported that the food made them sick—constipated or vomiting—or had led to considerable weight loss.

**Figure 64. Dining Hall, Otay Mesa.**



Cal DOJ’s medical expert noted that some detainees expressed frustration obtaining diets for diabetes and hypertension after medical staff had placed orders for the diets. Cal DOJ was not able to verify whether they were receiving their prescribed diets. Medical chart review showed that one detainee experienced a gap of five weeks pending renewal of his therapeutic diet by medical staff.

During Cal DOJ’s visit, food stock appeared organized and dated, and a rotation system is used to ensure use within expiration dates. The facility has sufficient food on hand to produce meals for several days. A tray of each meal is kept for three days at subzero temperatures for tracing purposes should food-related illness occur. All cooking tools are secured on a locked shadow board.

## **E. Non-Legal Visitation, Telephone Calls, and Mail**

**Visitation. Social visiting is more restrictive at Otay Mesa than other detention facilities.**

Contact visits are limited to weekends and federal holidays; on weekdays, detainees are limited to video visits. Visitors must be on-site for video visits, whereby the visitors call in from a room in the non-secure part of the facility using the facility’s tablets. Each pod is assigned a one-hour period per weekend for contact visits (**Figure 65**) and expanded hours for video visits, for which visitors must travel to the facility. All visits must be scheduled in advance. At least two detainees reported that visitation has been cancelled when family members who had to travel for several hours arrived even



**Figure 65. Visiting Area, Otay Mesa.**



a few minutes late. **In addition, Otay Mesa negotiated a waiver from the PBNDS to allow strip searches of detainees after all contact visits.**

**Telephone Calls.** Telephone service for ICE detainees at Otay Mesa is provided by Talton Communications. Detainees are given a free three-minute call when they arrive at the facility, during which they may contact family to explain how to create a phone account, as well as five minutes of credit on the Talton telephone system that they can use once they reach their housing unit. Cal DOJ observed 10 phones for 128 people in the open bay housing units and 12 phones for 168 detainees in one of the celled housing units used for high security classification male detainees. All phones are located in the dayroom, affording no privacy for calls. There are telephones on rolling carts that are wheeled to detainees' cell doors in the restricted and medical housing units. Telephones are available from 5:00 a.m. to 10:00 p.m., except during count and lockdowns.

Seventy-two percent (48 out of 67) of the detainees interviewed by Cal DOJ stated that they experienced barriers in making telephone calls. Concerns reported by detainees included the cost of phone calls, particularly for international calls (18 out of 48); the phone system procedures or features (16 out of 48); calls not going through (12 out of 48), especially international calls; and limited access to phones (11 out of 48). Regarding the phone system, the majority (12 out of 16) described difficulties using the voice recognition feature and some (3 out of 16) indicated they had difficulties navigating prompts in the telephone system and helping their families understand how to use it. One detainee also noted detainees cannot leave voicemail messages or navigate automated answering systems because a live person must accept the call. Several detainees (4 out of 11), who indicated limited access to phones was a barrier, reported that some phones within their housing units do not work, with one indicating only four of the 12 phones in their housing unit were in working order. Cal DOJ was able to inspect only a small sample of phones, which appeared to be in working order. PBNDS requires that there be one phone for every 25 detainees.

Otay Mesa staff interviewed by Cal DOJ stated that indigent detainees can request free calls and that family and others may leave messages for detainees. These options are not listed in the facility

handbook, though the ICE detainee handbook states that free calls to family are available for emergencies. Five interviewed detainees expressed they were not aware they could request free calls.

**Mail.** Mail is received by the mail clerk, who opens all non-legal mail to check for contraband. Mail is delivered by unit management staff. Outgoing mail can be placed in the mail box in the dining hall or handed to a detention officer. Indigent detainees can request and receive envelopes and stamps.

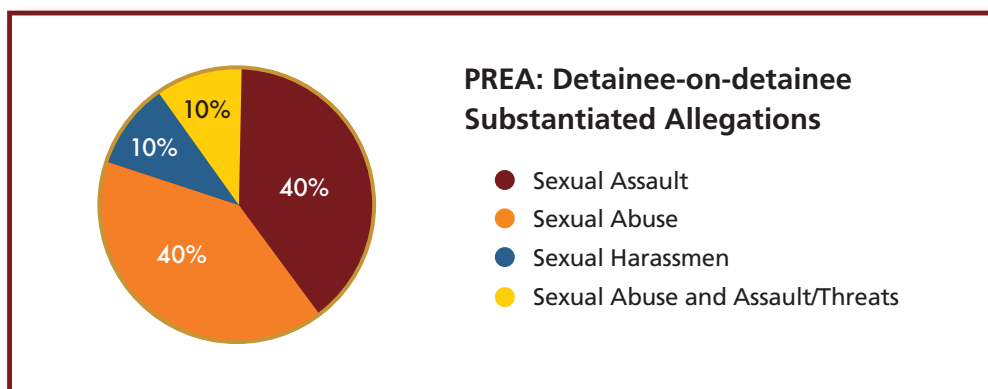
Nearly half (25 out of 53) of interviewed detainees indicated they had experienced problems receiving or delivering mail. Most detainees (17 out of 25) complained that they did not receive expected mail because it was missing, confiscated, or it was returned to the sender, including mail from attorneys and materials that they needed for their cases. A Russian detainee said he did not receive a number of books and letters, even those that were marked “legal mail.” Based on staff interviews, Cal DOJ learned that the facility returns any packages that are not preapproved and any items it considers contraband.

## F. Sexual Harassment and Abuse Prevention and Investigations

Otay Mesa has a PREA coordinator. Signs are posted throughout the facility in English and Spanish informing detainees how to report sexual assault or harassment. Upon making a PREA allegation, the victim is sent to medical to be checked in by a nurse. During clinic hours, the detainee is referred immediately for a visit with a healthcare clinician. Upon receipt of a PREA report, the facility’s investigator reviews the files of any detainees who are involved; interviews the victim, alleged perpetrator, and any witnesses; and reviews any available video. The San Diego Sheriff’s Department also opens investigations to evaluate allegations of sexual assault.

Based on facility incident logs, there were 54 PREA complaints from January 19, 2018, to June 21, 2019. The majority of cases involved detainee-on-detainee allegations (45 out of 54) while nine involved staff-on-detainee allegations. Of those cases, ten were substantiated and included detainee-on-detainee sexual assault, sexual abuse, sexual harassment, and sexual abuse and assault/threats (**Figure 66**).

**Figure 66. Breakdown of Detainee-on-detainee Substantiated Allegations by Sexual Incident, Otay Mesa.**



CoreCivic reported a **284 percent increase** in PREA reports from 2017 to 2019 at Otay Mesa, with 21.9 percent (16 of 73) reported in 2019 being substantiated.<sup>150</sup> Health and custody leadership were unable to explain the increase, but mentioned facility efforts to increase PREA and transgender awareness, and one leader observed that “many” PREA claims are unsubstantiated. From the 2018 to mid-2019 logs reviewed by Cal DOJ, nine cases involved PREA allegations from detainees identifying as transgender. Of these cases, seven were detainee-on-detainee allegations and two were staff-on-detainee allegations. Only one case, categorized as detainee-on-detainee, was found to be substantiated and involved an instance of sexual assault.

Cal DOJ’s file review revealed that required mental health assessments of victims and alleged perpetrators of PREA allegations were missing, including in one case where the medical evaluation noted that the incident had “triggered past sexual abuse...[with] an increase in symptoms, with insomnia, memories and sadness,” but no subsequent medical evaluation occurred. One of the use of force videos reviewed by the Cal DOJ team showed a new admittee who claimed to have been drugged and sexually assaulted (including digital penetration) while in custody at the border and was unwilling to relinquish his clothing. Custody staff used pepper spray to gain compliance with intake procedures, which involved turning over his clothing to be washed and having a shower. There was no indication in the detainee’s record that he was referred for a medical examination to evaluate his report of sexual assault.

Cal DOJ’s experts agreed that Otay Mesa could do more to respond to the increase in PREA allegations through more complete screening, analyzing possible causes, and committing to maintain a culture of unbiased documentation and investigation of all claims, including referrals for Sexual Assault Nursing Exam (SANE) exams for alleged penetration.<sup>151</sup> The culture of taking all complaints seriously—even if “many” are unsubstantiated—becomes even more important to avoid complacency, which itself can be a safety risk.

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<sup>150</sup> In 2019, Otay Mesa opened 73 PREA cases for both ICE detainees and U.S. Marshals Service prisoners. Sixteen of those reports were substantiated (21.9%).

Otay Mesa PREA Complaints	2017	2018	2019
Staff-on-Pop Sexual Abuse	5	13	19
Pop-on-Pop Sexual Abuse	12	30	49
Staff-on-Pop Sexual Harassment	2	1	1
Pop-on-Pop Sexual Harassment	0	5	4
	19	49	73

CoreCivic 2018 PREA Annual Report, <[http://www.doc.sc.gov/preaweb/prea\\_corecivic\\_2018.pdf](http://www.doc.sc.gov/preaweb/prea_corecivic_2018.pdf)> (as of Dec. 2, 2020); CoreCivic 2019 PREA Annual Report, <<https://www.corecivic.com/hubfs/files/PREA/2019-PREA%20AnnualReport.pdf>> (as of Dec. 2, 2020).

<sup>151</sup> See *infra*, Section 5 *Healthcare*, Part A *Medical Care*.

## G. Staff and Detainee Relations

### (i) Staffing, Overtime, and Training

Otay Mesa has a bifurcated staffing structure with detention officers, lieutenants, and sergeants under the Chief of Security; and housing unit management staff—detention counselors, case managers, and unit managers—reporting to the Chief of Unit Management. Detention officers move detainees through their daily schedule, handle count, and carry pepper spray. Unit management staff deliver mail, run programs, and handle detainee requests. This structure should allow the unit management staff to focus on meeting the needs of detainees, but—based on the significantly higher number of grievances submitted by detainees at Otay Mesa—it appears to fall short of that intended outcome.

Otay Mesa detention staff completes a seven-week pre-service training program of which one week is on-the-job training. All staff routinely receive PREA instruction. Housing unit staff receive training on recognizing signs of mental health and medical distress, including suicide prevention.

At the time of Cal DOJ’s visit, the facility had vacancies in its detention staff, and even without vacancies, its staffing plan does not include positions to provide relief shifts for vacations and illness, which must be covered by overtime. Under Otay Mesa’s overtime policy, custody staff may work as many as 50 overtime hours per two-week pay period. There appear to be no measures in place to ensure staff do not exceed 50-hour limit or are otherwise not so fatigued as to be unfit for duty.

**The most common concern raised by detention and unit management staff in interviews with Cal DOJ was insufficient staffing and related issues such as excessive overtime and inability to take bathroom breaks.**

### (ii) Demeanor of Detention and Unit Management Staff

Detainees at Otay Mesa described a wide range of feelings toward and treatment from different custody staff. Detainees described certain staff as helpful and kind, and two detainees even compared officers to family members such as fathers and brothers. Only two out of 63 detainees claimed that staff had threatened or intimidated them. However, many detainees who commented on staff demeanor expressed concerns, including favoritism (4), abuse of disciplinary tactics (3), and disrespectful behavior. Specifically, though slightly over half (34 out of 63) of interviewed detainees reported that detention officers do not insult or verbally abuse them, some detainees reported officers had yelled at them (18 out of 63) and/or used disrespectful language towards them (7 out of 63), including expletive language (e.g., swearwords and insults). For instance, two Chinese detainees reported that detention officers yell at them for not understanding instructions in English and one said that detention officers yell at them to “go away.”

Regarding other reported concerns about staff demeanor, at least two male detainees in the open bay dormitory-style housing unit noted that one or more of the detention officers do not allow them to use the common bathroom or get up to get a drink of water at night after count. **Detainees**

**have the understanding that unit management keeps track of disciplinary strikes, which in turn can result in elevating a detainee's security classification (with significant housing consequences). In this way, the threat of even minor disciplinary action serves as a powerfully coercive tool.**

### **(iii) Bunk, Cell, and Personal Searches**

Detention officers conduct bunk and cell searches, once per each daytime shift, with the night shift searching common areas of the housing unit. Detainee experiences differ, with some reporting that detention officers return their belongings to their places and others reporting officers leave items in disarray. Except in the restricted housing units, searches are conducted based on a rotation to ensure fairness.

There is no search of detainees' persons during intake; instead, incoming detainees are placed in a security chair that detects metal. Detainees are subject to pat down searches when returning to their housing unit. Detainees in the RHU are scanned with a hand-held metal detector and patted down every time they leave their cells. As mentioned elsewhere, all detainees are strip searched after contact visits, including attorney visits.

### **(iv) Use of Force**

The continuum of control begins with verbal commands and under limited circumstances may include other forms of control. **Otay Mesa issues pepper spray to all custody staff and does not require line staff to obtain approval from their supervisor prior to its use. The pepper spray is intended to be used as an alternative to physical force. The facility also applies arm and leg restraints and spit masks when escorting detainees with known behavioral issues through the facility. Additionally, the Special Operations Response Teams are issued batons and electric stun shields. Pursuant to a waiver received from ICE, Otay Mesa may dispense tear gas by means of grenades to regain control of non-compliant groups of detainees and discharge special impact (pepper ball) munitions when circumstances warrant.** Cal DOJ's corrections expert expressed concern about the need for these waivers as the facility classified the vast majority of detainees as low custody.

