Report for the U.S. Department of Homeland Security Office for Civil Rights and Civil Liberties

Environmental Health and Safety Report

West Texas Detention Facility, Sierra Blanca, Texas

(b) (6)

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Introduction

On August 14-16, 2018, I assessed the environmental health and safety conditions at the West Texas Detention Facility (WTDF), Sierra Blanca, Texas. This review was provided under contract with the United States Department of Homeland Security, Office for Civil Rights and Civil Liberties (CRCL). Accompanying me on this investigation were (b)(6) Senior Policy Advisor, CRCL, and (b)(6) Policy Advisor, CRCL, as well as three other subject matter experts who examined WTDF's medical care, mental health care, and conditions of detention.

The purpose of this review was to investigate complaints made by U.S. Immigration and Customs Enforcement (ICE) detainees of various alleged violations of civil rights and civil liberties at WTDF. In particular, I examined allegations contained in Complaint Numbers 18-04-ICE-0139, 18-07-ICE-0282, 18-04-ICE-0322, 18-04-ICE-0312, 18-05-ICE-0318, 18-06-ICE-0156, 18-07-ICE-0175, and 18-10-ICE-0471. This investigation was conducted to obtain an impression of the validity of the allegations and issues by assessing the facility's adherence to applicable standards and best practices related to environmental conditions. The areas of review included the intake area, kitchen, laundry, medical unit, detainee living units, and special housing unit.

Methodology

The basis of this report includes document reviews, tour of the facility, interviews with facility staff and detainees, visual observations, and environmental measurements. The findings and recommendations contained in this report are solely those of the author. The report cites specific examples of conditions found during this investigation, however, they should not be considered as all inclusive of the conditions found during the onsite. Consideration was given to national and state standards including the 2000 ICE National Detention Standards (NDS) and Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, published by the American Correctional Association (ACA).

Facility Overview

The facility is owned by Hudspeth County, and LaSalle Correctional Management is responsible for the daily operation of WTDF. Food service is provided by Aramark. The 2000 NDS are applicable.

Findings

Complaint No. 18-04-ICE-0322 – Overcrowding

Complaint No. 18-04-ICE-0322 alleged that the facility was overcrowded and, specifically, that unit 1-A housed 104 detainees in January 2018, despite having a maximum capacity of 60.

Finding: The allegation that overcrowding conditions exist at WTDF is **substantiated.**

Applicable Standard: The NDS Environmental Health and Safety standard is applicable.

Analysis:

The detainees are primarily housed in four semi-permanent modular buildings and each building is split into two dormitory-style housing units. The contracted ICE bed capacity is 759 and the detainee census was 518 on August 14, 2018. Detainees were not housed in unit 1-A during the CRCL onsite.

A diagram of the housing units, including measurements and icons for the showers, toilets, sinks, bunks, and tables, indicates that each housing unit is 99' by 50'4". Therefore, each housing unit, including the entrance and emergency exit vestibules, sleeping area, dayroom space, and bathroom is approximately 4,983 square feet. Although the NDS does not specifically address square footage and housing unit configurations, the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" applies and therefore, ACA Standards Multiple Occupancy Rooms/Cells 4-ALDF-1A-10, Cell/Room Furnishings 4-ALDF-1A-11, Dayrooms 4-ALDF-1A-12, and Plumbing Fixtures 4-ALDF-4B-08 and 4-ALDF-4B-09 are applicable.

The WTDF housing unit diagram shows 30 bunks per unit, assuming they are double bunks, the diagram represents that the housing unit holds a population of 60 detainees. ACA Multiple Occupancy Rooms/Cells standard 4-ALDF-1A-10 states that rooms housing between two and 64 occupants should provide a minimum of 25 square feet of unencumbered space per occupant and unencumbered space is usable space that is not encumbered by furnishings or fixtures. ACA Dayrooms standard 4-ALDF-1A-12 states that dayrooms should provide a minimum of 35 square feet per occupant, exclusive of lavatories, showers, and toilets. Therefore, each housing unit should provide a minimum of 60 square feet of space per occupant, excluding the bunkbeds and toilet fixtures. Each bunk at WTDF is 76" by 27" or 14.25 square feet and 30 bunk units occupy a total space of 427.5 square feet. For the sake of simplicity, the plumbing fixtures will not be deducted from the dimensions. Therefore, at WTDF, the total square footage of 4,983 less the 30 bunkbeds (427.5 square feet) leaves an unencumbered space of 4,555.5 square feet or 75 square feet per occupant based on the

configuration of 30 double bunks (60 occupants), although it should be noted that this calculation errs on the high side as it also includes the vestibule space that is not accessible to detainees. The square footage per detainee at WTDF, based on the August 14, 2018 census and the facility reported maximum capacities is listed in the table below, again erring on the high side because the calculations also assume that all current beds are double bunks, which they are not. The chart clearly indicates that the square feet per detainee calculations fall below the ACA standard in 100% of the housing units at maximum capacity, and only three of the seven detainee housing units (43%) exceeded the minimum ACA standard on August 14, 2018. The allegation specifically alleged that in January 2018, housing unit 1-A held 104 detainees. An occupancy rate of 104 detainees, results in 40.8 square feet per person, which is only 68% of the ACA standard requiring a minimum of 60 square feet per occupant, thereby supporting the allegation of overcrowding.

Table 1 - Square Footage per Detainee

Unit	Male or Female Unit	Maximum Reported Detainee Capacity	Square Feet per Occupant at Maximum Capacity	Detainee Census on 8/14/18	Square Feet per Occupant on 8-14-18	ACA Standard
1-A	--	103	**41.3***	0		*60*
1-B	Male	76	**58.4***	53	86.9	*60*
2-A	Male	99	**43.2***	93	**46.5***	*60*
2-B	Male	77	**57.6***	76	**58.4***	*60*
3-A	Female	100	**42.7***	77	**57.6***	*60*
3-B	Female	96	**44.8***	55	83.5	*60*
4-A	Male	106	**39.9***	70	64.1	*60*
4-B	Male	99	**43.2***	77	**57.6***	*60*

*Does NOT meet the ACA standard of a minimum of 60 square feet of space per occupant

Furthermore, adding more bunks equates to less space between them, which can lead to serious detainee health problems. Respiratory disease is a problem in crowded living conditions and is health concern at WTDF because detainees housed there have come from various locations around the country and therefore are vehicles for bacteria and viruses from around the country: in some cases, bacteria and viruses from around the world. The U.S. Army Public Health Command[1] recommends 72 square feet of floor space per person in barracks, exceeding the ACA standard, with at least 3 feet between bunks. The majority of bunks at WTDF were 34" to 36" apart. However, some bunks were measured at only 14" apart. Furthermore, additional bunks were added to the dayroom area in housing unit 4-B with bunks

[1] https://phc.amedd.army.mil/PHC%20Resource%20Library/Barracks%20Layout%20Jan%202010.pdf

placed only 16" from the dining table benches and 24" from the end of the dining table, which is not hygienic or acceptable. The addition of bunks in the dayroom space also reduces the available space for dayroom activities, including meal consumption, which is discussed later in this report.

A single bunk was observed in housing unit 2-A that was only an inch or two off the floor. The bunk does not comply with the ACA standard requiring sleeping surfaces be a minimum of 12" off the floor, and subjects the detainees that are, for all practical purposes, sleeping on the floor, to the rodents that enter the housing units at night.

The ACLU alleged that the meal schedule and lights-out time also contributes to inadequate sleeping conditions. They specifically alleged that breakfast is served at 4:30 a.m., lights-out on weekdays is 11:00 p.m. and midnight on the weekends, which results in detainees only sleeping a maximum of 5.5 hours during the weekday, and as little as 4.5 hours on the weekends. However, detainees did not report problems related to the meal service times, lights-out times, or lack of sleep when the investigation team conducted group and individual interviews. The existing meal schedule and lights-out times at WTDF are typical for detention facilities. The facility meal schedule lists breakfast at 4:00 a.m., lunch at 11:30 a.m., and dinner at 4:00 p.m. Breakfast in detention facilities is usually served early in the morning to ensure that everyone is fed before court-related activities start for the day and dinner is generally served early in the evening so that it does not conflict with programming and visitation. The overriding factor in the meal schedule is the NDS Food Service standard requiring that no more than 14 hours elapse between the evening and breakfast meals. The overcrowding at WTDF lends credibility to this allegation. The lack of dayroom space results in detainees utilizing their bunks rather than dayroom seating for leisure activities. Therefore, it is likely that detainees are chatting with one another on and around the bunks, which may disturb others and disrupt their sleep.

ACA Plumbing Fixtures standard 4-ALDF-4B-08 specifying that toilets be provided at a minimum ratio of one for every 12 inmates in male facilities and one for every 8 inmates in female facilities was not met in 71% of the WTDF housing units at the facility reported maximum capacity, and was not met in 43% of the housing units on August 14, 2018, as indicated in the table below.

Table 2 - Ratio of Toilets to Detainees

Unit #	Male or Female Unit	Actual # Toilets	Maximum Reported Detainee Capacity	Ratio of Toilets:Detainees at Max Capacity	Detainee Census on 8/14/2018	Ratio of Toilets:Detainees on 8/14/2018	*ACA Standard*
1-B	Male	6	76	1:12	53	1:8	*1:12*

2-A	Male	6	99	**1:16***	93	**1:15***	*1:12*
2-B	Male	6	77	1:12	76	1:12	*1:12*
3-A	Female	6	100	**1:16***	77	**1:12***	*1:8*
3-B	Female	6	96	**1:16***	55	**1:9***	*1:8*
4-A	Male	6	106	**1:17***	70	1:11	*1:12*
4-B	Male	6	99	**1:16***	77	1:12	*1:12*

*Does NOT meet the ACA standard of 1 toilet for every 12 male detainees and one toilet for every 8 female detainees

ACA Plumbing Fixtures standard 4-ALDF-4B-08 specifying that washbasins be provided at a minimum ratio of one for every 12 inmates was not met in 71% of the WTDF housing units at maximum capacity, and was not met in 14% of the housing units on August 14, 2018, as indicated in the table below.

Table 3 - Ratio of Washbasins to Detainees

Unit #	Male or Female Unit	Actual # Lavatories	Maximum Reported Detainee Capacity	Ratio of Washbasins:Detainees at Max Capacity	Detainee Census on 8/14/2018	Ratio of Washbasins:Detainees on 8/14/2018	*ACA Standard*
1-B	Male	7	76	1:10	53	1:7	*1:12*
2-A	Male	7	99	**1:14***	93	**1:13***	*1:12*
2-B	Male	7	77	1:11	76	1:10	*1:12*
3-A	Female	7	100	**1:14***	77	1:11	*1:12*
3-B	Female	7	96	**1:13***	55	1:7	*1:12*
4-A	Male	7	106	**1:15***	70	1:10	*1:12*
4-B	Male	7	99	**1:14***	77	1:11	*1:12*

*Does NOT meet the ACA standard of 1 washbasin for every 12 detainees

ACA Plumbing Fixtures standard 4-ALDF-4B-09 specifying that showers be provided at a minimum ratio of one for every 12 inmates was not met in 100% of the WTDF housing units at maximum capacity, and was not met in 71% of the housing units on August 14, 2018, as indicated in the table below.

Table 4 - Ratio of Showers to Detainees

Unit #	Male or Female Unit	Actual # Showers	Maximum Reported Detainee Capacity	Ratio of Showers:Detainees at Max Capacity	Detainee Census on 8/14/2018	Ratio of Showers:Detainees on 8/14/2018	*ACA Standard*
1-B	Male	5	76	**1:15***	53	1:10	*1:12*

2-A	Male	5	99	**1:19***	93	**1:18***	*1:12*
2-B	Male	5	77	**1:15***	76	**1:15***	*1:12*
3-A	Female	5	100	**1:20***	77	**1:15***	*1:12*
3-B	Female	5	96	**1:19***	55	1:11	*1:12*
4-A	Male	5	106	**1:21***	70	**1:14***	*1:12*
4-B	Male	5	99	**1:19***	77	**1:15***	*1:12*

*Does NOT meet the ACA standard of 1 shower for every 12 detainees

Conclusion:

The detainee census was 518 on August 14, 2018, which is 68% of the 759 total ICE beds. Even at 68% of the maximum capacity, only 3 of the 7 housing units exceeded the ACA standard of 60 square feet of floor space per occupant and minimum ratio of one shower per twelve occupants. At maximum capacity, none of the housing units satisfy the ACA minimum square footage requirement nor do any of the housing units meet the minimum ratio for showers to occupants, and only two housing units satisfy the minimum requirements for the number of toilets and washbasins per occupant. The overcrowded conditions at the facility place the detainees at increased risk of disease, especially respiratory illnesses.