Use of force videos reviewed by Cal DOJ revealed both appropriate uses of pepper spray and occasions where it appeared officers had unholstered the can on their utility belt, seemingly as a threat, prior to issuing detainees verbal orders to comply. In addition, pepper spray was used to subdue an incoming detainee who refused to comply with the intake shower process because he claimed he had been sexually assaulted. This planned use of force appeared excessive based on Cal DOJ's review of the video. Although most (59 out of 63) interviewed detainees reported that officers do not physically abuse them, two noted that officers are quick to threaten the use of pepper spray.

Officers assigned to transportation, perimeter patrol, and off-site detainee hospitalizations are required to be weapons qualified and carry a firearm when on assignment.

**Based on Otay Mesa’s immigration detainee use of force records from 2018 and the first half of 2019, the facility has a rate of using force more than double the other two facilities reviewed in this report, with a rate of 43.5 uses of force per 1,000 detainees compared to 21.3 (Imperial) and 21.1 (Adelanto).** From January 18, 2018, to June 12, 2019, Otay Mesa logged 47 use of force incidents involving 51 unique immigration detainees. Seventy percent (33 of 47) of the incidents were categorized as Reactive rather than planned uses of force; and, of those Reactive uses of force, eight involved the use of pepper spray and 37 percent had conflicting information about whether chemical agents were used. Sixty percent (28 out of 47) of cases involved a use of force incident against a detainee with a known mental health issue.

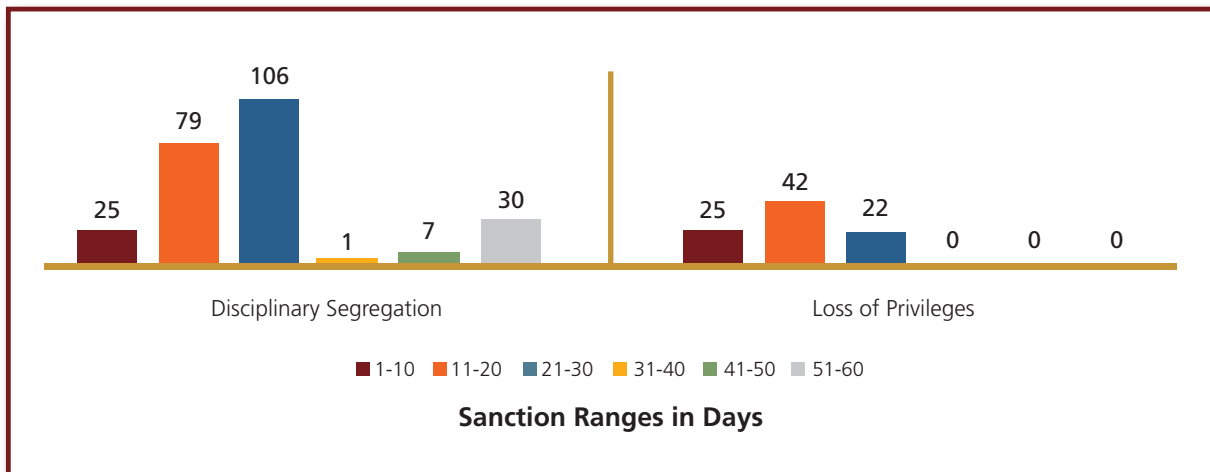
**(v) Discipline and Control**

Cal DOJ reviewed 653 detainee disciplinary actions from a log of hearings from January 2, 2018, to July 18, 2019. These hearings resulted in 613 (94%) Guilty findings, including 466 for major charges (76%) and 147 for minor charges (24%). Only 31 (5%) were found Not Guilty. Another six cases (1%) were dismissed. Two adjudications were withheld and one was deferred.

In 45 percent (275 out of 613) of the guilty disciplinary actions, detainees were punished with disciplinary segregation, including 25 who were listed as “time served.” Twenty-eight percent (171 out of 613) of the cases resulted in a loss of privileges, of which loss of commissary privileges was by far the most common accounting for 68 percent (117 out of 171) of all such sanctions. The average length of disciplinary segregation sanctions was 28 days and the average for loss of privileges sanctions was 12 days. **With a rate of 213.17 disciplinary segregation placements for every 1,000 detainees for cases in 2018 (191 total cases), Otay Mesa used disciplinary segregation more frequently than Imperial (183.24) and Adelanto (141.75) during the same period.**

**Figure 67** illustrates the types of sanctions based on guilty outcomes as well as the sanction ranges for these outcomes in 10-day increments.

**Figure 67. Guilty Outcomes Sanctions and Sanction Ranges, Otay Mesa.**<sup>153</sup>



Although ICE modified its PBNDS in 2016 to reduce the use of restricted housing in general and disciplinary segregation in particular, Otay Mesa's charging practices continue to be harsh. Penalties of 30, 45, and 60 days are not uncommon.

On-site file review by Cal DOJ's corrections expert revealed three disciplinary charges that contribute to high rates of disciplinary segregation. They are (1) Causing a Disturbance, (2) Three or more Minor or Medium Infractions within 90 Days, and (3) Disobeying a Direct Order. **As used, the charge Causing a Disturbance is a catchall for disruptive behavior including suicide attempts and hunger strikes.** For the charge Three or More Lesser Infractions in 90 Days, a more severe penalty—usually 30 days, but sometimes 45 or 60 days, of disciplinary isolation—is imposed for a minor offense following two previous infractions for which the detainee has already been punished. Disobeying a Direct Order is used when the facility determines a detainee no longer needs protective custody but the detainee refuses to return to general population because they believe they will not be safe and cannot succeed in general population. Otay Mesa issues these detainees a write-up but usually allows them to remain in administrative segregation.

These are extremely problematic charging practices. First, discipline is an inappropriate response to detainees who are suffering from such mental distress that they attempt suicide, and the PBNDS treats hunger strikes under the topic of Care rather than Safety or Security. Second, discipline should be progressive and not jump from the loss of a privilege to a retroactive stacking of prior charges as a new offense to impose disciplinary segregation. Third, the practice of returning unwilling detainees in protective custody to the general population promises to place them at unnecessary risk.

#### **(vi) Requests and Grievances**

Paper request and grievance forms are available in the general population housing units. Detainees in segregation must request a form from a staff member. Requests may be handed to a detention or unit management staff member and are handled by unit management staff. **Otay Mesa does not keep a log of requests, and some staff acknowledged that it can be easy for requests to fall through the cracks and that it is frustrating to detainees when answers to requests are delayed.**

Eighty-two percent (49 out of 60) of detainees interviewed by Cal DOJ indicated that they had submitted request forms. The majority of requests were for clothing exchange, questions for ICE, property requests for telephone numbers and legal documents, changes to housing assignments,

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<sup>152</sup> Forty-six cases are not included in this figure. Twenty-seven of these cases correspond to the disciplinary segregation sanction, with 26 cases not specifying the number of days sanctioned, and one case, which included a sanction of 201 days was excluded from the figure as it was not clear whether it reflected a typo. Twelve cases corresponded to the loss of privileges sanction and did not specify the number of days sanctioned. The remaining seven cases include detainees who were restricted to their dorm (4), were placed on probation (1), or for which a sanction range was indicated but not the specific punishment (2).

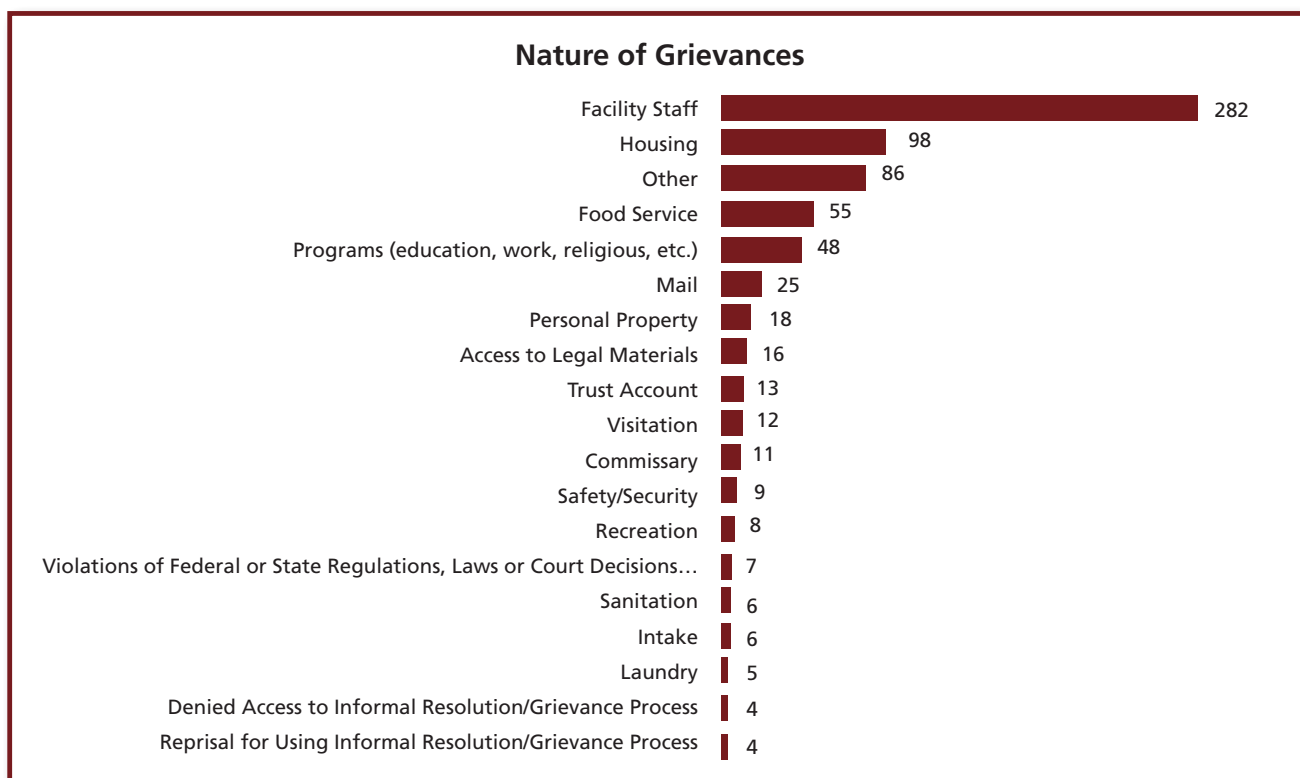
<sup>153</sup> ICE, PBNDS 2011, Part 4.2 Hunger Strikes, pp. 253-56.

or medical requests. Staff reported that the following are the most common detainee requests: clothing, shoes, and blankets; changes to housing assignments (to accommodate cultural and language background); toilet paper and soap; to obtain something from their property; and religious texts.

Detainees can place grievances in a metal drop box in the dining hall or hand them to a detention officer. There is a grievance coordinator who reviews and processes grievances. Thirty-seven percent (23 out of 61) of detainees interviewed by Cal DOJ had filed grievances. For this group, the topics of their grievances were (in order of frequency): staff conduct, medical or mental health care, ICE, food, work and payment for work, other detainees, missing personal items, and mail. Custody and unit management staff who were asked about detainees’ most common concerns listed the following: officer conduct, including cell or bunk searches; quality and quantity of food; not being called for a medical appointment; and complaints about medical staff, recreation, and missing property after a cell search.

A grievance log provided by the facility with immigration detainee grievances filed from January 4, 2018, to July 7, 2019, showed that 40 percent (282 out of 713) of grievances concerned facility staff—by far the most common subject for grievances. **Figure 68** illustrates the nature of the most common grievances lodged by detainees.

**Figure 68. Nature of Grievances Filed, Otay Mesa.**

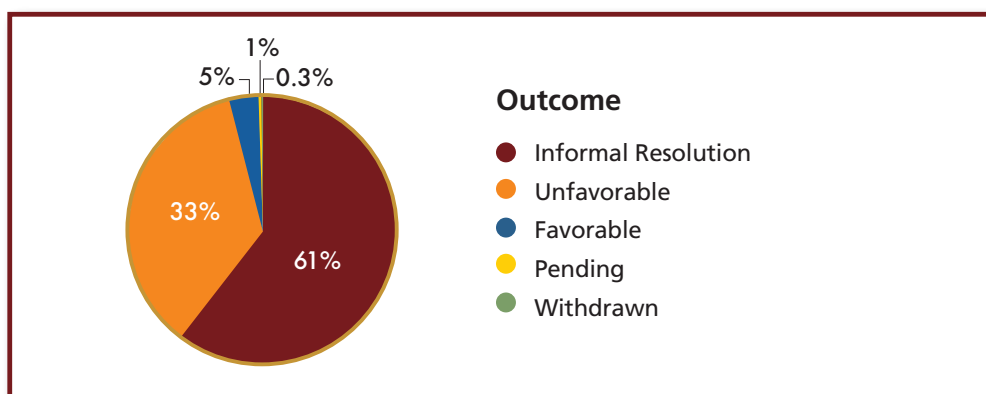




According to the facilities' grievance log (**Figure 69**), 61 percent (436 out of 713) of filed grievances received an informal resolution, with 74 percent of these (326 out of 436) logged as resolved; 17 percent (72 out of 436) rejected; eight percent (33 out of 436) withdrawn; and one percent (5 out of 436) unresolved. Thirty-eight percent (272 out of 713) received a formal grievance outcome with most logged as unfavorable to the detainee (232 out of 272) and only 14 percent logged as favorable to the detainee (38 out of 272).