Recommendations:

1. The overcrowded conditions at WTDF place detainees at increased risk of illness and disease. The number of detainees housed in each unit should be immediately assessed and evaluated based on accepted industry standards for square feet per occupant, and ratios of toilets, washbasins, and showers per occupant. The detainee housing units occupancy rates should be adjusted to comply with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies that, "The standards include those from the American Correctional Association" applies. Therefore, ACA Standards Multiple Occupancy Rooms/Cells 4-ALDF-1A-10, Cell/Room Furnishings 4-ALDF-1A-11, Dayrooms 4-ALDF-1A-12, and Plumbing Fixtures 4-ALDF-4B-08 and 4-ALDF-4B-09 are applicable. (Applicable standard: NDS, Environmental Health and Safety)
2. All bunks placed in dayroom areas should be immediately removed. It is not hygienic to place beds only 16" from the benches of the dining tables and 24" from the end of a dining table. Furthermore, all bunks should meet the requirement that sleeping surfaces be a minimum of 12" off the floor, unless authorized as medically necessary by a licensed medical provider. (Applicable standard: NDS, Environmental Health and Safety)

3. Adequate access to toilets, washbasins, and showers is essential to maintain health and hygiene. However, detainees may experience limited shower access secondary to the high ratio of detainees to showers, especially at full capacity. Therefore, until such time that the housing unit capacities are adjusted to accepted industry standards for square feet per occupant and ratios of toilets, washbasins, and showers per occupant, WTDF should actively monitor the access and use of the bathroom facilities to ensure that detainees have appropriate access to toilets, washbasins, and showers, and that the number of detainees housed in the unit does not impede access to toileting, hand washing, and the ability to shower at reasonable times, in compliance with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association," specifically ACA Plumbing Fixtures standards 4-ALDF-4B-08 and 4-ALDF-4B-09. (Applicable standard: NDS, Environmental Health and Safety)

Complaint Nos. 18-06-ICE-0156 and 18-10-ICE-0471 – Air Quality and Temperature

Complaint No. 18-06-ICE-0156 alleged poor air quality, specifically excessive dust and detainees coughing up yellow mucus due to the lack of clean and fresh air. Furthermore, Complaint No. 18-10-ICE-0471 alleged that the air conditioning is not turned on even when the temperature exceeds 100 degrees, and the windows are covered with black trash bags.

Findings: The allegation that detainees become physically ill as a result of dust and a lack of clean fresh air is **unsubstantiated** for the conditions observed during the CRCL onsite. Furthermore, the CRCL medical expert did not report findings to corroborate this allegation. The allegation that the facility does not turn on the air conditioning during hot weather is also **unsubstantiated**.

Applicable Standards: The NDS Environmental Health and Safety and Detainee Classification System standards are applicable.

Analysis:

The facility is located in the desert and therefore susceptible to sand and dust storms. Accumulations of dust were noted on top of the exposed HVAC ductwork in the detainee housing units. Although it was not feasible to perform air quality testing during the onsite, detainees did not report concerns related to air quality and the CRCL medical expert did not report findings of respiratory illnesses related to air quality or dust.

Ambient air temperatures were randomly measured in the housing units and ranged from 70 to 77 degrees Fahrenheit. The NDS Environmental Health and Safety standard states, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association." Therefore, ACA Standard 4-ALDF-1A-20, "Temperature and humidity are mechanically raised or lowered to acceptable comfort levels" is applicable. Although neither the NDS nor the ACA recommend specific indoor air temperatures, the measured range falls within generally accepted industry standards. When specifically asked about indoor air comfort, detainee responses predictably ranged from too hot, to comfortable, to cold. Several female detainees requested a facility-issued sweater because of the cold indoor temperatures, stating that they could not afford to purchase one from the commissary as they were directed to do by facility staff. The WTDF Monthly Climate Readings forms indicate that temperatures are checked and recorded on a monthly basis and a review of the completed forms for May through July 2018 indicates that the readings ranged between 73 and 75 degrees Fahrenheit. The detainees also reported that the facility experiences sporadic power outages however; they are generally short in duration. Power outages are not necessarily surprising due to the remote location of the facility and WTDF has electrical power generators that are maintained and tested in accordance with NDS Environmental Health and Safety standard, III, O., Emergency Electrical Power Generator.

Black plastic that looks like trash bags covers the outside of the majority of the windows in the housing units. A facility supervisor stated that the black plastic is used to establish sight separation between detainees and inmates, and between male and female detainees. However, the plastic is sagging and tattered thereby adding to the general shabby appearance of the facility as a whole.

Conclusion: Respiratory health problems associated with dust and poor air quality were **not substantiated**. It is not possible to keep all detainees comfortable at all times, as personal comfort levels and room temperature preferences can vary significantly from person to person. The findings of indoor air temperatures, ranging from 70 to 77 degrees Fahrenheit and the facility self-reported temperatures of 73 to 75 degrees Fahrenheit, fall within industry standards and therefore, no evidence was found to support the allegation that the facility does not operate the air conditioning system during hot weather.

Recommendations:

4. The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Additional clothing will be issued as necessary for changing weather conditions or as seasonally appropriate," is often interpreted to imply that sweaters are needed and issued only during the traditional winter months. However, as individual comfort levels

vary, some people find air conditioning temperatures to be uncomfortably cool and therefore need a sweater to maintain personal comfort during the summer months. WTDF allows detainees to purchase sweaters from the commissary thereby acknowledging that sweaters may be needed year round. Therefore, to comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "All new detainees shall be issued clean, temperature-appropriate, presentable clothing during in-processing," WTDF should issue sweaters, upon request. (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

5. The NDS Detainee Classification System standard requires that detainees be physically separated from detainees in other categories. Although WTDF achieves sight separation by placing black plastic over the windows, the black plastic is tattered and looks unprofessional. Therefore as a best practices recommendation WTDF should install permanent window coverings such as tint or glazing that obscures the view while allowing natural light to filter in, rather than covering them with sheets of black plastic. (Applicable standard: NDS, Detainee Classification System) (Best Practices)

Complaint Nos. 18-06-ICE-0156, 18-04-ICE-0139, 18-07-ICE-0282, and 18-06-ICE-0156 – Cleanliness, Sanitation, and Facility Conditions

Complaint No. 18-06-ICE-0156, alleged unsafe and filthy conditions including moldy showers, dirty toilets, no hot water, detainees being denied cleaning products, and that detainees were becoming ill due to the unsanitary conditions. Complaint Nos. 18-04-ICE-0139 and 18-07-ICE-0282 alleged that detainees were being forced to perform cleaning without being paid and that detainees were placed in segregation for refusing to clean. Similarly, Complaint No. 18-06-ICE-0156 alleged that detainees were being forced to clean the toilets and yet were denied cleaning products to do so.

Findings: The allegations of unsafe and filthy conditions are **substantiated**. The allegation that detainees have become ill due to unsanitary conditions is **unsubstantiated** due to a lack of documented medical diagnoses. However, detainees state that they have acquired foot fungus and that medical staff advised them to purchase ointment from the commissary for treatment. The allegation that detainees are required to perform cleaning other than maintaining their bed and immediate area, including cleaning toilets without pay, is **substantiated**. No evidence was found to substantiate that detainees were being placed in segregation for refusing to perform cleaning tasks. However, detainees reported that the officers deny them access to the television or microwave as punishment for not cleaning the housing units.

Applicable Standards: The NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards

of hygiene" and states, "The standards include those from the American Correctional Association" applies and therefore, ACA Standard 4-ALDF-1A-04 stating "The facility is clean and in good repair" is applicable. The NDS Food Service, Voluntary Work Program, Security Inspections, and Funds and Personal Property standards are also applicable.

Analysis:

The roof membrane is obviously collapsing and sagging in several of the detainee housing units, allowing rainwater to leak into the housing units and providing an entrance for mosquitoes and other insects. WTDF administration reports that the roofs are scheduled for replacement in November 2018. However, due to the serious nature of the problem, interim repairs are immediately required.

The row of sinks in each housing unit bathroom is covered with metal panels to restrict access to the pipes. However, in housing unit 4-B, eight of the nine screws holding two of the metal panels together were missing, leaving only one screw holding them together. Consequently, the panels separated, creating two very sharp metal points at the top corners of the panels, posing a safety hazard to detainees using the bathroom sink or cleaning the area. Additionally, several of the screws were found on the floor. Detainees should not have access to pieces of metal, including screws, for safety and security reasons. Additional safety hazards include exposed electrical wires in the segregation unit cell #9, and flat head screws, rather than tamper resistant security screws, were found securing a wall plate cover in cell #10.

Cell #289 in the intake unit is used as the shower and laundry changing room for detainees arriving at the facility. The cell clearly has not been adequately cleaned for a significant period of time, based on the accumulation of dirt and grime. The shower was extremely dirty, one of the shower floor drains was completely clogged, the floor was extremely dirty with a thick accumulation of dirt and mildew in the corner behind the toilet, and the toilet paper holder was rusty.

The floors throughout the detainee housing units are also extremely dirty with a buildup of dirt along the floor and wall junctures and the carpets are heavily soiled, rendering them a health hazard. When combined with the dust and sand that is tracked into the housing units due to the local terrain, the food debris and spills that result from the 50 to 100 or more detainees that are housed in the units and forced to eat on the floors or while sitting on their bunks with their tray on their lap, has led to the current state of the housing unit carpets, which are best described as "filthy." The same conditions were cited in the April 2018 Office of Detention Oversight (ODO) Compliance Inspection report stating, "ODO's inspection of the housing units found worn carpeting which appeared to be soiled. The areas where the sides of the building met the floors had a buildup of dust and debris...ODO also observed carpeting in

the coffee pot and microwave areas was extremely soiled with spilled coffee and food particles." It is rare to find carpet in detention facility housing units, especially in the dining areas, due to sanitary concerns. Although the WTDF housing unit carpets are professionally steam cleaned quarterly, this frequency is woefully inadequate to maintain the level of cleanliness and sanitation that is required for detention living quarters.

Detainees reported that they have contracted foot fungus at WTDF. The bathroom floor in housing unit 4-B is bare plywood, which cannot be properly cleaned and disinfected. Detainees should be removed from housing unit 4-B until proper durable, cleanable flooring is installed.

Disease carrying rodents and insects are entering the housing units through the many gaps and openings on the outside of the housing unit buildings. A detainee reported that he observes numerous mice enter through an opening in the exterior wall every night. WTDF administration admitted that the rodent problem is ongoing and that some detainees are exacerbating it by deliberately feeding them. Adding to the problem, detainees are not provided with sealable containers for personal property storage, to include commissary food purchases. Accordingly, detainees are piling their personal items and food at the foot of their beds, which further attracts the vermin. Therefore, the facility should immediately issue detainees appropriate, sealable property storage containers, such as plastic boxes with tight fitting lids and discontinue the practice of allowing detainees to store their personal property on their beds. Additionally, WTDF should enforce the section of the Detainee Orientation Handbook stating, "To avoid pest control issues, open food containers/packages shall not be allowed to be kept in the housing units and are subject to confiscation during shakedowns." Finally, the entry holes and building gaps should be immediately sealed off.

WTDF lacks a formal voluntary work program for cleaning the detainee housing units and therefore the detainees have instituted their own "talacha" system. The CRCL interpreter advised that talacha is a Spanish slang word that means 'to clean up'. The cleaning tasks are assigned through a rotating system based on rows of bunks, with half the row cleaning in the morning and the other half in the evening. When asked how he was informed of his obligation to clean, a detainee stated that he was told by other detainees and also stated through the CRCL interpreter, "I have to do what I am told to do because I am not from this country." Detainees should not be in control of their housing unit's cleaning schedule because it does not ensure adequate levels of sanitation. It also creates an environment in which some detainees may bully or exploit others, and especially in light of the reports that the officers deny access to the television or microwave as punishment for not cleaning. Detainees report that cleaning supplies are provided daily and mop buckets, mops; and manual carpet sweepers were observed in the housing units. However, the carpet sweepers are not particularly effective. I

attempted to use one to clean a small area and had to run over each small piece of debris multiple times in order to clean the floor. Two spray bottles for chemical cleaning fluids were also observed in the housing units at various times; however, in most cases the bottles were empty, which may indicate that either not enough cleaning solution was provided or that detainees are allowed to misuse it. The cleaning schedule, level of cleaning, and monitoring of the cleaning performed, should be conducted by the corrections officers assigned to each housing unit and regularly checked by their supervisors for adequacy. The facility maintenance manager should also ensure that the correct tools, equipment, and chemicals are being used, and the corrections officers should provide oversight and monitoring of the tools, equipment, and chemicals to ensure they are used appropriately and safely.

Although facility officials stated that no ICE detainees are used for work programs, in addition to cleaning the housing units, detainees also reported that they are utilized to move furniture and stock supplies. Although several of the detainees stated that the work is voluntary, it is not appropriate to utilize detainees to move furniture and perform work tasks other than maintaining their immediate living areas in a neat and orderly manner without complying with the criteria in the NDS Voluntary Work Program standard, which requires some level of compensation.