**Otay Mesa has a strikingly higher rate of grievances than other facilities. For the fourth quarter of 2018, Otay Mesa had a rate of 159.60 grievances per 1,000 immigration detainees, compared to 82.39 for Imperial and 41.75 for Adelanto. For the first quarter of 2019, Otay Mesa's rate was 174.11 compared to 157.67 at Imperial and 28.87 at Adelanto.** Otay Mesa's Warden suggested that there may be a high rate of grievances because detainees feel comfortable making use of the process.

**Figure 69. Outcomes for Filed Grievances, Otay Mesa.**<sup>154</sup>



## H. Hunger Strikes

A hunger strike log from January 1, 2018, to November 1, 2019, documented seven detainees with hunger strikes lasting one to 28 days. Cal DOJ's corrections expert found that detainees undertook hunger strikes to express their disapproval of health services, the infractions and penalties for infractions they received, food services, lack of access to their assigned ICE officer, and especially, the length of time they have remained detained after being pressured to "agree" to removal. In the event of a hunger strike at Otay Mesa, mental health staff assess whether there is a mental health condition that is contributing to the detainee's refusal to eat and offer supportive counseling.

<sup>154</sup> The Pending category includes five grievances that had not received a disposition at the time the log was provided to Cal DOJ. The Withdrawn category includes two grievances that were withdrawn at the formal grievance level.

## 4. Due Process

Detainees at Otay Mesa have the advantage of being near an urban center and have access to a legal orientation program at the facility that regularly informs detainees about the immigration legal system. Nevertheless, language barriers, limits on confidential telephone and mail communication, and limited accessible legal research resources obstruct many detainees from accessing justice in their immigration proceedings.

### A. Ability to Access Legal Services and Representation

#### (i) Legal Orientation Opportunities

The American Bar Association Legal Justice Project of San Diego provides a Legal Orientation Program (LOP) four days a week on-site at Otay Mesa. The program includes a presentation about the immigration legal system and individual meetings with detainees to help them identify claims and defenses, fill out paperwork, and make referrals for legal representation. Detainees can request to attend by signing up on a sheet in each housing unit. Close to half (31 out of 66) of the detainees Cal DOJ interviewed had attended the presentation, and slightly over half (16 out of 31) of the detainees who attended found it helpful. Some detainees reported having signed up for the LOP but had not yet attended.

#### (ii) Access to Legal Counsel

Sixty-five percent (42 out of 65) of the detainees who Cal DOJ met with in individual interviews indicated that they are represented by counsel. This is a much higher rate of representation than detained immigrants generally enjoy, and may not reflect the rate of representation at Otay Mesa generally.<sup>155</sup>

There are 17 attorney visit rooms at Otay Mesa. **The attorney visit rooms are not equipped with telephones and attorneys are not permitted to bring their own cell phones into the facility to access translation services. Translation can only be accomplished if the attorney brings a translator to the visit.** Most attorneys who responded to Cal DOJ's survey questions about Otay Mesa (6 out of 9) indicated they were allowed to bring laptop computers to the attorney visiting room. Five out of eight survey respondents who provided comments regarding their visitation experience said they experienced delays and/or time restrictions that impacted client meetings. The facility posts sign-up sheets in proximity to the telephones informing detainees in English and Spanish that they may request to arrange for a non-recorded phone call with their attorney. Unit management staff can designate telephone numbers to be free from monitoring; however, several detention officers were unaware of this option and some detainees reported that they had been told all calls are monitored. Even if a particular phone number is placed on a do-not-monitor list, the location of telephones in public areas of the housing unit precludes telephone conversations from being confidential.

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<sup>155</sup> See Eagley and Shafer, *Access to Counsel in Immigration Court*, American Immigration Council (Sept. 2016) <[https://www.americanimmigrationcouncil.org/sites/default/files/research/access\\_to\\_counsel\\_in\\_immigration\\_court.pdf](https://www.americanimmigrationcouncil.org/sites/default/files/research/access_to_counsel_in_immigration_court.pdf)> (as of Oct. 28, 2020) (nationwide study of immigration representation from 2007 to 2012 showed 14 percent representation rate for detained immigrants).

A few staff members were aware of the option to use the unit office phone for a confidential conversation with counsel. Of the eight detainees who provided comments regarding the availability of private legal calls, five were not aware of this option and three indicated they were aware. Of the three detainees who indicated they were aware, one specified that while some staff provide these calls to detainees, others do not; and the other indicated he was once able to obtain a private call from the unit manager's office but subsequent requests were denied. Of the attorney survey respondents who commented on telephone access (3 of 9 attorneys with clients at Otay Mesa), all stated that it was very difficult to schedule legal calls with their clients.

Similarly, messaging from attorneys is not reliable. One detainee received a telephone message from his attorney on a Sunday, but the call had come in on Friday, and the message had been for the detainee to call the attorney that Friday afternoon. Of the attorney survey respondents who commented on telephone access (3 of 9 attorneys with clients at Otay Mesa), two stated there is no option to leave a message and one stated that delivery of messages is not timely.

## B. Access to Materials Needed for Immigration Cases

**Mail.** Forty-four percent (11 out of 25) of detainees who commented on this topic reported delays in receiving or sending mail from the facility. Two detainees specifically noted court notifications often arrived late, with one reporting the mail is frequently six to seven days late. In addition, several detainees reported that they had difficulty obtaining documents, photos, and other material needed for their legal cases through the mail system. **Although Otay Mesa's detainee handbook describes a "Prohibited Correspondence Form" to which detainees have 24 hours to respond, facility staff reported that packages not previously approved are returned and that there is no mechanism for checking with the detainee to evaluate whether what appears to be contraband may, in fact, be necessary to the detainee's case.**

**Law Library.** Detainees in general population can go to the library with their housing unit every weekday, for up to an hour, other scheduling needs permitting (**Figure 70**). The library has books for leisure reading in English and Spanish. It also has 13 computer terminals which are updated periodically with immigration legal materials from ICE. Materials are primarily in English, with Know Your Rights guides in several additional languages and some additional material in Spanish. ICE's legal research materials do not have user-friendly search engines that attorneys and internet-users are familiar with, and they are extremely difficult to navigate. This is made more difficult at Otay Mesa, where the computers are configured differently, such that a resource that is shown as an icon on the desktop of one computer may be buried in a folder on another computer. Cal DOJ observed that some of the computers were missing material that was available on other computers and brought this to the library clerk's attention during the visit. Detainees reported that equipment in the library—computers and the copy machine—are frequently out of service.<sup>156</sup>

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<sup>156</sup> Five detainees reported concerns about library computers being out of service and four mentioned copy machine being out of service, but two of these said the copy machine is promptly fixed.

**Figure 70. Library, Otay Mesa.**



Similar computers with legal materials—also configured inconsistently and with some missing or outdated material—are in each of the housing units. At the time of Cal DOJ’s visit, the computer was missing from one of the units. According to facility staff, it had been vandalized weeks earlier and not yet replaced. Detainees in other housing units also reported to Cal DOJ that the housing unit computers are sometimes broken.

Detainees in RHU and medical housing unit may not visit the library outside their housing units, but may use the computer terminal within their housing units for research.

The library clerk informed Cal DOJ that detainees can use the computers to draft documents, and they are issued USB drives for saving their work. Eight detainees interviewed by Cal DOJ commented on access to law resources for their cases, with six stating that the lack of internet access on law library computers is a limitation, seven noting the provided legal materials are outdated, and one indicating the law library did not have enough resources to assist with her case. Two detainees mentioned they have to request cases that are not available through the materials provided, with a three- to four-day waiting period to receive them. The main benefits detainees cited with respect to the library is the ability to make copies for their cases. Several mentioned that they used to be able to conduct internet research, and lamented that they no longer could.

### **C. Access to Court**

The federal Executive Office of Immigration Review has immigration courtrooms upstairs from the housing units within the Otay Mesa facility. Detainees are escorted by detention officers and wait in holding cells outside the courtrooms, near the attorney visiting area. Eighty percent (53 out of 66) of detainees interviewed by Cal DOJ had attended an immigration court hearing since arriving at Otay Mesa.

## 5. Healthcare

### A. Medical Care

The ICE Health Service Corps (IHSC) provided healthcare at Otay Mesa at the time of Cal DOJ's review. As of September 10, 2020, CoreCivic took over healthcare services.

Clinical staff at Otay Mesa at the time of Cal DOJ's visit was comprised of Public Health Service Commissioned Corps officers, federal civil service employees, and contracted staff. Providers see patients from 7:00 a.m. until 10:00 p.m. in seven clinic exam rooms in the medical unit or in one of the 11 satellite medical rooms associated with the housing unit pods. Clinic patients wait in one of three 14-person holding tanks in the medical unit, with waiting times capped at two hours. During core hours of operation, there are three nursing shifts, and on-call duty for an administrator, a physician, an advanced practice provider (such as a physician assistant or nurse practitioner), and psychiatry staff.

The Medical Housing Unit (MHU) is comprised of two dorms with nine cots each and an adjacent corridor with fourteen cells and isolation rooms where patients are housed for contagious illness, hunger strike, mental health conditions, and subacute medical needs. Patients not housed in one of the two dorms are housed in cold, dim single cells in the medical unit that they are responsible for cleaning themselves, with little opportunity for socialization or programming. Inpatient-level care is not offered within the facility. Additionally, while the MHU provides for medical or mental health oversight, detainees housed there have little opportunity for programming or socialization.

No pregnant women were detained at Otay Mesa at the time of Cal DOJ's visit. The facility reports that pregnancy is accommodated with orders for low bunk/low tier housing, restrictions on restraints, and special diets. Orders for prenatal vitamins and off-site obstetrics appointments are the expected course of care.

Otay Mesa provides transportation to detainees for off-site medical appointments, courts, to the border, and to Los Angeles International Airport, with about 90 percent of trips being for medical purposes. Transportation requires two officers, and if one or more female detainees are being transported, one of the officers must be female. For medical emergencies, the facility calls an ambulance rather than transporting detainees with its own staff and vehicles. Transportation of detainees of different classifications or genders is accommodated by placing detainees in separate cages within the vehicle. Male detainees are restrained at the ankles and wrists and with a belly chain for all transportation outside of the facility. The facility reported that female detainees are restrained only if they have a high security classification and a history of escape or being combative. The facility also reported that pregnant detainees are never restrained for transportation. Detainees are subject to pat down searches before and after transportation, and to strip searches upon reasonable suspicion.

Based on observation and review of medical records, Cal DOJ believes the following important healthcare goals are generally being met by providers at Otay Mesa:

- Effective screening assessments take place within 12 hours and detainees receive a full physician assessment within two weeks of detainees' arrival at the facility.
- Detainees are generally seen the same day as putting in a sick call request.
- Follow-up appointments are scheduled appropriately.
- Off-site specialty care is being provided appropriately.

Cal DOJ's medical expert reviewed more than 30 medical records, and her findings are informed by the NCCHC, ACA, IHSC policies, the 2011 PBNDS, and Title 15 of the California Code of Regulations. Among the concerns are the way in which staffing shortages and logistical challenges present major obstacles to care at Otay Mesa.

#### **(i) Medical Care Concerns**

##### **a. Staffing Shortages**

At the time of Cal DOJ's visit, the physician, LVNs, most of the advanced practitioners, one of the dentists, and the majority of RNs were contract employees. Otay Mesa was, at the time, in need of a Clinical Director and a second Assistant Health Services Administrations to oversee clinic operations, staffing, and advanced practitioner competencies; more physician time to supervise care and/or treat complex patients; a Nurse Manager; and a full nursing staff. **With many vacant RN and LVN positions, and consistently short-staffed nursing shifts, staff and leadership agreed that nursing was "critically understaffed," impacting access to care.** Otay Mesa added a bonus incentive to aid its efforts to recruit full time contract nurses amidst a national and regional nursing shortage.

Record reviews revealed that two patients who had been referred to gynecology several months before had not received pap smears after their appointments were canceled "due to inadequate staffing." Also, due to short staffing in the pharmacy, nurses—instead of pharmacists—were distributing Keep on Person (KOP) medications, putting yet another burden on already strained nurses.

##### **b. Physical Plant and Logistical Obstacles**

Logistical difficulties based on the facility's layout and requirements to physically separate different categories of detainees delay care and created inefficiencies for a healthcare provider that was already struggling to keep up with demand. **Healthcare leadership at the facility noted that it was working on staffing to serve the additional 512 detainees accommodated by the facility's addition of four new housing units, but the expansion did not create any additional space for medical examinations or treatment. Custody staff at Otay Mesa also shared that the healthcare providers need more staff and more space. One officer noted that detainees are sometimes**

**returned to the housing unit while still in need of medical care, suggesting that more medical housing space is needed to properly care for the population.** Due to delays related to both staffing and logistics, detainees report that they may wait for several hours in a very cold holding cell to attend a medical appointment.

Medication administration (pill call) takes place four times a day. Detainees, accompanied by detention officers, are sent by housing unit to receive their medications. Pill calls are frequently delayed due to the logistical challenges involved in housing and moving several populations that must be kept physically separated. If a detainee does not appear for pill call, the detention officer will call him or her again; and, if the detainee does not receive the medication, a nurse must go to the housing unit to obtain a signed refusal form. Two detainees mentioned that they missed pill call because they were in the dining hall or had another conflict, and were required to sign a refusal form despite desiring to take the medication. In addition, delays related to logistical difficulties of getting detainees to pill call on schedule further limits the time nurses can spend on patient care.

### c. Access to Care

The publicly posted sick call clipboard compromises confidentiality and prevents healthcare staff from triaging care because detainees are deterred from sharing the nature of their health concern. In addition, detainees reported difficulty signing up between 5:00 and 6:00 a.m. Confidentiality is also compromised for detainees in restricted housing, who must speak to nurses doing their rounds in a non-private space, rather than submitting a private and detailed request for care. In addition, while imposing such an early deadline for requesting medical services inevitably lowers demand on the overburdened healthcare system, it fails to provide access for health concerns that come up later in the day. **Even though IHSC policy provides that detainees are to have “unrestricted daily opportunity to request health care using face to face sick call process,” practices vary between detention officers when detainees request medical treatment after 6:00 a.m. Some detainees reported being instructed to sign up the next day, whereas others reported that some detention officers will call in a request for care the same day.** IHSC plays no role in training detention officers in whether or how to screen requests for care, and oversight of these practices is not possible because there is no process for logging medical requests outside of the morning sick call sign-up sheet.

During the detainee interviews, Cal DOJ asked 50 detainees whether they had any problems with medical care at the facility. Seventy-four percent (37 out of 50) reported they had experienced problems. **The majority of concerns reported by detainees resulted from medication (18), lack of appropriate medical care (16), difficulty obtaining specialty care (13), and staff complaints (9).** Detainee complaints included a perceived lack of attention to their medical concerns. Specifically, among those reporting medication concerns or a lack of appropriate medical care, several reported they were given salt packets and told to gargle, told to drink more water, or given ibuprofen for serious concerns. Some

detainees also complained that nurses did not refer them to an advanced practitioner. Two detainees reported they were hospitalized after Otay Mesa healthcare staff failed to address their health concerns. Another said he could not get a referral to a doctor for a hernia. One detainee reported that a nurse refused to x-ray her shoulder despite ongoing pain stemming from the detainee falling from the top bunk. Two patients who used catheters to empty their bladders in the Medical Housing Unit reported that staff did not obtain replacements in a timely manner.

#### **d. Missed Opportunities at Intake**

Cal DOJ's experts noted that nurses did a good job of orienting detainees about how to sign up for medical appointments. However, the experts observed a few ways in which language obstacles are an impediment to effective screening and health education. First, the initial screening in the sallyport lacks needed interpretation services. Second, multiple intake records failed to flag detainees' lack of English literacy.

The intake screening includes detailed questions, vital signs, and a chest radiograph. A detainee with high blood pressure was appropriately flagged for follow-up and was hospitalized within three days of arrival. But, the process lacks the physical assessment necessary to identify abnormalities of the skin or breathing which are included on IHSC's intake screening form. In addition, certain detainees present particular risks for which screening would be beneficial. Opt-out screening for HIV would be reasonable for all new arrivals, or at least a portion, targeted by disease prevalence in their countries of origin. Similarly, many female detainees have never been screened for cervical cancer in their home countries, a fact that is not identified through current intake screening. Identifying adult women who have never had a pap smear and offering them cervical cancer screening would be consistent with World Health Organization and American Medical Association's recommendations regarding cervical cancer screening and IHSC policy providing for such a screening within 14 days of initial health assessment if a medical provider deems it appropriate.<sup>157</sup>

#### **e. Assessments Curtailed Due to PREA Fears**

Cal DOJ's experts noted that concerns about PREA allegations have led to inefficiencies and failure to complete essential assessments. For example, female detainees in need of pelvic exams and cervical cancer screening had been referred to off-site providers, although these exams would normally be within the scope of a primary care provider. Hesitancy related to increased reports of sexual assaults had prompted healthcare staff at Otay Mesa to avoid providing pap smears and pelvic exams. However, Cal DOJ confirmed that they may take place at Otay Mesa, with a chaperone. Cal DOJ's nursing expert also observed that nurses assessing detainee concerns declined to make assessments that required removal of

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<sup>157</sup> See World Health Organization, *Screening for cervical cancer* <<https://www.who.int/activities/screening-for-cervical-cancer>> (as of Oct. 28, 2020); American Medical Association, *Screening for Cervical Cancer US Preventive Services Task Force Recommendation Statement* (Aug. 21, 2018) <[https://www.who.int/medical\\_devices/diagnostics/selection\\_in-vitro/selection\\_in-vitro-meetings/00028\\_01\\_jama\\_curry\\_2018\\_us\\_180019.pdf](https://www.who.int/medical_devices/diagnostics/selection_in-vitro/selection_in-vitro-meetings/00028_01_jama_curry_2018_us_180019.pdf)> (as of Oct. 28, 2020).



clothing—such as looking at a rash on a detainee’s back—without a chaperone present due to fears of PREA allegations. Given the shortage of staff, requiring chaperones for routine assessments of non-sensitive areas is an obstacle to care.

#### **f. Dental Care**

Under IHSC policy, routine dental care may begin after six months and no later than twelve months of detention. Routine care includes the use of both restorative fillings and extractions. Root canal on the front teeth can be done according to acuity of need, and “additional treatment if sufficient caloric intake cannot be maintained.” Based on chart review and interviews, Cal DOJ found that fillings are not offered at Otay Mesa within the first six months of detention, root canals are not performed, and dentures are not offered.

## **B. Mental Health Care**

Otay Mesa receives detainees with serious mental illnesses who cannot be treated at other local detention facilities. At the time of Cal DOJ’s visit, mental health services at Otay Mesa were provided by IHSC. They consist of a mental health screening on arrival to the facility, daily sick call triages, crisis intervention for emergencies 24 hours a day, on call services, individual therapy, and medication evaluations and management. Care provided to the general population and detainees in RHUs is equivalent to outpatient care in the community, and the MHU is available for closer clinical monitoring. Psychiatry services are provided remotely via tele-health for 12 hours per week. With respect to psychotropic medication, one of the on-site pharmacists was recently certified as a psychiatric pharmacist, allowing for management of psychotropic medication via a collaborative practice agreement with licensed, remote staff. Otay Mesa’s programming, provided by custody staff without input from or the involvement of mental health services, nevertheless provides important enrichment to detainees in extremely challenging circumstances. If a detainee is in need of a higher level of care, the detainee may be transported to Paradise Valley Hospital in National City or Alvarado Pathway Institute in La Mesa, California.

Mental health service providers make use of language interpretation lines with regularity, with critical exceptions for wellness checks that take place at an isolated detainee’s cell door. Mental health staff respond appropriately to hunger strikes and participate in weekly RHU meetings. Unfortunately, despite these successes, Cal DOJ’s review of mental health care at Otay Mesa revealed an overburdened system that fails to address the suffering of mentally ill detainees due to underdiagnoses; delayed treatments; failure to monitor and adjust medications; and placement of detainees in excessive isolation, among other systemic failures.

Cal DOJ’s mental health expert reviewed 16 clinical charts. Her analysis is informed by PBNDS, Title 15, NCCHC, IHSC policy, and best practices in the field.

#### **(i) Inaccurate Screening, Failure to Refer, and Underdiagnoses**

Although the screening questionnaire used at intake is comprehensive and the screening is generally administered in a timely manner, five of the 16 charts reviewed (31%) showed

incomplete or inaccurate intake results—results that in turn failed to trigger a referral for mental health evaluation. Four charts stated there was no trauma history despite narrative information indicative of physical or sexual abuse, including one detainee’s family being killed and his three-year-old daughter having gone missing in his violence-ridden home country. Two detainees’ charts were marked “normal” despite documented auditory hallucinations in one and a history of bipolar disorder with treatment and multiple traumas in another.

Whether due to inaccurate screenings, other failures to refer, or unexplained lengthy delays between referral and a psychiatric evaluation, 15 out of 16 charts reviewed by Cal DOJ’s mental health expert revealed problems in the referral process that delayed critical treatment. **Several charts included clear indications, such as suicide attempts and hallucinations, two to three months before a detainee was evaluated by a psychiatric practitioner. Detainees who arrived with medications for depression, PTSD, anxiety and/or schizophrenia were not referred for a psychiatric evaluation for two or more months after arriving at Otay Mesa. In two particularly harrowing—but not unusual—cases, detainees were seen by a licensed clinical social worker or a non-behavioral health practitioner who did not refer them to the psychiatrist despite one detainee hearing voices that would not allow her to sleep and another detainee making multiple suicide attempts that resulted in psychiatric hospitalizations.**

Cal DOJ’s mental health expert also found that detainees with mental health concerns are frequently underdiagnosed, particularly with respect to the common experience of trauma. For example, two detainees were diagnosed with “moderate” disorders despite documentation showing symptoms that would have supported a “severe” diagnosis, which would have required closer monitoring, more precautions, and a safety alert on the detainees’ charts.

Ineffective evaluations also impact the care of detainees who are believed likely to harm themselves. According to suicide logs, there were 179 detainees placed on suicide watch in 2018, with five suicide attempts and 39 suicidal “gestures.”<sup>158</sup> Under the community standard of care and IHSC, ACA, and NCCHC guidelines, mental health staff must evaluate and provide treatment on a daily basis to detainees on suicide watch. Detainees reported, however, that they were simply isolated and asked if they were still suicidal—no steps were taken to identify and interrupt the thoughts and feelings that triggered suicidal ideation or equip the detainee to do so. Similarly, none of the charts reviewed showed completion of a comprehensive suicide risk assessment and treatment plan upon detainees’ release from suicide watch, as required by the PBNDS.<sup>159</sup>

## **(ii) Substandard Treatment: Unsafe Monitoring, Insufficient Formulary; Treatment Plans; Continuity of Care, Improperly Done Medication Consents**

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<sup>158</sup> CalDOJ’s mental health expert noted that she would have classified some of these “gestures,” such as ingesting cleaning chemicals, as suicide attempts.

<sup>159</sup> ICE, PBNDS 2011, Part 4.6 Significant Self-harm and Suicide Prevention and Intervention, Part V, § D & E.

Cal DOJ's mental health expert observed—through chart review and interviews—several aspects of substandard mental healthcare. Because mental illness can produce disruptive and distressing symptoms, unsuccessful treatment contributes to behavioral crises that impact the security of other detainees and staff as well.

**Failure to Monitor Medication.** Nearly all detainees prescribed psychotropic medication had psychiatric visits that were out of compliance with the required minimum of 30-day monitoring. Due to the infrequency of visits, detainees had to wait months to have their medications adjusted to address their original symptoms or side effects. Charts also revealed that standard monitoring—through the Abnormal Involuntary Movement Scale (AIMS) test, lab tests, and checking of vital signs—for side effects of certain psychotropic medications is not done or is not done consistently and recorded. The consequences of infrequent visits and failures to monitor were compounded by incomplete diagnoses and treatment at the outset of care. Cal DOJ's mental health expert identified several instances in which detainees suffered from multiple problems but were prescribed medication to address only one of them, or were prescribed lower doses than indicated under the community standard of care.

**In one example, a detainee arrived on three different antidepressants for anxiety, depression, and PTSD. The detainee was not referred to psychiatry upon arrival for two months, despite having several meetings with mental health and medical providers. The psychiatrist prescribed a low dose mood stabilizer-antipsychotic and did not address the detainees' previous diagnoses or treatment. The detainee was not seen again for three months, during which time the detainee became suicidal and was placed on suicide watch, which did not trigger followup psychiatric care. The next psychiatry visit resulted in a PTSD diagnosis, but no change in medication. It was not until the detainee's third psychiatric visit, seven months after arriving at Otay Mesa, that the detainee was prescribed a low dose of an antidepressant. The low dosage was not enough to address the detainee's condition, which had been worsening over months, and the detainee was placed on suicide watch about three weeks later. Again, this incident did not trigger a medication review. At the time of Cal DOJ's review, the detainee had been housed in the medical housing unit due to severe distress for over two weeks with the next psychiatry visit scheduled to take place over a month later.**

**Continuity of Care.** The previous example highlights another critical component of mental health care that is lacking at Otay Mesa: continuity of care. Like the detainee described above, four other charts described detainees arriving with psychotropic medications that were not continued upon their arrival at the facility. These examples included two detainees who had been sent to psychiatric hospitals from Otay Mesa. Upon their return, they were not provided their discharge medications for weeks and remained acutely symptomatic. With respect to releasing detainees who are receiving psychiatric care, Otay Mesa also fails to follow applicable standards of providing detainees a 30-day supply of current medications and a complete discharge summary.

**Treatment Plans.** Under IHSC policy, treatment plans must be created within three days of

diagnosis. However, as shown by chart reviews, the plans at Otay Mesa are of poor quality and are not modified based on changes in the detainees' health or circumstances. Under NCCHC recommendations, treatment plans for mental health patients "should incorporate ways to address the patient's problems and enhances patient's strengths, involve patients in their development, and include relapse risk management strategies." At Otay Mesa, Cal DOJ's mental health expert observed that the treatment plans for mental health patients merely stated three identical goals: (1) the detainee will not harm self or others; (2) the detainee will follow facility mandates; and (3) the detainee will take medications as prescribed. Some treatment plans did not even mention the patients' specific symptoms. Some plans also included goals such as "detainee will experience appropriate mood management at least 70 percent of the time" or "experience appropriate reality testing at least 70 percent of the time." Charts did not include patient signatures showing their awareness and approval of the plans.

Treatment plans should be created collaboratively with the patient and provide the patient with direction toward learning new coping skills by identifying interventions and timeframes for meeting measurable goals, identifying the patient's strengths and resources, and identifying staff responsible for working with the patient on specific components.