The medical unit was observed to be dirty and in a general state of disrepair. Although it is difficult to determine exactly how long the floor had been dirty, the accumulated dust, dirt, and debris along the walls and in the corners suggest that it has been building up over a period of at least several weeks if not considerably longer. This problem was previously brought to the attention of facility administrators when the ICE Office of Detention Oversight (ODO) Compliance Inspection Enforcement and Removal Operations' inspection report, dated April 10 –12, 2018, reported, "The medical observation unit had bubbling and peeling paint, as well as walls, toilets, and wash basins which were not clean, and concrete floors throughout were in poor repair. ODO noted the flooring had epoxy which was heavily deteriorated and multiple imperfections to include stains and build-up of dust and debris in the corners and sidewalls." My additional findings include a vinyl cover on a medical exam table that was cracked, exposing the foam cushion. Once the integrity of the vinyl cover is compromised, it can no longer be properly cleaned and disinfected. This is particularly concerning in a medical area because microorganisms and viruses, including MRSA can be spread from person to person via the exam table. A cabinet door was hanging off its hinges in the staff work area. The medical devices used to look into the ears and eyes (Otoscope and Ophthalmoscope) were dusty and grimy. The countertop in an exam room was cluttered, which provides harborage for vermin, and a dead roach was also found on the counter. Accumulations of food debris were found on the surface and hinges of various cell door food pass slots in the medical observation unit on August 14, 2018, and the doors were still dirty with the same buildups of food grime on August

16, 2018; the final day of the CRCL onsite. These unclean surfaces are capable of supporting the growth of pathogenic bacteria that can then be spread when food and items are passed through the opening or the detainee uses the opening to talk on the telephone, etc. The medical unit should be thoroughly renovated and then maintained in sanitary condition before it is used to treat detainees.

Conclusion: A high level of sanitation is immediately required in detainee living areas to ensure good health. Deficiencies in sanitation coupled with the compromised integrity of the walls and ceilings in the housing units pose serious health and safety hazards to detainees. Furthermore, deficiencies in the medical unit place detainees at increased risk of nosocomial infections.

Recommendations:

6. WTDF's administration should take all possible measures to limit the hazards posed by the collapsing, sagging roofs in housing units 1-B and 3-B, which allow rainwater to leak into the housing units and provide an entrance for mosquitoes and other insects. Due to the serious nature of the problem, the roofs of all four modular buildings should be inspected and sufficient interim repairs made before the scheduled November 2018 roof replacements. Furthermore, the perimeter walls of the buildings should be inspected and any holes or gaps should be sealed off to preclude the entrance of vermin. (Applicable standard: NDS, Environmental Health and Safety)

7. To safeguard good detainee health and hygiene, WTDF should ensure that the intake unit, including cell #289, which is used as the shower and laundry changing room for detainees arriving at the facility, is regularly inspected, cleaned, and disinfected. Furthermore, the rusty toilet paper holder should be refurbished or replaced. All areas that are accessed by detainees should be maintained in a manner that complies with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and states, "The standards include those from the American Correctional Association" and therefore includes, ACA Standard 4-ALDF-1A-04 stating "The facility is clean and in good repair." (Applicable standard: NDS, Environmental Health and Safety)

8. To ensure detainee safety and security, WTDF should regularly inspect all access panels, plate covers, and the metal panels covering the pipes and plumbing in the detainee bathrooms and ensure repairs are made when problems are found, use tamper resistant security screws, and account for any that are missing to facilitate the elimination of safety hazards, as required by the NDS Security Inspections standard. (Applicable standard: NDS, Security Inspections)

9. The detainee housing unit carpets are so heavily soiled they constitute a health hazard. The quarterly professional steam-cleaning plan is grossly inadequate. Therefore, the housing units' carpeting should be replaced with appropriate durable flooring as soon as possible and, in the meantime, the carpets should be professionally steam cleaned on a monthly basis until proper flooring is installed in all housing units. (Applicable standard: NDS, Environmental Health and Safety)

10. The microorganisms that cause MRSA, Tinea pedis (athlete's foot), and nail fungus thrive in warm, moist environments and are readily transmitted in communal showers. The bathroom floor in housing unit 4-B consists of bare plywood that cannot be properly cleaned and disinfected, and also poses a splinter hazard. Therefore, detainees should be removed from housing unit 4-B until proper flooring is installed. Furthermore, WTDF should ensure that all bathroom surfaces including the floors, walls, ceilings, and drains are routinely inspected, cleaned, and maintained in a sanitary manner. (Applicable standard: NDS, Environmental Health and Safety)

11. Rodents and their parasites are capable of spreading a variety of diseases including Salmonellosis and Lyme disease. Cockroaches also spread disease-causing microorganisms and can trigger asthma. The NDS Food Service standard specifies, "The premises shall be maintained in a condition that precludes the harboring or feeding of insects and rodents." To comply with this standard, detainees should not be allowed to stockpile food in the housing units. Additionally, all kitchen meal trays and disposable food containers should be removed from the housing units after every meal, as they contain food and residues that attract vermin. Additionally, the facility rule stating, "To avoid pest control issues, open food containers/packages shall not be allowed to be kept in the housing units and are subject to confiscation during shakedowns" should be enforced. (Applicable standard: NDS, Food Service)

12. Accumulations of food and personal property create harborage and breeding sites for insects and rodents, including cockroaches and mice. WTDF should immediately issue detainees appropriate, sealable property storage containers, such as plastic boxes with tight fitting lids and discontinue the practice of allowing detainees to store their personal property on their beds. Issuing boxes will also facilitate compliance with the NDS Funds and Personal Property standard stating, "Detainees may keep a reasonable amount of personal property in their possession, provided the property poses no threat to facility security." (Applicable standard: NDS, Funds and Personal Property)

13. To ensure the adequate levels of cleanliness necessary to support a hygienic living environment, WTDF should discontinue the practice of housing unit cleaning and oversight by detainees and instead implement a formal detainee voluntary work program that includes a cleaning schedule, assign the housing unit corrections officers to oversee and monitor the cleaning, and assign the housing unit supervisors to conduct regular checks for adequacy. The facility maintenance manager should also be assigned to ensure that the correct tools, equipment, and chemicals are being used, and the corrections officers should be assigned to provide oversight and monitoring of the tools, equipment, and chemicals to ensure they are used appropriately and safely. The voluntary work program should comply with all aspects of the NDS Voluntary Work Program standard. (Applicable standards: NDS, Environmental Health and Safety, Voluntary Work Program)

14. WTDF should either discontinue the practice of using detainees to perform physical labor, including moving furniture, or implement a formal voluntary work program that complies with the NDS Voluntary Work Program standard, including compensation whether monetary, extra food or meals, or additional privileges. (Applicable standard: NDS, Voluntary Work Program)

15. The medical unit should be renovated and then maintained in sanitary condition before it is used to treat detainees, to ensure compliance with the NDS Environmental Health and Safety standard stating, "The key to the prevention and control of nosocomial infections due to contaminated environmental surfaces is environmental cleanliness. Responsibility for ensuring the cleanliness of the medical facility lies with the Health Service Administrator (HSA) or with an individual designated by the HSA or other health care provider utilized. The HSA or designee will make a daily visual inspection of the medical facility noting the condition of floors, walls, windows, horizontal surfaces, and equipment." (Applicable standard: NDS, Environmental Health and Safety)

16. Trusties and detainees should not be utilized to clean the medical unit; rather it should be professionally and regularly cleaned and disinfected. WTDF and the contract medical provider should develop and implement a cleaning program in compliance with the NDS Environmental Health and Safety standard stating, "The medical facility HSA is responsible for implementing a program that will assist in maintaining a high level of environmental sanitation." The cleaning program should be designed to comply with the NDS Environmental Health and Safety standard stating, "Methods of cleaning; cleaning equipment; cleansers; disinfectants and detergents to be used; plus, the frequency of cleaning and inspections will be established using an acceptable health

agency standard as the model." (Applicable standard: NDS, Environmental Health and Safety)

17. The facility should inspect all medical exam tables to ensure that the vinyl covers are in good condition, intact, and without rips, cracks, or exposed inner foam that hinders proper cleaning and disinfection and could result in the transmission of disease causing microorganisms from person to person. In the event that the cover is found to be compromised, either the cover or the table should be replaced to ensure compliance with the NDS Environmental Health and Safety standard stating, "The key to the prevention and control of nosocomial infections due to contaminated environmental surfaces is environmental cleanliness" and "Proper housekeeping procedures include the cleaning of surfaces touched by detainees or staff with fresh solutions of appropriate disinfectant products, applied with clean cloths, mops, or wipes." (Applicable standard: NDS, Environmental Health and Safety)

Complaint No. 18-06-ICE-0156 – Drinking Water

Complaint No. 18-06-ICE-0156 alleged that the drinking water was contaminated with dirt and floating particles.

Finding: The exteriors of the Igloo style plastic beverage coolers used to dispense drinking water in the housing units were found to be extremely dirty, which can lead to contamination of the spout and/or the water contained therein. Therefore, the allegation that the drinking water contains dirt and floating particles is **substantiated**.

Applicable Standards: The NDS Environmental Health and Safety and Food Service standards are applicable.

Analysis:

Municipal water quality reports were reviewed and the facility complies with the NDS Environmental Health and Safety standard requiring that the facility water supply be certified by a state laboratory.

However, the handling and cleanliness of the Igloo style plastic beverage coolers used to dispense beverages and drinking water in the detainee housing units does not comply with the NDS Food Service standard stating, "Food and ice will be protected from dust, insects and rodents, unclean utensils and work surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, overhead leakage, and other sources of contamination. Protection will be continuous, whether the food is in storage, in preparation/on display, or in transit." The food service department at WTDF prepares and provides ice water and beverages with meals to the

detainee housing units in the beverage coolers. The coolers are delivered on carts to the housing units. However, during observation of meal service, an employee was observed taking the coolers off a cart, setting them on the open-air walkway outside of the housing unit building, opening the exterior door, and then picking the cooler up off the ground to carry it into the unit. Setting the coolers on the dirty ground is a violation of the NDS Food Service standard and the bottoms of several of the coolers were observed to be covered with sandy soil. Additionally, the food service director reports that the coolers are washed in the kitchen between uses. However, the exterior of numerous coolers were observed to be dirty and/or stained, and what appeared to be dried food splatter was observed on several of the coolers.

Conclusion: The municipal water supply is safe; however, the mishandling and inadequate cleaning of the Igloo style plastic beverage coolers places the detainee drinking water and beverages at risk of contamination. Furthermore, improper handling and the dirty, stained appearance of the coolers can lead to detainee distrust of the water and beverages provided to the detainee population.

Recommendations:

18. WTDF should evaluate and change the transport and handling procedures of the Igloo style plastic beverage coolers to ensure compliance with the NDS Food Service standard stating, "Food and ice will be protected from dust, insects and rodents, unclean utensils and work surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, overhead leakage, and other sources of contamination. Protection will be continuous, whether the food is in storage, in preparation/on display, or in transit" and "The sanitary standards applicable in the food service department apply during the entire satellite feeding process, from preparation to actual delivery." (Applicable standard: NDS, Food Service)

19. Dirty water containers in the housing units create a health hazard. WTDF should immediately implement policy and procedures requiring the water containers be regularly cleaned and sanitized in compliance with the NDS Food Service standard stating, "To prevent cross-contamination, kitchenware and food-contact surfaces should be washed, rinsed, and sanitized after each use and after any interruption of operations during which contamination could occur" and washing, rinsing, and sanitizing of the beverage coolers complies with the guidelines specified in either the manual cleaning and sanitizing or mechanical cleaning and sanitizing sections of the NDS Food Service standard. (Applicable standard: NDS, Food Service)

Complaint Nos. 18-04-ICE-0139, 18-07-ICE-0282, 18-06-ICE-0156, 18-07-ICE-0175, and 18-10-ICE-0471 – Food Service and Meals

Complaint Nos. 18-04-ICE-0139 and 18-07-ICE-0282 alleged that an insufficient quantity of poor quality food was being served to detainees. Additionally, Complaint No. 18-06-ICE-0156 alleged that the pork-free diet was inadequate and so repetitive that Muslim detainees were resorting to eating pork. Complaint No. 18-07-ICE-0175 alleged that religious and special diets were lacking sufficient quantities of nutritious foods and instead consisted of flour tortillas, beans, and boiled carrots, causing unhappy detainees to threaten a hunger strike, in protest of the food problems. Complaint No. 18-10-ICE-0471 alleged that detainees were being denied ice and the food was covered in flies.

Findings: The allegation that detainees are served insufficient quantities of poor quality food is **unsubstantiated**. The allegation that Muslim detainees were resorting to eating pork is **unfounded** because the facility does not serve pork. The allegation that flies were present on and around the food is **substantiated**. The detainees are provided ice water, they are not provided ice; however, the NDS does not require it.

Applicable Standards: The NDS Food Service, Religious Practices, and Environmental Health and Safety standards are applicable.