**Medication Consents.** Chart review revealed that non-behavioral health nurses and social workers are being tasked with counseling detainees on their psychiatric medications outside of their scope of practice, and with notable errors. In order to facilitate true informed consent for psychiatric medications, as required by policy, additional oversight by the tele-psychiatrist is needed.

**Limited Modalities of Treatment.** The scarcity of mental health resources at Otay Mesa limits the facility's ability to provide effective mental health care. Other than individual therapy and medication, detainees may be provided self-help education handouts, but there are no options for group treatment to help detainees address grief and loss, trauma, depression, anxiety, conflict resolution, anger management, and substance use disorders. The main option—individual therapy sessions—are too short (15 to 20 minutes) and infrequent to address serious distress. For example, at an initial evaluation, a licensed clinical social worker noted that a detainee expressed significant difficulties with past traumas and current functioning. Her condition had worsened by her next appointment, 43 days later. She was not scheduled to be seen again for another 21 days—an unreasonable delay given the intensity of her distress. In the meantime, she had a panic attack, which triggered an urgent mental health referral with a different provider.

**Inadequate Formulary and Stock Medications.** The 2020 IHSC Formulary (list of medications on-site) is fairly comprehensive. However, it is missing second generation long acting antipsychotics for patients who do not tolerate the older antipsychotics in stock. The formulary is also missing some key injectable medications needed to treat severe reactions to antipsychotics and other medications for treating severe agitation from mania or psychosis that poses an immediate danger. Despite a prevalence of substance use disorders in the detained population,

the formulary contains limited options for treating opioid and alcohol use disorders.

### **(iii) Deficiencies Related to Remote Care**

**Tele-psychiatry Concerns.** At the time of Cal DOJ's review, psychiatry services were provided remotely, for 12 hours a week, evenly split between a psychiatrist and a psychiatric nurse practitioner. There was a recently accredited mental health pharmacist who provided psychiatric prescriptions 12 hours a week in-person, and an RN on staff recently became board certified as a psychiatric nurse practitioner with the expectation of providing full time, in-person psychiatric care.

Cal DOJ's mental health expert observed that Otay Mesa's reliance on tele-psychiatry came at a cost, and included several preventable deficiencies:

- The tele-psychiatry system had poor quality video and did not allow the provider to magnify the image, which is necessary to monitor skin conditions and involuntary movements that are signals of adverse side effects of certain medications.
- Because remote treatment does not allow for close physical examination, the collaboration of a co-facilitator with medical training is important. The facility's plan at the time of Cal DOJ's visit, however, was to have a licensed clinical social worker with no medical training play that role.
- The facility does not have standard operating procedures for tele-psychiatry as recommended by the American Psychiatric Association and American Telemedicine Association.
- Charts did not include confirmation of verbal consent and detainees said they had not been asked to consent to tele-psychiatry as required by California law professional best practices.

**On Call Emergency Care.** Otay Mesa has a mental health provider who can prescribe medications on call 24 hours a day in case of mental health emergency. However, the on call provider is not expected to come into the facility, in contrast to the community standard of care under which on call providers must be available on-site within an hour.

### **(iv) Isolation of Detainees with Mental Illness**

As noted above, *Systemic Issues*, Section 2.B, RHU is a common destination for disruptive, rule breaking, or time-consuming detainees with mental illness. The RHU, the MHU, and suicide watch are all isolating housing options with insufficient measures for evaluating and intervening in the decompensation of detainees with mental health challenges. Cell door wellness checks do not provide the privacy required for sharing difficult feelings, and medical and mental health staff routinely "clear" detainees for isolation despite the impact of isolation on mental health.

**One detainee who arrived with unlabeled antipsychotic and antihistamine medications and a previous schizophrenia diagnosis was initially placed in an observation room,**

**but was not placed on any medication. Despite multiple emergencies in custody, auditory hallucinations, an episode of self-harming, and an emergency room visit, he went without medication for 10 days and was repeatedly “cleared” for segregation.**

Suicide watch placement is also extremely isolating, and not therapeutic. **One detainee explained to Cal DOJ’s mental health expert in Spanish, “Suicide watch doesn’t help. It is more torture. There is a camera. There is no privacy to use the bathroom. There is no toilet in the room. I refused to eat while in suicide watch so I would not need to defecate...The room is cold and dirty. The custody doesn’t talk to you. They just watch constantly.”** The severe nature of suicide watch placement creates the risk that patients may refrain from sharing suicidal thoughts for fear of the harsh, lonely placement that will result.

**(v) Confidentiality and Language Access Concerns**

The lack of confidentiality for sick call—both the sign-up sheet process where a detainee must mark whether they seek medical, dental, or mental health care and RHU rounds wherein a detainee must communicate with a nurse standing outside his or her cell—is particularly problematic for detainees with mental health needs, due to stigma associated with seeking such services.

In addition, while language interpretation appears to be effectively used for counseling in the medical unit, neither nurses nor mental health providers have access to a handheld interpretation device that can be used for wellness checks in the RHU, or at the cell doors or within the cells of the MHU.

# COVID-19 at Immigration Detention Facilities in California

SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19), has swept across the globe in an unprecedented manner, leaving no country unaffected by its impact. On March 4, 2020, the State of California declared a state emergency; on March 11, 2020, the World Health Organization declared it a global pandemic; and on March 13, 2020, the United States declared a national emergency. In response, states and localities across the nation issued stay-at-home orders, office workers and students began working and learning from home, and non-essential businesses were closed. Detention facilities remained operational.

This section of the report is intended to share with the public the information that Cal DOJ was able to ascertain about the experiences of detainees grappling with the same medical concerns, fear, and uncertainty that the public at large has faced throughout this pandemic. This section also highlights the additional reality that detainees' exposure to COVID-19 is amplified by the congregate settings in which they are detained and is wholly dependent on the protocols and safety measures implemented by the facilities.

Advocates, congressional representatives, and California Attorney General Xavier Becerra have been among those who have urged the Department of Homeland Security to depopulate immigration detention facilities and implement practices that ensure social distancing and availability of cleaning products to prevent and mitigate the spread of COVID-19.<sup>160</sup> Individual immigration detainees, class action plaintiffs, and detention staff across the country and in California have also filed lawsuits against detention facility operators and ICE for coronavirus-related actions or inaction. According to ICE's website, as of December 23, 2020, 504 detainees have been released from detention in California on account of court orders related to COVID-19.<sup>161</sup>

As of January 4, 2021, there have been 8,455 confirmed cases of COVID-19 in ICE detention facilities nationwide, including 267 at Adelanto, 201 at Otay Mesa, 59 at Mesa Verde, 12 at Imperial, five at Yuba, and four at the new Golden State Annex.<sup>162</sup> In addition, at least 45 ICE employees assigned to detention facilities across the nation have contracted COVID-19, including 11 staff members working

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<sup>160</sup> Attorney General of California Letter to DHS Acting Secretary Chad F. Wolf, et al. (April 13, 2020) <<https://tinyurl.com/CalAGLtrDHS>> (as of Oct. 28, 2020); Joint Congressional Letter to DHS Acting Secretary Chad F. Wolf, et al. (May 19, 2020) <<https://tinyurl.com/JointLtrDHS>> (as of Oct. 28, 2020); Senate Letter to DHS Acting Secretary Chad F. Wolf, et al. (April 1, 2020) <<https://tinyurl.com/SenLtrDHS>> (as of Oct. 28, 2020); Congress Letter to ICE Acting Director Matthew T. Albence, et al. (May 4, 2020) <<https://tinyurl.com/CongLtrICE>> (as of Oct. 28, 2020); Hispanic Caucus Letter to Dept. of State Secretary Michael R. Pompeo, et al. (May 20, 2020) <<https://tinyurl.com/CaucLtrDHS>> (as of Oct. 28, 2020).

<sup>161</sup> ICE, ICE Guidance on COVID-19, Judicial Releases (Dec. 23, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021).

<sup>162</sup> These numbers include total numbers of detainees who have tested positive at the respective facilities since February 2020; these individuals may not be detained at those facilities at this time. ICE, ICE Guidance on COVID-19, ICE Detainee Statistics (Dec. 30, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021).

at Otay Mesa and one staff member at Adelanto, but that count has not been updated since June 13, 2020, and is no longer available on the ICE website.<sup>163</sup> Although not reported by ICE, over three hundred private detention facility employees have also reportedly tested positive as of June 13, 2020.<sup>164</sup> Through December 30, 2020, ICE had reported the deaths of eight detainees due to coronavirus while in ICE custody nationally, including one detainee at Otay Mesa.<sup>165</sup>

## 1. Federal Guidance on COVID-19 and Detention Facilities

Since the start of the COVID-19 pandemic, ICE and the CDC have periodically issued guidance on how to prevent COVID-19 exposure and outbreak at detention facilities. In March 2020, ICE Enforcement and Removal Operations (ERO) and ICE Health Service Corp (IHSC) issued instructions specific to the operation of immigration detention facilities for the duration of the pandemic.<sup>166</sup> These guidance documents put forth recommendations, but did not make any precautionary action mandatory for any facility, nor were they purported to be standards that contract facilities were required to meet. Also in March 2020, the CDC issued interim guidance specifically tailored to detention facilities in light of the unique challenges these facilities and their populations face; the guidance was updated in July, October, and December 2020.<sup>167</sup> This guidance, like the ICE-issued guidance is not legally enforceable in most detention facilities.<sup>168</sup>

On April 4, 2020, ICE released guidance ordering Field Office Directors across the country to identify individuals in certain CDC-defined high-risk categories and to make individualized determinations regarding their continued custody.<sup>169</sup> Then, effective April 10, 2020, ICE directed all its immigration detention facilities,<sup>170</sup> including the five detention facilities in California, to comply with (1) their ICE contract or service agreement, (2) the ICE detention standards applicable to the facility, and (3) the CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.<sup>171</sup> This guidance also provided parameters for discretionary release of detainees.

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<sup>163</sup> ICE, Employee Confirmed Cases (June 18, 2020) <<https://www.ice.gov/coronavirus>> (as of Oct. 28, 2020).

<sup>164</sup> Com. on Homeland Security, *Oversight of ICE Detention Facilities: Examining ICE Contractors' Response to COVID-19* (June 13, 2020) <<https://homeland.house.gov/activities/hearings/oversight-of-ice-detention-facilities-examining-ice-contractors-response-to-covid-19>> (as of Oct. 29, 2020).

<sup>165</sup> ICE, ICE Guidance on COVID-19, ICE Detainee Statistics (Dec. 30, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021).

<sup>166</sup> ICE Health Service Corps, Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19) (Mar. 6, 2020); ICE ERO, Memorandum on Coronavirus Disease 2019 (COVID-19) Action Plan, Revision 1, ICE (Mar. 27, 2020), <<https://www.ice.gov/doclib/coronavirus/attf.pdf>> (as of Oct. 28, 2020); Centers for Disease Control and Prevention (CDC) Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, March 23, 2020.

<sup>167</sup> CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities <<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>> (as of Jan. 5, 2021).

<sup>168</sup> Pursuant to court order, the CDC guidance must be substantially followed at Adelanto. *Roman v. Wolf* (9th Cir., May 5, 2020, No. 20-55436) 2020 WL 2188048, at \*1 (upholding district court's order to require ICE to follow CDC guidance at Adelanto).

<sup>169</sup> *Fraihat v. ICE* (C.D. Cal. April 20, 2020, No. 5:19-cv-01546-JGB-SHK) ECF No. 121-4 at 15.

<sup>170</sup> ICE, Facility Inspections, Dedicated and Non Dedicated Facility List, <<https://www.ice.gov/doclib/facilityInspections/dedicatedNonDedicatedFacilityList.xlsx>>, available at <<https://www.ice.gov/facility-inspections>> (as of Oct. 28, 2020).

<sup>171</sup> ICE ERO, COVID-19 Pandemic Response Requirements (April 10, 2020, revised Oct. 27, 2020) <<https://www.ice.gov/coronavirus/prr>> (as of Oct. 28, 2020); CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities <<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>> (as of Jan. 5, 2021).



While ICE has released some detainees in its discretionary capacity, many have been ordered released in response to court orders. Since February 2020, ICE's average daily detained population has decreased nationwide from approximately 38,000 to approximately 20,000 detainees in September 2020. In the same time period, the average length of a detainee's stay has increased from approximately 56 to 91 days.<sup>172</sup> There is no indication that ICE has ceased transfer of detainees between facilities, even if these transfers carry additional risks of spreading COVID-19 between facilities.<sup>173</sup>

## 2. Efforts to Prevent, Mitigate, and Shed Light on the Spread of COVID-19 Inside Immigration Detention Facilities

Data reported on ICE's website does not provide information on the number of tests conducted among the currently detained population, does not disclose who is eligible to be tested, how often tests are conducted, how tests are counted, or whether testing is required prior to transfer, release, or deportation.<sup>174</sup>

Government and non-governmental organizations and entities have called on ICE to take actions to prevent and mitigate the spread of coronavirus within detention facilities, and have endeavored to shed light on the experience of being in immigration detention during the pandemic.

**Congressional Hearings on Immigration Detention and COVID-19.** Congress convened several hearings concerning the impact of the pandemic on immigration detention in the spring and summer of 2020.<sup>175</sup> Issues raised by the Senate Judiciary Committee and the House Committee on Oversight and Reform included ICE's late and limited testing of detainees, conditions of detention during COVID-19 including concerns about sanitation and social distancing, and the limited release of medically vulnerable detainees. In July 2020, the CEOs of the four largest private companies operating immigration detention facilities<sup>176</sup> appeared before the House Homeland Security Subcommittee on Border Security, Facilitation, and Operations. Collectively, the CEOs reported that over 300 employees at their contract facilities have tested positive for COVID-19.<sup>177</sup> The CEOs also committed to Congress that they would require their staff to wear masks inside facilities, which they had not done before.<sup>178</sup>

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<sup>172</sup> ICE, Detention Management, Detention Statistics, FY 2020 ICE Statistics <<https://www.ice.gov/doclib/detention/FY20-detentionstats.xlsx>> (as of Jan. 4, 2021).

<sup>173</sup> CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities <<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>> (as of Jan. 5, 2021).

<sup>174</sup> See Kuo et al., *The Hidden Curve, Estimating the Spread of COVID-19 among People in ICE Detention*, Vera Institute for Justice <<https://www.vera.org/the-hidden-curve-covid-19-in-ice-detention>> (as of Dec. 2, 2020).

<sup>175</sup> Misra, *ICE's COVID-19 test figures hint at health crisis in detention*, RollCall (Apr. 17, 2020) <<https://www.rollcall.com/2020/04/17/ices-covid-19-test-figures-hint-at-health-crisis-in-detention/>> (as of Oct. 28, 2020); Sen. Judiciary Com., Examining Best Practices for Incarceration & Detention during COVID-19 (Jun. 2, 2020) <<https://www.judiciary.senate.gov/meetings/examining-best-practices-for-incarceration-and-detention-during-covid-19>> (as of Oct. 29, 2020).

<sup>176</sup> GEO Group, Management Training Corporation, CoreCivic, and LaSalle Corrections.

<sup>177</sup> Com. on Homeland Security, Oversight of ICE Detention Facilities: Examining ICE Contractors' Response to COVID-19 (June 13, 2020) <<https://homeland.house.gov/activities/hearings/oversight-of-ice-detention-facilities-examining-ice-contractors-response-to-covid-19>> (as of Oct. 29, 2020).

<sup>178</sup> *Id.*

**DHS Inspector General Report.** In June 2020, the DHS Office of Inspector General (OIG) issued a report, based on a survey of ICE’s detention facility administrators conducted in April 2020 about difficulties they have encountered managing COVID-19.<sup>179</sup>

Among the steps that facilities reported taking in response to COVID-19 were: screening and quarantining newly arrived detainees; increasing the cleaning and disinfecting of common areas; staggering meal times or recreation; providing masks to detainees, including those who are not sick and not exhibiting symptoms; performing routine temperature checks of detainees and staff; and suspending visitations.

Facilities reported the following challenges: inability to maintain detainees’ social distancing in the housing units where the majority of the population’s time was spent; handling staffing shortages; having few or no quarantine beds; limited availability of intensive care unit (ICU) beds at nearby hospitals; difficulty accessing personal protective equipment (PPE) and hand sanitizer when demand is great; and lack of on-site testing capacity. Even those facilities that reported having enough equipment to mitigate the spread of COVID-19 when they completed the survey in April 2020 expressed concern that this would not be the case if the pandemic continues.

Notably, as of the final response date of the DHS OIG survey (April 20, 2020), only about 30 percent of immigration detention facilities nationwide had tested at least one detainee, and approximately 40 percent of facilities reported that they could not test detainees on-site.<sup>180</sup>

### 3. Conditions Inside Immigration Detention Facilities in California

COVID-19 continues to pose a public health threat to detainees, facility staff, and communities surrounding California’s immigration detention facilities. According to the CDC, the coronavirus is spread mainly through person-to-person contact. The coronavirus is especially communicable in crowded, indoor spaces, without sufficient ventilation. The nature of detention facilities, however, does not lend itself to the minimum six-foot distancing suggested to prevent the spread of COVID-19. COVID-19 spreads easily in immigration detention facilities where sleeping quarters, dining, work, worship, leisure time, exercise, bathing, and toilets may all be combined in each housing unit, and access to outdoors is limited. Further, there are many medically vulnerable people in the detained immigrant population, and many of them speak languages other than English or Spanish and cannot convey their concerns to detention staff.

In [Cal DOJ’s February 2019 report](#), and as discussed in this report, immigration detention facilities in the State have overburdened healthcare programs. Detainees with serious medical conditions regularly struggle to obtain adequate care at these detention facilities even without the strain of an infectious disease outbreak. None of the facilities Cal DOJ visited are equipped with sufficient options for

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<sup>179</sup> DHS Office of Inspector General, *Early Experiences with COVID-19 at ICE Detention Facilities* (June 18, 2020) <<https://www.oig.dhs.gov/sites/default/files/assets/2020-06/OIG-20-42-Jun20.pdf>> (as of Oct. 28, 2020).

<sup>180</sup> *Id.* at 27.

meaningful testing, quarantining, or social distancing. Detainees, via their advocates, have reported that they are unable to remain at least six feet apart from others, and they are not provided enough soap, cleaning agents, hand sanitizer, or PPE, such as face masks.<sup>181</sup>

Even detention officers at some facilities reportedly do not routinely wear face masks or gloves. Detention officers at Yuba were reportedly coughing and wiping their noses with gloved hands and continued on to touch detainees' property. The pandemic has also impacted immigration court proceedings, as many court locations are only accepting filings and conducting detained dockets remotely.<sup>182</sup> Since March 2020, detainees at every detention facility in California have gone on hunger strikes to protest and call attention to COVID-19-related conditions.<sup>183</sup>

In May 2020, Cal DOJ requested policies, procedures, and protocols related to the prevention and management of coronavirus from the immigration detention facilities currently operating in California. Imperial and Yuba produced documents responsive to our requests. Otay Mesa provided one document and its healthcare provider directed Cal DOJ to the CDC for applicable policies. Adelanto and Mesa Verde directed Cal DOJ to publicly-available representations made in ongoing COVID-19 litigation.

Additionally, Cal DOJ conducted an attorney survey in June 2020 for attorneys who had represented detained clients in California between March 1, 2020, and June 15, 2020, to assess legal advocates' ability to access their clients within immigration detention facilities during the pandemic. Fifty-three attorneys responded, representing counsel for detainees held at all of California's five immigration detention facilities.<sup>184</sup>

### **(i) Adelanto ICE Processing Center**

As of December 30, 2020, ICE reports that 267 detainees have tested positive at Adelanto since February 2020.<sup>185</sup>

Adelanto has six negative-pressure isolation rooms for a population of up to 1,940 detainees. According to declarations filed in *Fraihat v. ICE*, as of mid-March 2020, detention officers were not wearing gloves or masks; as of late March, there was no additional soap provided, older detainees were being housed together but had not had their temperatures checked and were not provided the opportunity to maintain a six-foot distance from others. In court documents,

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<sup>181</sup> See also *id.* at 8 (nine percent of facilities nationwide did not report that they had sufficient supplies to provide masks to immigration detainees who exhibited COVID-19 symptoms).

<sup>182</sup> U.S. Dep't of Justice, EOIR Operational Status <<https://www.justice.gov/eoir-operational-status>> (as of Dec. 2, 2020)

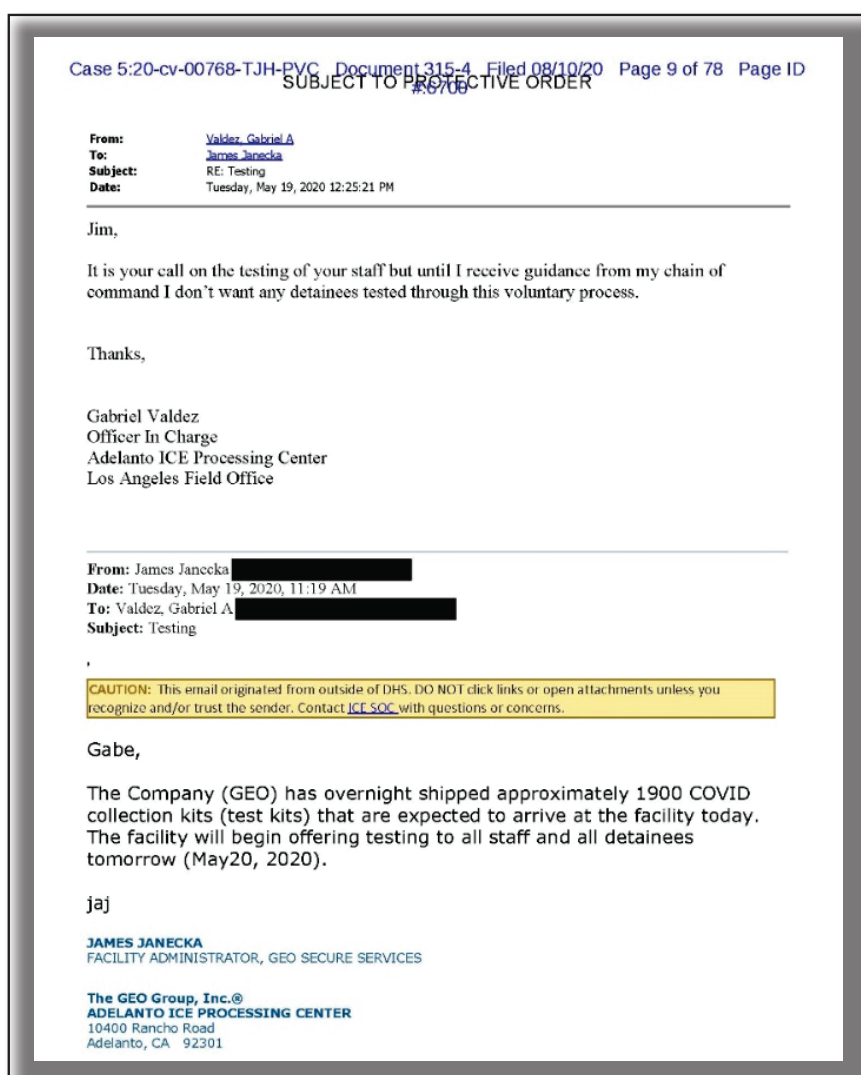
<sup>183</sup> Brown, 'This Virus Kills Way Too Many People.' *Hunger-Striking ICE Detainees Demand Answers.*, The American Prospect (April 17, 2020) <<https://tinyurl.com/AdelHungStrike>> (as of Oct. 29, 2020) (Adelanto); Freedom for Immigrants, *COVID-19 in ICE Custody Biweekly Analysis & Update* (April 14, 2020) <<https://tinyurl.com/ImpHungStrike>> (as of Oct. 29, 2020) (Imperial); Egelko, *Coronavirus hunger strike at immigration lockup? ICE says no, but California detainees say otherwise*, SF Chronicle (April 13, 2020) <<https://tinyurl.com/SFChronstr>> (as of Oct. 29, 2020) (Mesa Verde); Morissey, *COVID-19 concerns prompt hunger strikes and protests inside Otay Mesa Detention Center*, LA Times (April 17, 2020) <<https://tinyurl.com/OMHungStrike>> (as of Oct. 29, 2020) (Otay Mesa); Plevin, *Immigrants in California detention centers launch hunger strikes to call for COVID-19 protections, advocates say*, Desert Sun (April 19, 2020) <<https://tinyurl.com/Plevinstrike>> (as of Oct. 29, 2020) (Otay Mesa); Vellucci, *Death, Hunger Strikes, Plague – COVID-19 Lurks at ICE Detention Camps in Marysville, Bakersfield*, Davis Vanguard (May 20, 2020) <<https://tinyurl.com/YubaHungStrike>> (as of Oct. 28, 2020) (Yuba).

<sup>184</sup> Thirty attorneys reported they had clients at Adelanto; 15 had clients at Yuba; 14 had clients at Mesa Verde; 11 had clients at Otay Mesa; and five had clients at Imperial.

<sup>185</sup> ICE, ICE Guidance on COVID-19, ICE Detainee Statistics (Dec 30, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan 4, 2021).

the facility represented that it would cohort—i.e. house together—individuals with suspected exposure to COVID-19.<sup>186</sup> Detainees have reported that the chemical agents given to detainees for cleaning were so toxic that they caused bloody noses and burning eyes.<sup>187</sup> **Furthermore, emails produced in the course of litigation in *Roman v. Wolf*, Case No. 5:20-cv-00768-TJH-PVC (C.D. Cal.), indicate that ICE stopped a plan proposed by Adelanto personnel to voluntarily test all detainees in May 2020. Figure 71** is an excerpt of emails between the Adelanto facility administrator and the Officer in Charge at the ICE Los Angeles Field Office, which oversees Adelanto.

**Figure 71. Excerpt of Emails Between the Adelanto Facility Administrator and the Officer in Charge at the ICE Los Angeles Field Office.**



<sup>186</sup> *Fraihat v. ICE* (C.D. Cal., April 20, 2020, No. 5:19-cv-01546-JGB-SHK) ECF No. 132 at 15.

<sup>187</sup> Inland Coalition for Immigrant Justice and Freedom for Immigrants Letter to DHS (May 21, 2020) <<https://assets.documentcloud.org/documents/6923000/Adelanto-CRCL-Complaint-052120.pdf>> (as of Oct. 28, 2020).