Analysis:

People expect to be provided with food that is wholesome, appetizing, and safe to eat. This expectation is often amplified in a detention setting, where the taste, appearance, and presentation of meals can affect the health and general mood of a facility. The WTDF food service department is operated by Aramark. The dietitian-certified menu plans including regular, lacto-ovo vegetarian, vegan, cardiac, diabetic, and modifications to accommodate food allergies comply with the NDS Food Service standard. Pork products are not served and therefore detainees requesting a no pork diet are provided with a regular diet or a medical diet, if prescribed. The facility reports that a kosher menu plan is offered to meet religious dietary requirements. Detainees requesting a religious diet must submit a request to the medical department. Although it is not recommended that medical staff members grant or authorize religious meal requests, WTDF reports that all kosher diet requests are automatically granted and that the process is in place to ensure that there are no medical contraindications which complies with the NDS Religious Practices standard stating, "Before approving a special diet, the Chaplain will consult with the medical department to ensure the diet is nutritious and does not pose a threat to the detainee's health." There were no detainees on a kosher diet during the CRCL onsite. A review of the kosher menu reveals that it is a five-week lacto-ovo vegetarian diet that lists some items as "kosher." The facility does not serve certified, packaged,

precooked kosher meals. The food service director states that kosher foods are prepared in designated pots utilizing designated utensils. However, I observed that, once prepared, kosher foods are placed in metal serving pans that have been washed and sanitized in the dishwasher but not reserved for kosher foods only. Therefore, even if properly prepared, once placed in the general use pans, the food is no longer kosher. It is extremely difficult to prepare kosher foods in a non-kosher kitchen and it is unethical to present non-kosher foods as kosher. Therefore, the NDS Food Service standard "requires all facilities to provide detainees requesting a religious diet reasonable and equitable opportunity to observe their religious dietary practice within the constraints of budget limitations and the security and orderly running of the facility through a common fare menu."

The kitchen was inspected on August 15, 2018. The kitchen floor was observed to be in poor condition, which was also documented in a January 22, 2018, Aramark Food Safety Audit report stating, "Floors throughout the kitchen were observed in poor repair, epoxy heavily deteriorated and multiple imperfections around the kettle present." The food service director reports that the kitchen floor was supposed to be resurfaced; however, the project was delayed. The condition of the kitchen floor is vital to good sanitation and is not simply cosmetic. Floors must be designed, constructed, and installed so they are smooth and easily cleanable yet the peeling, deteriorated condition of the epoxy flooring is neither smooth nor easily cleanable. The exteriors of the large plastic containers holding bulk supplies of dry goods, including rice, sugar and flour, were soiled with heavy accumulations of food debris and appeared as though they had not been cleaned for an extended period of time. An infestation of ants was found on the floor under the storage racks in the dry storage room, along with food debris, and leaking syrup was running down the wall. Numerous flies were observed throughout the kitchen including in the pantry, dishwashing room, and they were landing on food, equipment, and kitchen supplies, while the workers were preparing the food and trays for the dinner meal. Flies are a health hazard because they land on dirty surfaces such as garbage or sewage and then transfer disease-causing microorganisms to food and clean surfaces via their body. In addition to leaving their excrement, flies initially vomit digestive enzymes on their food source before consuming it, and the vomit itself may be contaminated with germs. Numerous flies were also observed in the detainee housing units. The exterior doors open directly into the housing units and therefore it is impractical to prevent the entry of all flies. However, pest control measures including keeping trashcans covered, not propping the exterior doors open, and repairing holes that allow their entry should appreciably reduce their numbers.

While some detainees stated that they do not like the food served at WTDF, others reported that it is okay. None of the interviewed detainees reported that the food was inedible or that they had considered a hunger strike or protest related to the meals. Detainees stated that the food portions are small and during the male group interviews, several detainees

alleged that they had lost alarming amounts of weight while at the facility. However, the CRCL medical expert reports that their allegations of weight loss were either unfounded or not medically significant.

During my inspections in one of the housing units, a detainee showed me a tray as an example of a typical breakfast meal. The oatmeal looked more like gravy than hot cereal and the solitary one-ounce breakfast sausage patty appeared very small, shriveled, and dry. However, these unappetizing characteristics of the food are related to the preparation techniques rather than the quality of the food itself. Inspections of the cooler, freezer, and pantry reveal that the ingredients comply with the NDS Food Service standard that requires foods are fit for consumption. However, preparation and cooking methods can result in foods, such as the watery oatmeal, that do not comply with the NDS Food Service standard that requires that foods be appropriately presented.

Service of the lunch meals was observed on August 14 and 15, 2018. WTDF utilizes the satellite feeding method. Meals are served on trays in the kitchen, placed in meal delivery carts, transported to the housing units, and rolled into the vestibule of each housing unit at which time the detainees are offered a tray. While some detainees sat at the dining room tables to consume their meal, the majority sat on the beds or the floor, even though there were empty seats at some of the dining tables. However, in the densely populated housing units, there are not enough dining tables to afford every detainee a seat in one meal sitting, as would also be the case if the housing units were at maximum capacity. Several detainees were observed kneeling on the already discussed filthy housing unit floors while placing their tray on their bunk to eat. Pairs of detainees were observed sitting and eating on one bed. It is unsanitary to eat on the dirty floor or on a bed, and consuming meals in the sleeping area of a housing unit versus the dayroom is unhygienic because dropped food crumbs and spills create dirty conditions that also attract insects and rodents.

Conclusion: Although the allegation that insufficient quantities of repetitive, poor quality food is driving detainees to the point of hunger strikes is **not substantiated**, improvements in the food service program are needed to ensure compliance with the NDS Food Service standard stating, "The overall goal of a quality food service program is to provide nutritious and appetizing meals, efficiently and within the budgetary restrictions, manpower resources, equipment, and physical layout."

Recommendations:

20. The WTDF kitchen does not comply with the stringent requirements of kosher dietary laws. Therefore, it is not only a misrepresentation; it is unethical to present foods that are prepared in the WTDF kitchen as kosher. WTDF should immediately suspend the

preparation of the kosher diet and implement a common fare diet that complies with the NDS Food Service standard stating, "Common fare is intended to accommodate detainees whose religious dietary needs cannot be met on the main line. The common-fare menu is based on a 14-day cycle, with special menus for the 10 Federal holidays. The menus must be certified as exceeding minimum daily nutritional requirements" and, "To the extent practicable, a hot entree shall be available to accommodate detainees' religious dietary needs, e.g., kosher and/or halal products. Hot entrees shall be offered three times a week and shall be purchased precooked, heated in their sealed containers, and served hot. Other cooking is not permitted in the common-fare program." Implementation of a common fare program will also facilitate compliance with the NDS Religious Practices standard stating, "The food service department will implement procedures for accommodating, within reason, detainees' religious dietary requirements." (Applicable standards: NDS, Food Service and Religious Practices)

21. In order to maintain cleanliness, the kitchen floors must be maintained in good repair. WTDF should ensure that the kitchen floor is resurfaced or renovated as soon as feasible to comply with the NDS Environmental Health and Safety standard stating "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and further specifies, "The standards include those from the American Correctional Association." ACA Housekeeping standard 4-ALDF-1A-04 stipulates, "The facility is clean and in good repair." (Applicable standard: NDS, Environmental Health and Safety)

22. WTDF should ensure that the kitchen, including the dry goods storage room, is maintained in a clean and sanitary manner at all times to ensure compliance with the NDS Food Service standard stating, "Good sanitation practices are essential to an effective pest control program. The FSA is responsible for pest control in the food service department" and ensure "Vigilant housekeeping, to keep the room clean and free from rodents and vermin." (Applicable standard: NDS, Food Service)

23. Flies can contaminate surfaces with microorganisms that cause food borne illnesses and diarrhea. WTDF should ensure air curtain units or similar devices are operable and install new units where they are lacking in the kitchen and detainee housing units to comply with the NDS Food Service standard stating, "Air curtains or comparable devices shall be used on outside doors where food is prepared, stored, or served to protect against insects and other rodents." (Applicable standard: NDS, Food Service)

24. WTDF should perform routine inspections to identify and take immediate corrective action when inferior conditions are found that provide pest entry points or harborage, including keeping trashcans covered, not propping the exterior doors open, and repairing holes that allow their entry. (Applicable standards: NDS, Environmental Health and Safety, Food Service)

25. The taste, appearance, and presentation of meals can affect the health and general mood of the facility. Therefore, WTDF should ensure that the food service contractor operates a quality food service program, including preparing and serving foods in compliance with the NDS Food Service standard stating, "Food is appropriately presented." (Applicable standard: NDS, Food Service)

26. The NDS Food Service standard recognizes that "The food service program significantly influences morale and attitudes of detainees and staff, and creates a climate for good public relations between the facility and the community." Therefore, WTDF should hold the food service contractor accountable for full compliance with the NDS Food Service standard including the requirement that "The food service program shall be under the direct supervision of a professional food service administrator. The FSA is responsible for planning, controlling, directing, and evaluating food service; training and developing the cook foremen; managing budget resources; establishing standards of sanitation, safety, and security; developing nutritionally adequate menus and evaluating detainee acceptance; developing specifications for the procurement of food, equipment, and supplies; and establishing a training program which ensures operational efficiency and a quality food service program." (Applicable standard: NDS, Food Service)

27. Sitting on a dirty floor or a bed while consuming meals is unsanitary, therefore, WTDF should ensure that all detainees are accommodated with seating at a dining table to consume their meals in accordance with the NDS Food Service standard stating, "Meals will be served in as unregimented a manner as possible. To this end, the Food Service Administrator's (FSA) table arrangement must facilitate free seating, ease of movement, and ready supervision. The dining room will have the capacity to accommodate all detainees in no more than three sittings." (Applicable standard: NDS, Food Service)

Complaint Nos. 18-06-ICE-0156 and 04-ICE-0322 – Personal Hygiene

Complaint No. 18-06-ICE-0156 alleged that detainees were being denied toothbrushes, toothpaste, and hot water. Complaint No. 18-04-ICE-0322 alleged that toilets and showers were broken thereby limiting the amount of water available for personal hygiene needs.

Findings: The allegation that detainees are denied personal hygiene supplies is **unsubstantiated**. The allegation that detainees are denied access to hot water or that broken toilets and showers limit access to water for personal hygiene needs is **unsubstantiated**.

Applicable Standards: The NDS Issuance and Exchange of Clothing, Bedding, and Towels; Environmental Health and Safety; and Admission and Release standards are applicable.

Analysis:

The importance of hygiene is recognized in the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Basic hygiene is essential to the well-being of detainees." WTDF complies with the NDS Admission and Release standard requiring that detainees be provided with appropriate personal hygiene supplies respective to males and females and supplies are replenished as needed. During the intake process, all detainees are given a personal hygiene pack that contains a toothbrush, toothpaste, bar soap, shampoo, and skin lotion. During the onsite group and individual detainee interviews, both male and female detainees affirmed that WTDF replenishes personal hygiene supplies when needed. Furthermore, when inspecting the housing units I observed that ample inventories of personal hygiene supplies were stored in the housing units for distribution and that detainees possessed sufficient quantities of hygiene items in their personal property.

The NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" applies and therefore, ACA Plumbing Fixtures standards 4-ALDF-4B-08 stating, "Inmates have access to toilets and washbasins with temperature controlled hot and cold running water 24 hours per day and are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas" and 4-ALDF-4B-09, stating "Inmates have access to operable showers with temperature controlled hot and cold running water...Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices" are applicable. During inspections of the WTDF housing units, all tested plumbing fixtures were found to be operable and when specifically asked, detainees reported that all of the plumbing fixtures in their housing units were operable. Random water temperatures were measured in the sinks and showers and all were found to be within the ACA standard except for the lavatories in housing unit 4-A on August 14, 2018, where temperature readings ranged from 159 degrees to 161 degrees Fahrenheit, which is scalding. Scalding hot water is dangerous, as most adults will suffer third degree burns with a two-second exposure to 150 degree Fahrenheit water[2]. I reported the

[2] https://www.cpsc.gov/PageFiles/121522/5098.pdf

extremely hot water temperatures to a WTDF supervisor. Upon my return to housing unit 4-A on August 16, 2018, the lavatory hot water temperature was at 115 degrees Fahrenheit, which is within the ACA standard. It is likely that detainees did not report the extremely hot water because the sinks have separate handles to control the hot and cold water. However, while testing the water temperatures, a detainee approached without solicitation and stated that the hot water temperature was "better" after I was there on Tuesday. The WTDF Monthly Climate Readings forms indicate that the water temperatures are checked and recorded on a monthly basis, and a review of the forms for January 2018 through July 2018 indicates that the readings ranged between 102 degrees and 106 degrees Fahrenheit.

Conclusion: WTDF provides detainees access to personal hygiene supplies. As discussed previously in this report, the facility has inadequate numbers of toilets, washbasins, and showers to accommodate the reported maximum populations in all of the housing units except for toilets and washbasins in housing units 1-B and 2-B. Should WTDF restrict access to the bathroom areas, the ability to access water for personal hygiene could become a serious problem.

Recommendations:

28. WTDF should continue to monitor the water temperatures, and take immediate corrective action in the event that the washbasin or shower water temperature exceeds 120 degrees Fahrenheit, in order to prevent scalds and burns in compliance with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association," specifically, ACA 4-ALDF-4B-09, stating "Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices." (Applicable standard: NDS, Environmental Health and Safety)

Complaint Nos. 18-06-ICE-0156, 18-04-ICE-0312, and 18-05-ICE-0318 – Clothing and Laundry

Complaint No. 18-06-ICE-0156 alleged that detainees were being provided only one set of clothing per week, including underwear. Complaint Nos. 18-04-ICE-0312 and 18-05-ICE-0318 alleged that detainees were not provided with a change of clean clothing during the week. The ACLU also alleged that the underwear given to female detainees is visibly dirty and extremely stained.

Findings: The allegation that detainees are not provided an opportunity to launder or exchange their clothing is **unsubstantiated**. The allegation that some detainees are only issued one set of

undergarments, rather than the facility standard of two sets is **substantiated**. The allegation that female detainees are issued dirty, stained underwear is **unsubstantiated**.

Applicable Standard: The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard is applicable.

Analysis:

Clean laundry is vital to ensure good detainee health. Per the NDS Exchange of Clothing, Bedding, and Towels standard regarding exchange requirements, "Detainees shall be provided with clean clothing, linen, and towels on a regular basis to ensure proper hygiene. Socks and undergarments will be exchanged daily, outer garments at least twice weekly and sheets, towels, and pillowcases at least weekly." The laundry supply room was inspected and the inventory of linen and apparel was found to be in satisfactory condition. The inventory of women's underwear was specifically checked and no instances of filthy, stained undergarments were found. WTDF utilizes a laundry system by which detainees place their undergarments in a mesh laundry bag along with their loose uniform, t-shirt, and towel, which all goes into a plastic laundry basket in their housing unit. The laundry baskets are taken to the facility laundry and the laundered items are returned later the same day or the following morning, Monday through Friday. Sheets are exchanged on Tuesdays and blankets are exchanged on the second Tuesday of each month. Detainees confirmed that their sheets were exchanged on Tuesday, August 14, 2018. Several male detainees reported that the laundry does not pick up the baskets in housing unit 2-B; however, their experience seems to be the exception rather than the norm because the majority of detainees report that they do not encounter problems with the laundry service. Several detainees also report that they prefer to wash their clothing themselves with soap or shampoo in the sinks or showers and clothing items were observed soaking in a sink in housing unit 4-B. Self-laundering lacks the necessary hot water temperatures, proper detergent, and bleach provided by the commercial laundering process, and therefore, may not result in complete pathogen destruction during the washing process. Furthermore, it is difficult to rinse out the body soap or shampoo used for washing, leading to potential skin irritation issues.

Detainees confirmed that they are issued two sets of uniform pants and shirts. However, several detainees stated that they were only issued one t-shirt, boxer shorts, and a pair of socks, instead of the facility standard issue of two each. The laundry exchange process at WTDF leaves detainees with only one of their two issued sets of clothing while their uniform and undergarments are sent to the in-house laundry facility, which is potentially problematic after outdoor recreation because they do not have clean clothing to wear after showering. Therefore, detainees requested that WTDF issue athletic shorts that can be worn with their facility issued t-shirts for outdoor recreation.

Conclusion: The exchange process for soiled laundry complies with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard. However, in order for the laundry program to operate as designed, detainees must be issued the facility standard minimum quantity of undergarments. The practice of allowing detainees to wash laundry in sinks and showers and hang dry it in the housing units is placing detainees at risk of infections.

Recommendations:

29. Clean laundry is important for the maintenance of personal hygiene and good health. WTDF should monitor the laundry program to ensure that adequate supplies of laundry are issued and soiled laundry is exchanged, in accordance with the NDS Exchange of Clothing, Bedding, and Towels standard regarding exchange requirements, "Detainees shall be provided with clean clothing, linen, and towels on a regular basis to ensure proper hygiene. Socks and undergarments will be exchanged daily, outer garments at least twice weekly, and sheets, towels, and pillowcases at least weekly." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels, Level 1)

30. WTDF should discontinue the insanitary practice of allowing detainees to wash clothing in the lavatories and showers. Ending this practice will comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Detainees are not permitted to wash clothing, bedding, linens, tennis shoes or other items in the living unit, unless proper washing and drying equipment are available and the policy and procedures for their use are in place." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

31. WTDF should continue to inform and educate detainees on the policy and procedures for the laundry basket and laundry bag system, to ensure compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "facilities shall provide INS detainees with regular exchanges of clothing, linens, and towels for as long as they remain in detention" and "Each detention facility shall have a policy and procedure for the regular issuance and exchange of clothing, bedding, linens and towels." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

32. As a best practices recommendation, WTDF should consider issuing athletic shorts to detainees for outdoor recreation. The facility is located in the desert and the outdoor recreation yards are primarily in the sun and are very dusty. Detainees report that the current uniform exchange system requires them to send one of their two issued uniforms to the laundry, leaving them with only one uniform, and therefore they do not

have clean clothing to wear after showering. Issuing athletic shorts also facilitates compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "More frequent exchanges of outer garments may be appropriate, especially in hot and humid climates" and "Additional clothing will be issued as necessary for changing weather conditions or as seasonally appropriate." (Applicable standard: NDS Issuance and Exchange of Clothing, Bedding, and Towels) (Best Practices)

Other Observations and Complaints:

Upper Bunk Safety

The majority of beds at WTDF are double bunkbeds. In the male housing unit 1-B, only 6 of the approximate 64 bunkbeds had ladders and in the female housing unit 3-A only 7 of the approximate 51 bunkbeds had ladders. The average distance from the floor to the top bunk is 52" and they measure 38" from the bottom bunk to the top bunk. The majority of bunkbeds lack ladders for detainees to access the top bunks, making it extremely difficult for detainees, especially female detainees, to access their bed without scraping and bruising injuries to their knees and stomachs. Moreover, the lack of ladders to the top bunks increases the risk of falling.

Applicable Standard: The NDS Security Inspections standard is applicable.

Recommendation:

33. All bunkbed units should either be retrofitted with ladders or replaced with bunkbed units that have ladders. This should start with the female housing units and moving to the male housing units as soon as possible to facilitate the elimination of safety hazards as required by the NDS Security Inspections standard. (Applicable standard: NDS, Security Inspections)

Mattresses

Numerous mattress with cracked covers and open seams were observed. Once the integrity of the mattress cover is compromised, exposing the inner filling, it can no longer be properly cleaned and disinfected. Mattresses in this condition can transfer disease-causing pathogens from person to person.

Applicable Standard: The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard is applicable.

Recommendation:

34. Damaged mattresses are placing detainees at risk of infection, as they can no longer be properly cleaned and disinfected. WTDF should inspect all mattresses and replace those that have cracked or torn covers to facilitate compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "All new detainees shall be issued clean bedding." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

Summary of NDS Recommendations

1. The overcrowded conditions at WTDF place detainees at increased risk of illness. The number of detainees housed in each unit should be immediately assessed and evaluated based on accepted industry standards for square feet per occupant and ratios of toilets, washbasins, and showers per occupant. The detainee housing units occupancy rates should be adjusted to comply with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" applies and therefore, ACA Standards Multiple Occupancy Rooms/Cells 4-ALDF-1A-10, Cell/Room Furnishings 4-ALDF-1A-11, Dayrooms 4-ALDF-1A-12, and Plumbing Fixtures 4-ALDF-4B-08 and 4-ALDF-4B-09 are applicable. (Applicable standard: NDS, Environmental Health and Safety)

2. All bunks placed in dayroom areas should be immediately removed. It is not hygienic to place beds only 16" from the benches of the dining tables and 24" from the end of a dining table. Furthermore, all bunks should meet the requirement that sleeping surfaces be a minimum of 12" off the floor, unless authorized as medically necessary by a licensed medical provider. (Applicable standard: NDS, Environmental Health and Safety)

3. Adequate access to toilets, washbasins, and showers is essential to maintain health and hygiene. However, detainees may experience limited shower access secondary to the high ratio of detainees to showers, especially at full capacity. Therefore, until such time that the housing unit capacities are adjusted to accepted industry standards for square feet per occupant and ratios of toilets, washbasins, and showers per occupant, WTDF should actively monitor the access and use of the bathroom facilities to ensure that detainees have access to toilets, washbasins, and showers and that the number of detainees housed in the unit does not impede access to toileting, hand washing, and the ability to showers at reasonable times in compliance with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association," specifically ACA Plumbing Fixtures standards 4-ALDF-4B-08 and 4-ALDF-4B-09. (Applicable standard: NDS, Environmental Health and Safety)

4. The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Additional clothing will be issued as necessary for changing weather conditions or as seasonally appropriate" is often interpreted to imply that sweaters are needed and issued only during the traditional winter months. However, as individual comfort levels vary, some people find air conditioning temperatures to be uncomfortably cool and therefore need a sweater to maintain personal comfort during the summer months. WTDF allows detainees to purchase sweaters from the commissary thereby acknowledging that sweaters may be needed year

round. Therefore, to comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "All new detainees shall be issued clean, temperature-appropriate, presentable clothing during in-processing," WTDF should issue sweaters, upon request. (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

6. WTDF administration should take all possible measures to limit the hazards posed by the collapsing, sagging roofs in housing units 1-B and 3-B, which allow rainwater to leak into the housing units and provide an entrance for mosquitoes and other insects. Due to the serious nature of the problem, the roofs of all four modular buildings should be inspected and interim repairs made before the scheduled November 2018 roof replacements. Furthermore, the perimeter walls of the buildings should be inspected and any holes or gaps should be sealed off to preclude the entrance of vermin. (Applicable standard: NDS, Environmental Health and Safety)

7. To safeguard good detainee health and hygiene, WTDF should ensure that the intake unit, including cell #289 that is used as the shower and laundry changing room for detainees upon arrival to the facility is regularly inspected, cleaned, and disinfected. Furthermore, the rusty toilet paper holder should be refurbished or replaced. All areas that are accessed by detainees should be maintained in a manner that complies with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and states, "The standards include those from the American Correctional Association" and therefore includes, ACA Standard 4-ALDF-1A-04 stating "The facility is clean and in good repair." (Applicable standard: NDS, Environmental Health and Safety)

8. To ensure detainee safety and security, WTDF should regularly inspect all access panels, plate covers, and the metal panels covering the pipes and plumbing in the detainee bathrooms and ensure repairs are made when problems are found, tamper resistant security screws are used, and any that are missing are accounted for to facilitate the elimination of safety hazards as required by the NDS Security Inspections standard. (Applicable standard: NDS, Security Inspections)

9. The detainee housing unit carpets are so heavily soiled they constitute a health hazard. The quarterly professional steam-cleaning plan is grossly inadequate. Therefore, the housing units' carpeting should be replaced with appropriate durable flooring as soon as possible and, in the meantime, the carpets should be professionally steam cleaned on a monthly basis until proper flooring is installed in all housing units. (Applicable standard: NDS, Environmental Health and Safety)

10. The microorganisms that cause MRSA, Tinea pedis (athlete's foot), and nail fungus thrive in warm, moist environments and are readily transmitted in communal showers. The bathroom floor in housing unit 4-B consists of bare plywood that cannot be properly cleaned and disinfected and also poses a splinter hazard. Therefore, detainees should be removed from housing unit 4-B until proper flooring is installed. Furthermore, WTDF should ensure that all bathroom surfaces including the floors, walls, ceilings, and drains are routinely inspected, cleaned, and maintained in a sanitary manner. (Applicable standard: NDS, Environmental Health and Safety)

11. Rodents and their parasites are capable of spreading a variety of diseases including Salmonellosis and Lyme disease. Cockroaches also spread disease-causing microorganisms and can trigger asthma. The NDS Food Service standard specifies, "The premises shall be maintained in a condition that precludes the harboring or feeding of insects and rodents." To comply with this standard, detainees should not be allowed to stockpile food in the housing units. Additionally, all kitchen meal trays and disposable food containers should be removed from the housing units after every meal, as they contain food and residues that attract vermin. Additionally, the facility rule stating, "To avoid pest control issues, open food containers/packages shall not be allowed to be kept in the housing units and are subject to confiscation during shakedowns" should be enforced. (Applicable standard: NDS, Food Service)

12. Accumulations of food and personal property create harborage and breeding sites for insects and rodents, including cockroaches and mice. WTDF should immediately issue detainees appropriate, sealable property storage containers, such as plastic boxes with tight fitting lids and discontinue the practice of allowing detainees to store their personal property on their beds. Issuing boxes will also facilitate compliance with the NDS Funds and Personal Property standard stating, "Detainees may keep a reasonable amount of personal property in their possession, provided the property poses no threat to facility security." (Applicable standard: NDS, Funds and Personal Property)