Testing was limited to incoming detainees. In September 2020, there was an outbreak of coronavirus at the facility. As of September 15, 2020, 14 detainees at Adelanto had tested positive. Within the following week, the count more than doubled.<sup>188</sup> By October 8, 2020, nearly 20 percent of the 772 people housed at Adelanto at that time had tested positive for COVID-19, as well as 31 staff members.<sup>189</sup> Attorneys who responded to Cal DOJ's survey and represent clients at Adelanto reported that they were able to conduct non-contact visits and free legal telephone calls with clients between March 1 and June 15, 2020. One attorney reported that they were able to have a contact visit using PPE. Of the six attorneys who reported having non-contact visits with their clients, two reported that visits took place in non-private areas where detention officers and other detainees were in earshot, and one indicated that their visit took place in a private room. Attorneys reported that Adelanto implemented temperature screening and the completion of a symptom and travel questionnaire prior to visiting with their clients.

The free legal calls were generally provided through an alternative phone line (booking/office phone, phone designated for legal calls), though several indicated calls were also provided through an arrangement with the telephone service provider with which the facility contracts, Telmate. Attorneys reported calls made through the alternative phone line had to be scheduled by the attorneys, with most indicating these calls were confidential. However, some attorneys specified that they were only able to schedule telephone calls with clients as a result of the *Torres v. DHS* injunction,<sup>190</sup> that the calls must be scheduled 24 hours in advance, and that the calls are only available during certain time slots. Attorneys who scheduled calls reported detainees were able to make free non-confidential calls from their dorm, although some indicated these were limited to approximately five to ten minutes each. Most attorneys also reported that they were able to leave messages for their clients, although delivery of the messages was frequently delayed. Four attorneys expressed the need for additional methods of communication, including, for instance, videoconferencing.

Attorneys with clients in segregation reported additional difficulties with communication. Some were unable to communicate with their clients while they were placed in segregation and others reported their clients did not have regular access to the phone.

## **(ii) Imperial Regional Detention Facility**

As discussed in *Comprehensive Facility Review: Imperial*, Section 5.A.i.b, at the time of Cal DOJ's site visit, Imperial had no written protocol for addressing infectious diseases, despite having had mumps and chicken pox outbreaks in the months before our visit. With only six separate medical

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<sup>188</sup> Castillo, *COVID-19 cases leap in outbreak at ICE detention center in Adelanto*, LA Times (Sept. 17, 2020) <<https://www.latimes.com/california/story/2020-09-17/coronavirus-outbreak-adelanto-immigrant-detention-center>> (as of Oct. 28, 2020).

<sup>189</sup> Plevin, *'I'm scared for my life': Nearly 20% of detainees at Adelanto ICE facility have COVID-19*, Desert Sun (Oct. 8, 2020) <<https://www.desertsun.com/story/news/2020/10/07/nearly-20-detainees-adelanto-ice-facility-have-covid-19/5918914002/>> (as of Dec. 3, 2020).

<sup>190</sup> In *Torres v. DHS* (C.D. Cal., No. 5:18-cv-02604-JGB-SHK), plaintiffs filed a class action lawsuit in 2018 to challenge immigration conditions at Adelanto, and filed a motion for a temporary restraining order seeking relief from detainees' exacerbated challenges to accessing legal representation because of COVID-19, such as inability to socially distance while making calls in housing units, inability of attorneys to conduct legal visits in person, and inability of attorneys to call their clients directly. The district court ordered ICE to ensure that detainees at Adelanto could access free, confidential, unmonitored phone calls.

isolation rooms for a population of 704, the facility dealt with disease outbreaks by cohorting an entire 64-person housing unit. As of December 30, 2020, ICE reports that 12 detainees have tested positive for COVID-19 at Imperial since February 2020.<sup>191</sup> Imperial produced policies, procedures, and protocols regarding the facility's response to the coronavirus. According to these documents, the facility implemented COVID-19-specific protocols for staff in April 2020, placed hand-sanitizing stations around the facility, held at least one town hall with detainees in April 2020 to inform them of the pandemic situation at Imperial, and posted signage in English and Spanish in housing units and hallways about maintaining six-foot social distance and washing hands. Imperial also limited recreation time for detainees, precluded detainees from participating in recreation time if they refused to wear a mask, and required detainees to sleep foot-to-head on adjacent bunks. Imperial suspended social visits in March 2020, but allowed legal visits. Imperial implemented COVID-19 protocols for staff and public visitors, requiring them to wear face masks and undergo a temperature check before entering the facility.

Attorney survey respondents with clients at Imperial who visited the facility reported that they were concerned about the confidentiality of non-contact visitation because the lack of phones required clients and attorneys to shout to be heard through the Plexiglass barrier at times. Of the three attorneys who conducted non-contact visits, two reported that the visit took place in a private room. Requirements to wear PPE have been inconsistent, and were not always mandatory in order for the attorney to enter the facility and conduct a legal visit. Two out of the five respondents with clients at Imperial indicated they underwent a temperature screening and completed a symptoms and travel questionnaire before their legal visit.

Attorneys reported that free legal calls were provided through an alternative phone line (booking/office phone, phone designated for legal calls) and that these calls could be scheduled by attorneys through a legal visitation officer. Attorneys are allowed to schedule telephone calls with clients and leave messages for their clients, which they reported Imperial staff would sometimes deliver in a timely manner. Attorneys with clients in segregation reported additional difficulties with communication. One attorney reported not being able to have private videoconference calls with their client in segregation.

### **(iii) Mesa Verde ICE Processing Facility**

As of December 30, 2020, ICE reports that 59 detainees have tested positive at Mesa Verde for COVID-19 since February 2020.<sup>192</sup>

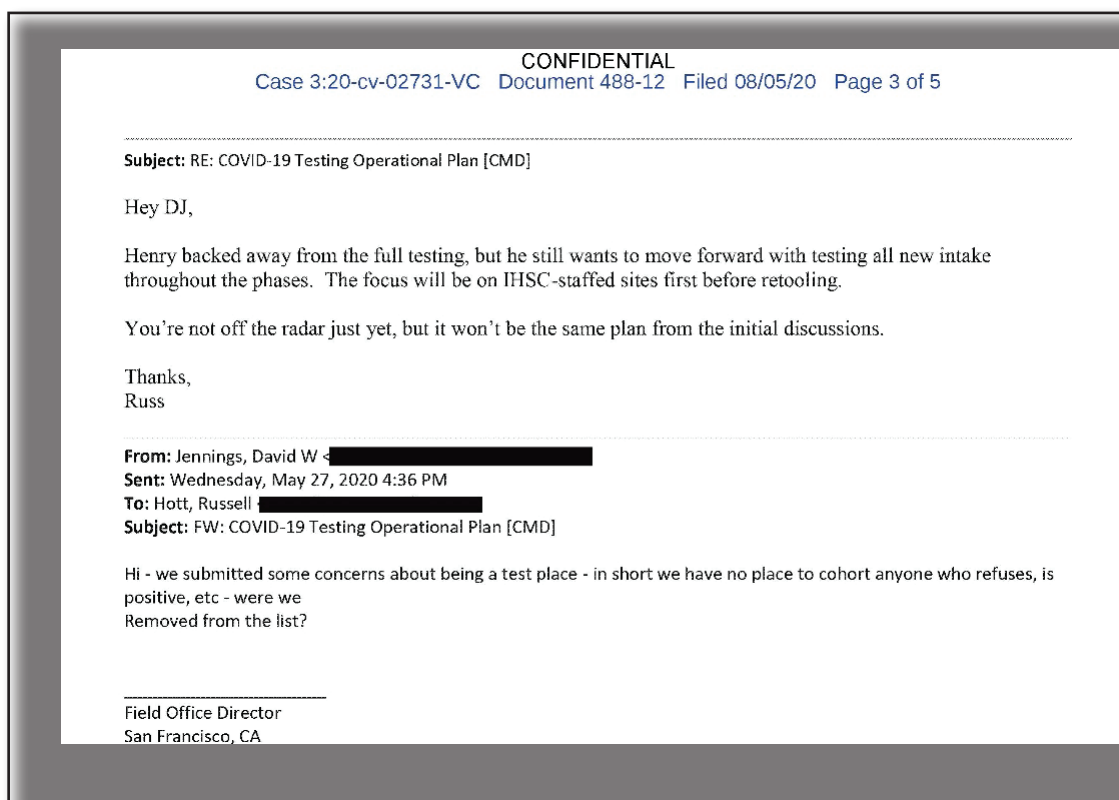
Mesa Verde has four housing units that each contain 50 double bunk beds. It also has two isolation rooms for its population of about 400. However, as of April 24, 2020—over one month after the United States declared COVID-19 a national emergency, and almost two months after California declared a state of emergency—no detainees at Mesa Verde had been tested for

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<sup>191</sup> ICE, ICE Guidance on COVID-19, ICE Detainee Statistics (Dec 30, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021).

<sup>192</sup> ICE, ICE Guidance on COVID-19, ICE Detainee Statistics (Dec 30, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021).

**Figure 72. Excerpt of an Email Between the San Francisco ICE Field Office and the Washington ICE Field Office.**



COVID-19.<sup>193</sup> Indeed, in May 2020, ICE personnel who oversee the facility rebuked a plan for implementing testing at Mesa Verde because of the facility's inability to quarantine detainees who test positive for COVID-19. **Figure 72** is an excerpt of an email between the San Francisco ICE Field Office and the Washington ICE Field Office, produced as part of litigation in *Zepeda-Rivas v. Jennings* (N.D. Cal., No. 3:20-cv-02731-VC). Detainees at Mesa Verde have held hunger strikes to protest conditions related to COVID-19, including in April, June, and July 2020.<sup>194</sup>

According to representations made by the federal government in *Zepeda-Rivas*, (N.D. Cal. June 9, 2020) ECF No. 357 (Prelim. Inj. Order), by June 9, 2020, more than half of the bunks in each housing unit at Mesa Verde were empty, and the facility had implemented staggered meal service, limiting each dining table to one detainee at a time, and provided free face masks to detainees.

<sup>193</sup> Plevin, *ICE releasing all women from Bakersfield immigration detention center during pandemic, advocates say*, Desert Sun (May 7, 2020) <<https://www.desertsun.com/story/news/politics/immigration/2020/05/07/ice-releases-least-13-women-immigration-detention-center-bakersfield-during-pandemic/3093339001/>> (as of Oct. 28, 2020).

<sup>194</sup> Plevin, *Immigrants in California detention centers launch hunger strikes to call for COVID-19 protections, advocates say*, Desert Sun (April 19, 2020) <<https://www.desertsun.com/story/news/health/2020/04/19/immigrants-california-detention-centers-launch-hunger-strikes-call-covid-19-protections-advocates-sa/5162354002/>> (as of Oct. 28, 2020); Morgen, *Hunger strike at Mesa Verde ends after four days, Bakersfield.com* (June 9, 2020) <[https://www.bakersfield.com/news/hunger-strike-at-mesa-verde-ends-after-four-days/article\\_490b6ee6-aa92-11ea-97a0-938736416877.html](https://www.bakersfield.com/news/hunger-strike-at-mesa-verde-ends-after-four-days/article_490b6ee6-aa92-11ea-97a0-938736416877.html)> (Oct. 28, 2020); Bolanos, *Mesa Verde On Hunger Strike Again Amid Positive COVID-19 Cases*, NPR (July 7, 2020) <<https://www.kvpr.org/post/mesa-verde-hunger-strike-again-amid-positive-covid-19-cases#stream/0>> (as of Oct. 28, 2020).

Detainees who show symptoms are placed in isolation in the medical unit. *Zepeda-Rivas* Prelim. Inj. Order at 8. Notably, the district court in *Zepeda-Rivas* stated that these changes were implemented in response to litigation, and that ICE “has shown a disinterest and lack of dexterity in adjusting its conduct to respond to a global crisis.” *Id.* at 3. The facility does not quarantine new arrivals unless the detainee is already experiencing symptoms or awaiting results, contrary to an initial assertion by the ICE official who oversees Mesa Verde. *Id.* at 5. On June 29, 2020, ICE noted that it would implement COVID-19 testing for all new arrivals to Mesa Verde.<sup>195</sup> By August 14, over half of the detainees in the facility tested positive for coronavirus, prompting the court in *Zepeda-Rivas* to require ICE to test the remainder of detainees and staff at the facility.<sup>196</sup>

Attorney survey respondents with clients at Mesa Verde reported they were allowed to conduct non-contact visits and free legal telephone calls with clients. One attorney reported that the non-contact visit took place in a private setting. Attorneys reported they could schedule free legal calls with clients through an alternative phone line (booking/office phone, phone designated for legal calls). Several attorneys also indicated detainees could make free non-confidential calls from the phones available to them in their dorms pursuant to the *Lyons* settlement.<sup>197</sup> Attorneys reported that their legal calls with clients were restricted to 30-minute increments, and one attorney experienced a nine-minute limit on a call with a client. Most attorneys indicated that they were able to leave messages for their clients, though there was no clear consensus on the timeliness of their delivery. Two attorneys with clients in segregation did not report experiencing issues communicating with their clients. However, one other attorney with a client in medical segregation (non-COVID-19 related) was unable to communicate with their client.

#### **(iv) Otay Mesa Detention Center**

Otay Mesa was the first facility in California in which a detainee tested positive for COVID-19, and remains one of the more widespread outbreak sites within an immigration detention facility in the nation. The first detainee who died in ICE custody due to COVID-19, Carlos Escobar-Mejia, became infected while detained at Otay Mesa. As of December 30, 2020, ICE reports that 201 detainees have tested positive at Otay Mesa since February 2020.<sup>198</sup>

When the virus began spreading at the facility, Otay Mesa withheld PPE from any detainee who did not sign an English-only waiver of liability related to COVID-19 infection. **Figure 73** is an excerpt of that liability waiver.<sup>199</sup>

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<sup>195</sup> *Zepeda Rivas v. Jennings, et al.* (N.D. Cal. June 29, 2020, No. 3:20-cv-02731-VC) ECF No. 407.