13. To ensure the adequate levels of cleanliness necessary to support a hygienic living environment, WTDF should discontinue the practice of detainees overseeing and administering the cleaning of the housing units and implement a formal detainee voluntary work program that includes a cleaning schedule, assign the housing unit corrections officers to oversee and monitor the cleaning, and assign the housing unit supervisors to conduct regular checks for adequacy. The facility maintenance manager should also be assigned to ensure that the correct tools, equipment, and chemicals are being used, and the corrections officers should be assigned to provide oversight and monitoring of the tools, equipment, and chemicals to ensure they are used appropriately and safely. The voluntary work program should comply with all aspects of

the NDS Voluntary Work Program standard. (Applicable standards: NDS, Environmental Health and Safety, Voluntary Work Program)

14. WTDF should either discontinue the practice of using detainees to perform physical labor including moving furniture or implement a formal voluntary work program that complies with the NDS Voluntary Work Program standard, including compensation whether monetary, extra food or meals, or additional privileges. (Applicable standard: NDS, Voluntary Work Program)

15. The medical unit should be renovated and then maintained in sanitary condition before it is used to treat detainees to ensure compliance with the NDS Environmental Health and Safety standard stating, "The key to the prevention and control of nosocomial infections due to contaminated environmental surfaces is environmental cleanliness. Responsibility for ensuring the cleanliness of the medical facility lies with the Health Service Administrator (HSA) or with an individual designated by the HSA or other health care provider utilized. The HSA or designee will make a daily visual inspection of the medical facility noting the condition of floors, walls, windows, horizontal surfaces, and equipment." (Applicable standard: NDS, Environmental Health and Safety)

16. Trusties and detainees should not be utilized to clean the medical unit; rather it should be professionally and regularly cleaned and disinfected. WTDF and the contract medical provider should develop and implement a cleaning program in compliance with the NDS Environmental Health and Safety standard stating, "The medical facility HSA is responsible for implementing a program that will assist in maintaining a high level of environmental sanitation." The cleaning program should be designed to comply with the NDS Environmental Health and Safety standard stating, "Methods of cleaning; cleaning equipment; cleansers; disinfectants and detergents to be used; plus, the frequency of cleaning and inspections will be established using an acceptable health agency standard as the model." (Applicable standard: NDS, Environmental Health and Safety)

17. The facility should inspect all medical exam tables to ensure that the vinyl covers are in good condition, intact, and without rips, cracks, or exposed inner foam that hinders proper cleaning and disinfection and could result in the transmission of disease causing microorganisms from person to person. In the event that the cover is found to be compromised either the cover or the table should be replaced to ensure compliance with the NDS Environmental Health and Safety standard stating, "The key to the prevention and control of nosocomial infections due to contaminated environmental surfaces is environmental cleanliness" and "Proper housekeeping procedures include the cleaning of surfaces touched by detainees or staff with fresh solutions of appropriate disinfectant products, applied with clean cloths, mops, or wipes." (Applicable standard: NDS, Environmental Health and Safety)

18. WTDF should evaluate and change the transport and handling procedures of the Igloo style plastic beverage coolers to ensure compliance with the NDS Food Service standard stating, "Food and ice will be protected from dust, insects and rodents, unclean utensils and work surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, overhead leakage, and other sources of contamination. Protection will be continuous, whether the food is in storage, in preparation/on display, or in transit" and "The sanitary standards applicable in the food service department apply during the entire satellite feeding process, from preparation to actual delivery." (Applicable standard: NDS, Food Service)

19. Dirty water containers in the housing units create a health hazard. WTDF should immediately implement policy and procedures requiring the water containers be regularly cleaned and sanitized in compliance with the NDS Food Service standard stating, "To prevent cross-contamination, kitchenware and food-contact surfaces should be washed, rinsed, and sanitized after each use and after any interruption of operations during which contamination could occur" and washing, rinsing, and sanitizing of the beverage coolers complies with the guidelines specified in either the manual cleaning and sanitizing or mechanical cleaning and sanitizing sections of the NDS Food Service standard. (Applicable standard: NDS, Food Service)

20. The WTDF kitchen does not comply with the stringent requirements of kosher dietary laws. Therefore, it is not only a misrepresentation; it is unethical to present foods that are prepared in the kitchen as kosher. WTDF should immediately suspend the preparation of the kosher diet and implement a common fare diet that complies with the NDS Food Service standard stating, "Common fare is intended to accommodate detainees whose religious dietary needs cannot be met on the main line. The common-fare menu is based on a 14-day cycle, with special menus for the 10 Federal holidays. The menus must be certified as exceeding minimum daily nutritional requirements" and "To the extent practicable, a hot entree shall be available to accommodate detainees' religious dietary needs, e.g., kosher and/or halal products. Hot entrees shall be offered three times a week and shall be purchased precooked, heated in their sealed containers, and served hot. Other cooking is not permitted in the common–fare program." Implementation of a common fare program will also facilitate compliance with the NDS Religious Practices standard stating, "The food service department will implement procedures for accommodating, within reason, detainees' religious dietary requirements." (Applicable standards: NDS, Food Service and Religious Practices)

21. In order to maintain cleanliness, kitchen floors must be maintained in good repair. WTDF should ensure that the kitchen floor is resurfaced or renovated as soon as feasible to comply with the NDS Environmental Health and Safety standard stating "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and further specifies, "The standards include those from the American Correctional Association."

ACA Housekeeping standard 4-ALDF-1A-04 stipulates, "The facility is clean and in good repair." (Applicable standard: NDS, Environmental Health and Safety)

22. WTDF should ensure that the kitchen including the dry goods storage room is maintained in a clean and sanitary manner at all times to ensure compliance with the NDS Food Service standard stating, "Good sanitation practices are essential to an effective pest control program. The FSA is responsible for pest control in the food service department" and ensure "Vigilant housekeeping, to keep the room clean and free from rodents and vermin." (Applicable standard: NDS, Food Service)

23. Flies can contaminate surfaces with microorganisms that cause food borne illnesses and diarrhea. WTDF should ensure air curtain units or similar devices are operable and install new units where they are lacking in the kitchen and detainee housing units to comply with the NDS Food Service standard stating, "Air curtains or comparable devices shall be used on outside doors where food is prepared, stored, or served to protect against insects and other rodents." (Applicable standard: NDS, Food Service)

24. WTDF should perform routine inspections to identify and take immediate corrective action when conditions are found that provide pest entry points or harborage including keeping trashcans covered, not propping the exterior doors open, and repairing holes that allow their entry. (Applicable standards: NDS, Environmental Health and Safety, Food Service)

25. The taste, appearance, and presentation of meals can affect the health and general mood of the facility. Therefore, WTDF should ensure that the food service contractor operates a quality food service program, including preparing and serving foods in compliance with the NDS Food Service standard stating, "Food is appropriately presented." (Applicable standard: NDS, Food Service)

26. The NDS Food Service standard recognizes that "The food service program significantly influences morale and attitudes of detainees and staff, and creates a climate for good public relations between the facility and the community." Therefore, WTDF should hold the food service contractor accountable for full compliance with the NDS Food Service standard including the requirement that "The food service program shall be under the direct supervision of a professional food service administrator. The FSA is responsible for planning, controlling, directing, and evaluating food service; training and developing the cook foremen; managing budget resources; establishing standards of sanitation, safety, and security; developing nutritionally adequate menus and evaluating detainee acceptance; developing specifications for the procurement of food, equipment, and supplies; and establishing a training program which ensures operational efficiency and a quality food service program." (Applicable standard: NDS, Food Service)

27. Sitting on a dirty floor or a bed while consuming meals is unsanitary, therefore, WTDF should ensure that all detainees are accommodated with seating at a dining table to consume their meals in accordance with the NDS Food Service standard stating, "Meals will be served in as unregimented a manner as possible. To this end, the Food Service Administrator's (FSA) table arrangement must facilitate free seating, ease of movement, and ready supervision. The dining room will have the capacity to accommodate all detainees in no more than three sittings." (Applicable standard: NDS, Food Service)

28. WTDF should continue to monitor and take immediate corrective action in the event that the washbasin or shower water temperature exceeds 120 degrees Fahrenheit to prevent scalds and burns in compliance with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association," specifically, ACA 4-ALDF-4B-09, stating "Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices." (Applicable standard: NDS, Environmental Health and Safety)

29. Clean laundry is important for the maintenance of personal hygiene and good health. WTDF should monitor the laundry program to ensure that adequate supplies of laundry are issued and soiled laundry is exchanged in accordance with the NDS Exchange of Clothing, Bedding, and Towels standard regarding exchange requirements, "Detainees shall be provided with clean clothing, linen, and towels on a regular basis to ensure proper hygiene. Socks and undergarments will be exchanged daily, outer garments at least twice weekly and sheets, towels, and pillowcases at least weekly." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

30. WTDF should discontinue the insanitary practice of allowing detainees to wash clothing in the lavatories and showers. Ending this practice will comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Detainees are not permitted to wash clothing, bedding, linens, tennis shoes or other items in the living unit, unless proper washing and drying equipment are available and the policy and procedures for their use are in place." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

31. WTDF should continue to inform and educate detainees on the policy and procedures for the laundry basket and laundry bag system, to ensure compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "facilities shall provide INS detainees with regular exchanges of clothing, linens, and towels for as long as they remain in detention" and "Each detention facility shall have a policy and procedure for the regular

issuance and exchange of clothing, bedding, linens and towels." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

33. All bunkbed units should either be retrofitted with ladders or replaced with bunkbed units that have ladders. This should start with the female housing units and moving to the male housing units as soon as possible to facilitate the elimination of safety hazards as required by the NDS Security Inspections standard. (Applicable standard: NDS, Security Inspections)

34. Damaged mattresses are placing detainees at risk of infection, as they can no longer be properly cleaned and disinfected. WTDF should inspect all mattresses and replace those that have cracked or torn covers to facilitate compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "All new detainees shall be issued clean bedding." (Applicable standard: NDS, Issuance and Exchange of Clothing, Bedding, and Towels)

APPENDIX A

Summary of Best Practice Recommendations

5. The NDS Detainee Classification System standard requires that detainees be physically separated from detainees in other categories. Although WTDF achieves sight separation by placing black plastic over the windows, the black plastic is tattered and looks unprofessional. Therefore as a best practices recommendation WTDF should install permanent window coverings such as tint or glazing that obscures the view while allowing natural light to filter in, rather than covering them with sheets of black plastic. (Applicable standard: NDS, Detainee Classification System) (Best Practices)

32. As a best practices recommendation, WTDF should consider issuing athletic shorts to detainees for outdoor recreation. The facility is located in the desert and the outdoor recreation yards are primarily in the sun. Detainees report that the current uniform exchange system requires them to send one of their two issued uniforms to the laundry, leaving them with only one uniform, and therefore they do not have clean clothing to wear after showering. Issuing athletic shorts also facilitates compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "More frequent exchanges of outer garments may be appropriate, especially in hot and humid climates" and "Additional clothing will be issued as necessary for changing weather conditions or as seasonally appropriate." (Applicable standard: NDS Issuance and Exchange of Clothing, Bedding, and Towels) (Best Practices)

On-site Investigation Report

West Texas Detention Facility

August 14-16, 2018

(b) (6)

MD, FACP

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Introduction

This report responds to a request by the Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) to review and comment on the medical care provided to detainees at the West Texas Detention Facility (WTDF) in Sierra Blanca, Texas. My opinions are based on the materials provided and reviewed in advance and during an on-site investigation of the facility on August 14-16, 2018. My opinions are expressed to a reasonable degree of medical certainty. WTDF personnel were most pleasant and cooperative during my investigation.

Expert Qualifications

(b) (6)

Methods of Review

In advance of the on-site investigation, I reviewed documents provided by CRCL. During the on-site investigation, I toured the facility including housing units, pill lines, and the medical clinic, reviewed documents and medical records, and interviewed staff and detainees. I did focused reviews of medical records for those detainees who had chronic medical conditions such as asthma or high blood pressure. Clinical performance was measured by a focused review of medical records using a standardized methodology. (The full methodology for the review is described in the document entitled Assessment of Quality of Medical Care in Detention Facilities, and its accompanying Reviewer Pocket Guide.) The measures are based on nationally accepted clinical guidelines, or consensus guidelines where there are no published clinical guidelines. I reviewed roughly 60 individual detainee medical records in total. I conducted individual interviews with ten detainees selected at random from chronic care rosters or selected because of complaints received. Where relevant to findings, reference is made to the 2000 National Detention Standards (NDS) and the National Commission on Correctional Health Care Jail Standards (NCCHC 2014).

Overview

This report represents the result of an off-site review of documents (including medical records) and my focused three-day on-site medical review at the facility in response to a request by CRCL to investigate specific complaints at WTDF.

WTDF is located in Sierra Blanca, Texas. It has the capacity to house roughly 1050 inmates and detainees. The reported capacity to house detainees for ICE is roughly 500. Medical care is provided by LaSalle Corrections. The medical program is not accredited by the National Commission on Correctional Health Care (NCCHC).

This report will focus on deficiencies and areas requiring further attention in order to meet those standards.

Findings

Overall medical care of ICE detainees at WTDF meets 2000 NDS and 2014 NCCHC Jail Standards with the exception of the following areas where care **does not** currently meet those standards:

1. **Medical professional staffing:** Insufficient medical staffing contributes to delays in access to care and results in poor and incomplete documentation in some cases. There is insufficient staffing to support the basic needs of the population in multiple categories including physicians, dentists, and nurses. The medical director, a physician, is off-site, never comes to the facility, and simultaneously covers the local emergency room and

hospital without back-up. A nurse practitioner, the only licensed medical clinician is also only on-site three consecutive days a week, leaving four consecutive days every week without an on-site clinician. This results in clinician sick-call only three days a week; two days less than required by the NDS. The dentist visits the facility only once a month and sees fewer than ten ICE detainees monthly. The Health Services Administrator (HSA), who is a nurse, must back-fill line nurse shifts, pulling her away from her administrative duties, such as quality assurance. Due to lack of availability of licensed clinicians and dentists, nurses are overly reliant on nursing protocols for most of the episodic care and there are delays in timely access to proper care.

PERFORMANCE does NOT meet the 2000 NDS (III(A, C, F)) and 2014 NCCHC (J-C-07).

2. **Medical Records:** The facility does have an electronic health record (EHR), but it is quite primitive and unwieldy. Unlike most EHR's which are based on searchable database programs with functions, the EHR used at WTDF is basically a collection of scanned (pdf format) documents. It is nearly impossible to reconstruct a clinical timeline in an efficient manner. In addition, there are very few narrative notes, most are scanned check lists, and they are often completely inaccurate. A medical record that is difficult to navigate that contains inaccurate or incomplete information impairs the ability of medical staff to adequately and efficiently communicate with other clinicians across shifts and is a considerable legal liability for the facility.

   PERFORMANCE does NOT meet 2014 NCCHC (J-H-01).

3. **Clinic Space and Cleanliness**: Clinic space is inadequate for the delivery of medical care. In the medical unit itself, there is basically one fully functioning exam room. A second room appears to be improperly maintained and equipped and appears to be rarely used. In addition, a great deal of clinical care is provided in space not adequately designed for medical care. This includes the intake area and the dormitory areas. Neither of those areas have proper space for history taking and examination. Finally, the cleanliness and upkeep of the medical unit is unacceptable. The clinic itself is old and surfaces of furniture, exam tables, counters and floors are deteriorating, making it impossible to properly sanitize.

   PERFORMANCE does NOT meet the 2000 NDS (III B) 2014 NCCHC J-D-03

4. **Lack of Privacy:** In intake where sensitive screening questions are asked, there is a total lack of privacy. There is no medical room, and medical interviews are conducted out in the open. Likewise, when sick-call is held in the dormitories, medical histories and even rudimentary exams take place at dining tables on the open dormitory.

   PERFORMANCE does NOT meet the 2000 NDS (III(A,B)) 2014 NCCHC (J-A-09).

and is a HIPAA violation.

5. **Security Support for Clinic Operations:** Clinic functions are constrained by inadequate support of custody staff to transport detainees to and from clinic. Several medical records included notations that detainees could not be seen due to "safety issues," which I learned is a reference to lack of custody support. (Including Cases 6 and 11 in Appendix I)

   PERFORMANCE does NOT meet the 2014 NCCHC (J-E-10).

Complaints and Issues Reviewed

1. 18-04-ICE-0312 and 18-05-ICE-0318 - **alleged inadequate medical care for an eye condition** *[Case 1 in Appendix I]*. My investigation of the medical record ***substantiated*** this complaint.

2. 18-06-ICE-0156 alleged inadequate medical care following a use of force incident. The allegations were made by 16 detainees *[cases 2-16 in Appendix I]*. Of the 16 cases, only 5 were seen by medical staff following the use of force incident *[cases 6, 8, 9, 14 and 15],* of those, four had proper documentation on the medical use of force form, the last *[case 9]* had a note but no use of force form. Only case 9 had minor injuries noted. The other four had no injuries noted. The remaining 11 cases had no record of use of force evaluation at all. However, the CRCL corrections expert advised me that, based on his review of records and video tape of the incident, none of the other cases had been directly involved in the use of force. My investigation of the medical record ***substantiated*** this complaint. I also ***substantiated*** the complaint *[case 19 in Appendix I]* alleging inadequate care of an ankle injury (both chronic and re-injury in the facility).

3. **Other substantiated complaints:** CRCL received a number of complaints about medical care that were not referenced in the retention memo. These include complaints received in writing prior to the on-site investigations and complaints raised verbally by detainees during the on-site investigation. *Substantiated* complaints included complaints about inadequate or delayed referral by nurses to nurse practitioner and absence of an on-site medical doctor. These complaints *were* ***substantiated.***

Discussion

While this report focuses on deficiencies in the medical care at WTDF, it is important to comment briefly on the medical program as a whole. Performance of the medical program met the NDS in all other areas not cited. Strengths include the quality of the few personnel that make up the medical leadership team in the facility, specifically the Health Services Administrator and the nurse practitioner.

The focus of this report is on deficiencies. The deficiencies cited in this report are all correctable, and recommendations for correction are provided below.

While I cite five specific areas requiring attention, it should be acknowledged that deficiencies in those cited areas create other problems. For example, inefficiencies created by inadequate staff in the clinical operation all have impact on the timeliness of medical care. My review of 60 medical records of patients requiring ongoing care for chronic medical problems such as diabetes, hypertension, and asthma revealed that frequency of evaluation does not meet published disease-specific standards guidelines (including NIH and NCCHC guidelines). Many patients with chronic illnesses were only scheduled for follow-up with the nurse practioner infrequently, and much of the care was done by the physician reviewing medical records and ordering medications remotely when he should have seen the patient face-to-face. This void in appropriate care is also well below the standard. Informed consent was not always obtained when starting new medications. Abnormal lab results were not always shared with and explained to the patients.

During the on-site investigation, medical leadership shared plans to recruit staff to fill critical vacancies.

SUMMARY OF MEDICAL RECOMMENDATIONS – WEST TEXAS DETENTION FACILITY

Overall medical care of ICE detainees at the West Texas Detention Facility (WTDF) meets 2000 NDS and 2014 NCCHC Jail Standards with the exception of the following areas:

1. **Medical professional staffing:** Insufficient medical staffing contributes to delays in access to care and results in poor and incomplete documentation. There is insufficient staffing to support the basic needs of the population in multiple categories including physicians, dentists, and nurses. The medical director, a physician, is off-site, never comes to the facility and simultaneously covers the local emergency room and hospital without back-up. A nurse practitioner, the only licensed medical clinician is also only on-site three consecutive days a week, leaving four consecutive days every week without an on-site clinician. This results in clinician sick-call only three days a week; two days less than required by the NDS. The dentist visits the facility only once a month and sees fewer than 10 ICE detainees monthly. The Health Services Administrator (HSA), who is a nurse, must back-fill nursing shifts, pulling her away from her administrative duties, such as quality assurance. Due to lack of availabelicensed clinicians and dentists, nurses are overly reliant on nursing protocols for most of the episodic care.
   PERFORMANCE does NOT meet the 2000 NDS (III(A, C, F)) and 2014 NCCHC (J-C-07).

   Recommendation: Staffing must be increased to support the needs of the population. The clinical medical authority, typically a physician, should have some on-site presence in order to properly supervise the mid-level clinical staff and to be available to evaluate more complex cases than can be managed by a mid-level provider. For facilities that house more than 200 detainees, provider sick-call must be available 5 days a week. There is need for additional nursing. Until medical professional staffing can be increased to meet the need, I recommend that ICE only place healthy detainees at the WTDF. I further recommend that until staffing is improved seriously ill and chronically ill detainees be moved to the El Paso Service Processing Center and no seriously ill or

chronic care detainees be placed at WTDF.

2. **Medical Records:** The facility does have an electronic health record (EHR), but as EHR's go, it is quite primitive and unwieldy. Unlike most EHR's which are based on searchable database programs with functions, the EHR used at WTDF is basically a collection of scanned pdf documents. It is nearly impossible to reconstruct a clinical timeline in an efficient manner, which can put ill detainees at risk, especially detainees who have serious illnesses. In addition, there are very few narrative notes, most are scanned check lists and they are often completely inaccurate.
PERFORMANCE does NOT meet 2014 NCCHC (J-H-01).

   Recommendation: A proper electronic health record package should be purchased for the facility. In the meantime, providers must take more care in completing medical documentation fully and accurately.

3. **Clinic Space and Cleanliness**: Clinic space is inadequate for the delivery of medical care. In the medical unit itself, there is basically one fully functioning exam room. A second room is improperly maintained and equipped and appears to be rarely used. In addition, a great deal of clinical care is provided in space not adequately designed for medical care. This includes the intake area and the housing units. Neither of those areas have proper space for history-taking and examination. Finally, the cleanliness and upkeep of the medical unit is unacceptable. The clinic itself is old and surfaces of furniture, exam tables, counters and floors are dirty and deteriorating, making it impossible to properly sanitize.
PERFORMANCE does NOT meet the 2000 NDS (III B) 2014 NCCHC J-D-03

   Recommendation: If a private space cannot be provided in Intake and in the housing units, medical screening and care should not be delivered in those settings. The main medical clinic needs a complete renovation with new cabinets, flooring and furniture so that proper hygiene can be maintained. Routine cleaning of the medical clinic should be performed by a professional contractor; not by inmates or detainees.

4. **Lack of Privacy:** In intake where sensitive screening questions are asked there is a total lack of privacy. There is no medical room, and medical interviews are conducted out in the open. Likewise, when sick-call is held in the housing units, medical histories, and even rudimentary exams, take place at dining tables in the open, inside the housing units.
PERFORMANCE does NOT meet the 2000 NDS (III(A,B)) 2014 NCCHC (J-A-09). and is a HIPAA violation.

   Recommendation: As mentioned above, if a private space cannot be provided in Intake and in the housing units, medical screening and care should not be delivered in those settings.

5. **Security Support for Clinic Operations:** Detainee medical care is constrained by inadequate support of custody staff to transport detainees to and from clinic.
PERFORMANCE does NOT meet the 2014 NCCHC (J-E-10).

   Recommendation: The facility must provide sufficient staff to support the medical

program operations in order to provide timely access to care.

These corrective measures will require monitoring to ensure they adequately address the substantiated deficiencies.

Appendix I

This section includes identifiers to protected health information. Disclosure/distribution of this appendix should be limited accordingly.

Identity of Cases Cited in this Report

My Case No.	A #	Name	CRCL Complaint #
(b)(6)			18-04-ICE-0312
			18-05-ICE-0318
			18-06-ICE-0156
			18-06-ICE-0156
			18-06-ICE-0156
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			18-06-ICE-0156

REPORT FOR THE
U.S. DEPARTMENT OF HOMELAND SECURITY
OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES
Onsite August 14 – August 16, 2018

Investigation regarding West Texas Detention Facility, Sierra Blanca, Texas

Complaints reviewed in this report included the following:

Complaint No. 18-04-ICE-0139
Complaint No. 18-07-ICE-0282
Complaint No. 18-04-ICE-0322
Complaint No. 18-04-ICE-0312
Complaint No. 18-05-ICE-0318
Complaint No. 18-05-ICE-0317
Complaint No. 18-05-ICE-0320
Complaint No. 18-06-ICE-0156
Complaint No. 18-06-ICE-0321

Prepared by (b) (6) (b) (6) PhD, MPA, CCHP

Report date August 27, 2018

Protected by the Deliberative Process Privilege

Introduction and Referral Issues

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL), enlisted me to participate in an onsite investigation regarding complaints it received alleging civil rights and civil liberties abuses of individuals in U.S. Immigration and Customs Enforcement (ICE) custody at the West Texas Detention Facility (WTDF) in Sierra Blanca, Texas. Each complaint comprises allegations raised by multiple detainees regarding conditions of confinement including adequacy of medical or mental health care at WTDF. One complaint (18-06-ICE-0156) specifically relates allegations from three detainees in which each were reportedly prescribed psychiatric medication and were receiving mental health treatment prior to placement at WTDF that was allegedly not continued when they moved to the facility. One noted that he had expressly indicated at his intake interview that he was receiving mental health care prior to admission that was not then continued. One added that the lack of care had resulted in aggravation of mental health symptoms resulting in periods of suicidal ideation.

The allegations regarding access to mental health services prompted the need to evaluate the facility's compliance with the ICE 2000 National Detention Standards (NDS) related to mental health care during this onsite review of conditions of confinement and general medical care.

Method of Review

I was onsite at WTDF over the course of three days, August 14 through August 16, 2018, totaling approximately 25 hours. While there, I toured the facility including general housing units for both male and female detainees, the intake unit, indoor and outside recreation space, special management units, and the health care unit.

Prior to the onsite, I reviewed the applicable 2000 NDS, mental health forms and policies provided by the facility, material on quality improvement activities, staffing patterns, detainee handbook, and suicide prevention activities.