<sup>196</sup> Smith, *Federal judge orders COVID-19 testing at Bakersfield immigration detention facility*, LA Times (Aug. 16, 2018) <<https://www.latimes.com/california/story/2020-08-16/federal-judge-orders-covid-19-testing-at-bakersfield-immigration-detention-facility>> (as of Oct. 28, 2020).

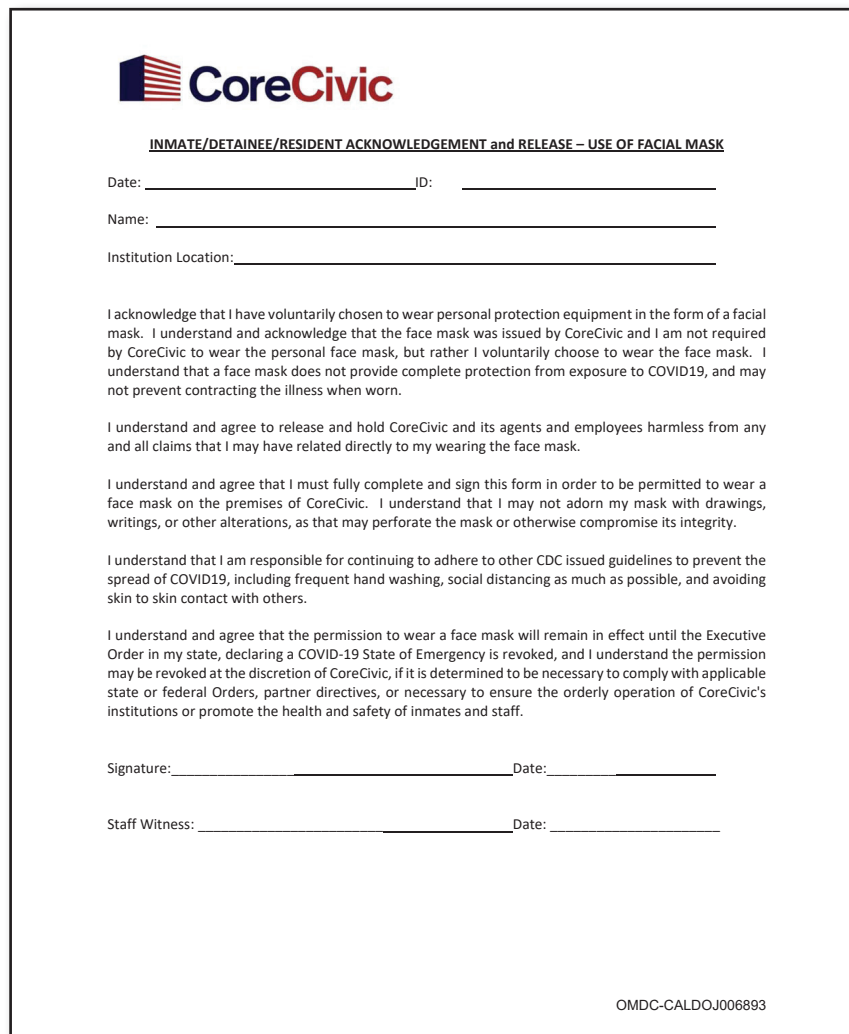
<sup>197</sup> *Lyons v. ICE* (N.D. Cal. 2016, No. 3:13-cv-05878). As a result of the *Lyons* settlement, Mesa Verde and Yuba are required to provide phone booths in housing units for additional privacy, expanded options for free, direct, and unmonitored calls to attorneys and government agencies, and prompt access to a phone room for other legal calls upon request, among other requirements, to immigration detainees.

<sup>198</sup> ICE, ICE Guidance on COVID-19, ICE Detainee Statistics (Dec 30, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021).

<sup>199</sup> CoreCivic voluntarily produced the waiver to Cal DOJ.



Figure 73. Excerpt of CoreCivic Liability Waiver.



The image shows a document titled "CoreCivic" with a logo featuring a stylized American flag. Below the logo is the heading "INMATE/DETAINEE/RESIDENT ACKNOWLEDGEMENT and RELEASE – USE OF FACIAL MASK". The form contains several lines for personal information: "Date: \_\_\_\_\_ ID: \_\_\_\_\_", "Name: \_\_\_\_\_", and "Institution Location: \_\_\_\_\_". There are four paragraphs of text, each starting with "I understand and agree...". The first paragraph states that the individual voluntarily chose to wear a face mask issued by CoreCivic. The second paragraph states that the individual agrees to release and hold CoreCivic harmless from any claims related to wearing the mask. The third paragraph states that the individual must fully complete and sign the form to wear a mask and that the mask should not be altered. The fourth paragraph states that the individual is responsible for following CDC guidelines and that the permission to wear a mask will remain in effect until a state of emergency is revoked. At the bottom, there are two sets of lines for "Signature: \_\_\_\_\_ Date: \_\_\_\_\_" and "Staff Witness: \_\_\_\_\_ Date: \_\_\_\_\_". The document ID "OMDC-CALDOJ006893" is printed in the bottom right corner.

Detainees who cannot read, or who do not speak English, may not have understood the purpose or consequences of the waiver. Moreover, by withholding PPE, Otay Mesa placed detainees, staff, and the community at risk of contracting the virus. After public outcry about the waiver, Otay Mesa ceased using it.<sup>200</sup>

Otay Mesa has only one negative-pressure isolation room for a population capacity of about 1,994. Twenty-three detainees at Otay Mesa began a hunger strike in early April 2020 to protest being detained amidst the spread of COVID-19.<sup>201</sup> In mid-April, detainees in at least 11 housing units at Otay Mesa began a hunger strike.<sup>202</sup> Conditions at Otay Mesa, including the facility's failure to

<sup>200</sup> *Alcantara v. Archambeault* (S.D. Cal., No. 3:20-cv-00756-DMS-AH).

<sup>201</sup> Detention Resistance, Twitter (Apr. 3, 2020) <<https://tinyurl.com/OtayTweet>> (as of Dec. 3, 2020).

<sup>202</sup> Morissey, *COVID-19 concerns prompt hunger strikes and protests inside Otay Mesa Detention Center*, LA Times (April 17, 2020) <<https://www.latimes.com/california/story/2020-04-17/coronavirus-hunger-strikes-protests-otay-mesa-detention-center-immigration>> (as of Oct. 28, 2020).

provide officers face coverings or allow officers to wear their own face masks, and inadequate sanitation and social distancing, prompted detention officers to file lawsuits against CoreCivic, the private company which operates the facility.<sup>203</sup>

In response to the outbreak, according to court documents, Otay Mesa implemented several policies, including: (1) the suspension of new detainee admissions, social visits, volunteer entry and regularly scheduled facility audits, (2) requiring health screening of all persons entering the facility, (3) posting educational materials throughout the facility, (4) increased sanitation, (5) provisions of masks to detainees, and (6) requiring employees to use PPE.<sup>204</sup> The facility also practiced “protective cohorting” whereby detainees free of COVID-19 are housed together to keep an area free of COVID-19, rather than quarantine an area due to COVID-19 exposure. Cal DOJ is not aware whether the facility tests detainees before placing them into protective cohorting housing units. By May 26, 2020, the facility was operating at 38 percent of the 1,994 capacity, including 389 ICE detainees.

Attorney survey respondents representing clients at Otay Mesa between March 1, 2020, and June 15, 2020, reported that they are able to communicate with their clients through free videoconference calls, but that the calls may take place in a shared space and are not confidential. Regarding the free legal calls, attorneys reported calls were provided through an arrangement with the telephone service providers with which the facility contracts, Telmate. Attorneys specified that through this arrangement, their clients could make free non-confidential calls through the phones available in their dorms, but they were only able to speak by telephone for 10 minutes at a time. There was no clear consensus on whether attorneys could schedule private legal calls with clients. Attorneys reported that they were able to leave messages for their clients, though there was no clear consensus on the timeliness of their delivery. Three attorneys with clients in segregation indicated they were not able to communicate with their clients placed in segregation.

Regarding visitation, two attorneys, out of the 11 survey respondents with clients at Otay Mesa, reported that the facility did not allow legal visitation between March 18 and June 18, 2020. When visitation was allowed, attorneys were subject to a temperature screening and completion of a symptom and travel questionnaire. Attorneys who visited their clients at the facility reported that the non-contact visitation took place in non-private rooms, where phone and video equipment did not always function, making it necessary for both the client and attorney to yell in order to communicate with each other through Plexiglass.

### **(v) Yuba County Jail**

As of December 30, 2020, ICE reports that five detainees have tested positive at Yuba since

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<sup>203</sup> Cook and Morrissey, *Guards Sue CoreCivic Over Allegedly Dangerous Workplace Amid COVID-19*, San Diego Union-Tribune (Apr. 30, 2020) <<https://www.sandiegouniontribune.com/news/watchdog/story/2020-04-30/guards-sue-corecivic-over-allegedly-dangerous-workplace-amid-covid-19>> (as of Oct. 28, 2020).

<sup>204</sup> *Alcantara v. Archambeault* (S.D. Cal. May 1, 2020, No. 3:20-cv-00756-DMS-AH).

February 2020.<sup>205</sup> Detainees have reportedly held hunger strikes in protest of COVID-19-related conditions in at least May and July 2020.<sup>206</sup> The facility provided policies, procedures, and protocols regarding the facility's response to coronavirus. Using a pandemic preparedness assessment tool created by Wellpath, the company that provides medical care at Yuba, the facility created a COVID-19 preparedness planning committee and appointed personnel to be responsible for tracking cases and public health advisories. Yuba and Wellpath also created a video on COVID-19 in English and Spanish to explain what the virus is, what common symptoms are, and how to prevent its spread, including wearing a mask, washing hands, covering one's cough, disinfecting often, and not sharing items such as cups, utensils, and bedding.

According to the documents, the facility screens all new detainees and transportation officers before they are allowed into the facility. While Yuba quarantines all newly arrived county inmates for 14 days in one of the two housing units dedicated to quarantine, the facility does not quarantine ICE detainees if the detainee transferred from another ICE facility, had spent at least 14 days there, and is asymptomatic upon arrival to Yuba. Yuba requires all staff to wear at least surgical face masks at all times; detainees are provided one clean cloth face mask on a weekly basis but per facility policy, are not allowed to wash these face masks themselves. Detainees are provided cleaning supplies and paper towels for sanitizing the telephone after each use, and are instructed to sleep head-to-foot on bunk beds. Yuba closed all visitation on March 23, 2020.

Yuba's detainee population has been significantly reduced. By June 2, 2020, Yuba was housing a total of 69 detainees, compared to 127 on May 4, 2020, which accounts for the majority of the depopulation that took place at Yuba County Jail during that month.

Attorney survey respondents with clients at Yuba reported they were able to conduct non-contact visits and free legal telephone calls with their clients. Attorneys reported non-contact visitation took place in a private setting, but respondents reported that the facility had not implemented additional screening measures. From the information provided, it is unclear whether detainees could access free legal non-confidential calls from their dorms; however, attorneys reported they could schedule legal calls with clients. Nonetheless, attorneys reported obstacles to communicating with clients, noting it was difficult to schedule calls due to delays or lack of available times to set up a call and that calls were reportedly limited to 20-30 minutes. Attorney survey respondents reported that they were able to leave messages for clients, although their messages were not always promptly delivered. Of the four attorneys with clients in segregation, one noted delays in communication with their client(s), and another indicated their client was only allowed out of their cell during certain hours, which therefore limited the client's access to phones.

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<sup>205</sup> ICE, ICE Guidance on COVID-19, ICE Detainee Statistics (Dec. 30, 2020) <<https://www.ice.gov/coronavirus>> (as of Jan. 4, 2021)

<sup>206</sup> Vellucci, *Death, Hunger Strikes, Plague – COVID-19 Lurks at ICE Detention Camps in Marysville, Bakersfield*, Davis Vanguard (May 20, 2020), <<https://www.davisvanguard.org/2020/05/death-hunger-strikes-plague-covid-19-lurks-at-ice-detention-camps-in-marysville-bakersfield/>> (as of Oct. 28, 2020); Centro Legal De La Raza, *Undocumented immigrants held in two different detention facilities host strikes, protesting inaction from state leaders as COVID-19 spreads* (July 23, 2020) <[https://www.centrolegal.org/wp-content/uploads/2020/07/PR-MV\\_YCJ-Strikes-3.pdf](https://www.centrolegal.org/wp-content/uploads/2020/07/PR-MV_YCJ-Strikes-3.pdf)> (as of Oct. 28, 2020).



# Conclusion

Over the last two fiscal years, the federal government continued to increase the number of immigrants held in immigration detention. Even when the COVID-19 pandemic exploded across our country and our State, it was only after extensive litigation that ICE was forced to temporarily decrease the immigrant detainee population. Reports like this, which shine a light on the conditions under which immigration detainees are held, are crucial to highlight the many deficiencies found at immigration detention facilities throughout the State, particularly the significant issues with medical and mental health services provided at these facilities. Cal DOJ will continue its implementation of AB 103 with ongoing site visits and the review of public and requested documentation from facility operators and will provide the public with necessary information about how detention facilities are operating and treating immigrants.

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