During the onsite, I reviewed the following documents:

1. Policy and procedures
2. Program descriptions of all mental health services
3. Grievances related to medical and mental health care over the past year
4. Various written complaints submitted by ICE detainees
5. Roster of detainees receiving mental health services
6. Roster of detainees receiving psychiatric medications
7. Roster of detainees transferred to outside mental health facility
8. Roster of detainees placed on suicide precautions
9. Roster of detainees housed in segregation
10. Sick call requests and responses
11. Twenty-nine healthcare records (see Appendix 2) of detainees chosen from the above-mentioned sources or referred by other CRCL experts who participated in the onsite.

Additionally, I conducted individual interviews with ten (six female) detainees who were chosen from a list of patients on the chronic care list for medical or mental health treatment. These interviews were in collaboration with Dr. (b) (6) , the medical expert assigned to this investigation team, along with the aid of a qualified Spanish-language interpreter. Three of the nine interviewees were also part of the group for whom I completed a file review. A list of the interviewees is provided in Appendix 3.

I also had the opportunity to interview the mental health and medical staff.

Analysis, Conclusions, and Recommendations

Review of overall mental health care activities

The following section provides an assessment of compliance with the 2000 NDS relevant to the mental health care program at WTDF. Recommendations are offered later in the report.

Staffing, Space, and Access to Care

Mental health and medical services are conducted as part of the overall administration of the facility by LaSalle Corrections. The facility houses both male and female detainees who remain separated at all times. There are Marshall's service detainees located at the facility who remain separate from ICE detainees. The mental health program staffing pattern includes: 1.0 FTE HSA spread across the entire facility health service operation, 1.0 FTE Registered Nurse (Psychiatric), and 1.0 FTE Licensed Professional Counselor. The HSA was hired into her position approximately one year ago, after providing direct care services full time for two years prior. The psychiatric RN is a new nurse having completed nursing school a year ago while working as medical records staff. There is a newly developed Licensed Professional Counselor position that has been posted for hire and will augment the current counselor position. Psychiatric services are provided via telemedicine two days per week by a psychiatric nurse practitioner located off site who receives consultation from a licensed psychiatrist located in El Paso. The telemedicine days are Wednesday and Friday typically, which leaves four consecutive days without psychiatric services. The Licensed Professional Counselor provides 24-7 on call services and weekend suicide watch observations when needed. The Psychiatric Nurse Practitioner must be called to order emergency intervention and is available 24-7. The HSA reported that access to patients is limited by number of security staff dedicated to transport. She indicated three security staff would be sufficient but only two are allocated and at times that number is reduced to one. The counselor reported that the expectation is that detainees referred to mental health services by health care staff are to be seen within three days. He noted that is an unrealistic time frame. The staffing level is inadequate to fulfill the mental health needs of the facility.

The medical unit has minimal exam rooms and office space that is shared among multiple staff. The upkeep of the area is poor with inadequate cleaning, old paint and equipment, cement floors with worn sealant, and worn-out furniture. There is a medical isolation unit within the medical unit that is used for observation when self-harm is a concern. Patients placed into observation for suicide watch all receive the same property – a suicide resistant smock and minimal other items.

The facility routinely uses 1:1 supervision for observation placements, and step-down must be ordered by the nurse practitioner. Step-down occurs in the same unit and reduces 1:1 supervision to regular checks. Removal from observation status and step-down requires an order by the nurse practitioner. When necessary, patients in mental health crisis can be transferred to one of two emergency facilities located in El Paso. This appears to occur without delay.

The medical formulary is reportedly adequate and the facility has two back-up pharmacies to ensure prescribed medications are received promptly.

Medical and mental health care providers utilize the language line for interpretation needs if the provider is not fluent in the detainee's language. There are a large number of Spanish-speaking staff members at the facility. Group activities or individual therapy are conducted with the aid of a Spanish-speaking security staff member. Security staff members should not be used to provide interpretation for mental health or medical care purposes. Intake screenings are conducted by Spanish speaking staff or by using interpretation either in person or via the language line. The ICE Detainee Handbook is available in Spanish. Detainees reported understanding how to access care using the sick call system.

Detainees receiving mental health medication are seen at regular intervals by the psychiatric nurse practitioner. The notes that I reviewed are short but meaningful.

Counselor services are generally group-based and entail leisure-related activities such as origami or coloring, watching popular movies that are then discussed, and watching videos detailing the lives of bible characters and religious events which are then used in spiritual discussion. There are no similar activities created for Muslim, Jewish, or other detainees of other, non-Christian faiths so those detainees' ability to participate in mental health group activities is, at best, limited. Individual therapy is available on a short term basis to a limited number of detainees. Required segregation rounds are conducted twice weekly. The counselor reported that individual therapy is offered in a confidential setting to segregation detainees at their request, however there is no record or other evidence demonstrating that it ever occurs.

Individual counseling, group counseling, and psychosocial/psychoeducation programs are considered basic mental health care, which is essential for meeting the NCCHC (2014) standards.

Health Care Record

WTDF utilizes a rudimentary electronic health care record called Sapphire. The system generally consists of documents that are scanned and uploaded into the software. Uploaded documents are placed into one of several areas within the system, making searching for notes or gaining a full understanding of a patient case cumbersome and unwieldy. Completeness of the record depends on the timeliness of document upload. The HSA reports that documents are uploaded quickly upon completion. However during record reviews there were many instances where services occurred several days before documentation was complete and uploaded, which can negatively impact continuity of care.

Communication and Quality Improvement

There are quarterly meetings of medical staff during which both ICE detainees and Marshall's inmates are discussed. There are also monthly meetings that include the HSA and other facility leaders, led by facility administrators. Meetings include a report-out of major departments but do not include discussions about quality improvement needs and do not include discussions about specific detainee cases for programmatic or treatment planning purposes.

The HSA reports that a rudimentary QI/QA system has been in place but quality improvement reviews such as audits have not occurred since April 2018. Leadership was unable to identify any recent reviews of timeliness or quality of service and there is no dedicated quality improvement/quality assurance committee. The continuous quality improvement efforts at WTDF do not meet the 2000 NDS or the current National Commission on Correctional Health Care Jail Standards (2014) as required by 2000 NDS.

Suicide Prevention Program and Management of Mental Illness in Segregation

(Standard: 2000 NDS, Suicide Prevention and Intervention, §§ III.A-C.)

WTDF has an adequate suicide prevention program, and there were no detainee suicides at the facility in the last year. Staff participates in required suicide prevention training. Health services staff receive ongoing training by the HSA. The initial intake screening process uses a mental health questionnaire that asks questions specific to self-harm risk. The initial intake is conducted without privacy by a security staff person, which may compromise the veracity of the information. Facility policy requires that detainees who express self-harm ideation or engage in self-harm behavior be placed into an observation/isolation cell in the health service unit. As previously mentioned, property in observation status is minimal.

When placed into suicide watch status, detainees are seen every eight hours by health care staff, and reviewed by mental health staff daily. The detainee is held under 1:1 constant monitoring until moved to a step down status which requires a nurse practitioner order. The step down status occurs in the same observation cell. There is no plan-driven mental health treatment provided to detainees while in suicide watch. There is evidence from two file reviews that detainees remain in suicide watch or the step down watch status for days after the daily suicide assessment indicates reduced risk. The cells in which suicide watch or medical isolation occur are located in the health services unit where staff are available 24/7.

The segregated housing unit is comprised of 2 units with 10 cells each, and 4 additional cells outside of those closed wings for a total of 24 available beds. The HSA reported that detainees with significant mental health concerns whose behavior has resulted in a need for segregation and those with significant mental health diagnoses who request placement outside of general population may be placed into one of those 4 cells. The cells are not suicide resistant. The door windows have a sliding metal plate that can be used to block view into and out of the room. On the day of the onsite, one of those window covering plates was closed. Covering the door

window negates the effectiveness of placing high-need or mentally ill detainees in those cells. It is strongly recommended that those coverings be immediately removed.

Detainees in administrative segregation reportedly receive the same privileges as general population detainees receive, including access to television, pots used to heat water etc. Detainees in segregated housing receive 1 hour daily for out-of-cell recreation. This is identical to the amount of recreation offered to detainees housed in the general population barracks. If there are more detainees requiring administrative segregation than there is space, detainees can be placed into the disciplinary segregation cells and still have access to similar amenities and privileges as the detainees in administrative segregation (except for television, which is not available in disciplinary segregation).

Screening, Assessment and Referral

(Standards: 2000 NDS, Admission and Release, §§ A.3 & H; Medical Care, §§ III.A & D)

Facility policies clearly delineate the process for detainee referrals to mental health services. The intake screening is conducted by a health-trained officer or nurse at a desk in full view and hearing of other detainees and staff, which provides little privacy. The screening tool and interview conducted by security staff adequately provides the required information including suicide risk factors associated with PREA, and asks questions related to current and historical psychiatric symptoms or treatment, criminal victimization, recent loss, traumatic experiences, and other information. Staff conducting the screening makes referrals to mental health providers based on the answers to questions asked during the intake process. However file reviews indicate that the information on the screening form is inaccurate and, accordingly, serious active mental health concerns sometimes go unnoticed. There were two file reviews that noted a referral to psychological or medical services resulting from the intake screen, but there was no evidence that those follow-up appointments ever occurred.

Detainees who enter the facility on psychiatric medications usually receive a continuing prescription pending review by the psychiatric prescriber at the next available opportunity. Transfer summaries are reported to accompany the detainee only 50% of the time, which leaves 50% of detainees at risk for a possible psychotic or deteriorating mental health event.

Medical assessments and referral-driven mental health assessments are required within 14 days of arrival; a timeframe that was not regularly met. Notes from the quarterly medical staffing meetings reflect on the need to more regularly complete physicals, including mental health evaluations, within the 14-day time frame. While the HSA reported that she believes they are meeting the timeline typically, there are no routine quality assurance reviews so information is anecdotal.

Sick Call

Sick call is accomplished when detainees place sick-call requests into locked boxes inside the housing units. Slips are triaged daily by nursing staff. In the restricted housing units detainees

verbally request medical or mental health care at the cell door when visited by the nurse. This request process in segregated housing is not confidential and should be improved.

Several detainees stated fear of requesting a consultation with mental health or medical care staff more than once, concerned that they would be placed into the medical housing isolation cells. Additionally, minutes from one quarterly medical staffing indicated that detainees should not be placed on a provider schedule until they have expressed concern over the same issue at least three times. This 3-request rule, coupled with a general fear of being placed into an isolation cell if they request care more than once, can cause detainees to be unwilling to request needed care, and therefore places detainees at risk.

The detainee handbook details the process for making sick-call requests for health care or to report suicidal ideation. During interviews several detainees reported being unaware of how to request mental health services. Continual education for detainees on how to access medical and mental health care is needed.

Medical Isolation, Involuntary Medication, and Use of Restraints

Isolation for medical purposes generally occurs in the medical housing unit. Detainees in need of treatment intervention beyond the scope of WTDF are routinely transferred to an El Paso hospital. This has been generally successfully accomplished. The facility does not administer involuntary psychiatric medication nor restrain detainees for mental health purposes. Medication refusals are noted in records. There is evidence from the file reviews that some detainees remain in suicide watch or medical isolation several days after the risk of suicidal harm has been noted to have resolved. This delay should be resolved.

Continuity of Care

(Standard: 2000 NDS, Medical Care, §§ III.F.)

Detainees arriving at the facility with prescribed medications are typically evaluated within required timeframes. When there is no prescription and yet the detainee indicates they have been taking specific medications, there are noted occasional delays pending evaluation by mental health provider staff. As noted above, transfer summaries reportedly accompany the detainees 50% of the time, which suggests that some arriving detainees in need of care go unnoticed. Detainees being released from the facility are reportedly provided with at least a 7-day supply of medication. File reviews indicate that a detailed medical care summary is completed to aid in transition to the next living situation.

Review of Health Care Records

I reviewed the mental health records of 29 ICE detainees. As noted above, one of the complaints prompting this onsite encompasses mental health issues alleged by many detainees. It contains allegations by three detainees that are directly related to continuity of and access to mental health medication and treatment upon arrival at WTDF. I have commented on those directly, later in

this report. Additionally, where significant concerns are identified in the course of reviewing the file, I discuss more details of the case to reflect areas that prompt recommendations. A list of the reviewed files is provided in Appendix 2.

Complaint allegations:

Detainee 7 alleged that he was taking prescription medications and regularly seeing a psychiatrist for depression and hallucinations prior to his detention, which he reported during intake, but he was not provided the same care at WTDF. The lack of care allegedly aggravated his mental health condition and caused him to sometimes feel suicidal.

- This complaint is not substantiated. The file review showed that the detainee was referred to psychiatric services following a request for sleeping pills, but there was no evidence that the mental health concerns stated in the complaint were reported to medical staff.

Detainee 8 alleged that he did not receive medications for his chronic PTSD, depression and anxiety, which he reported receiving prior to his detention.

- This complaint is substantiated through review of the detainee's file. The file review clearly indicated that the detainee reported his mental health concern at intake and no follow-up care was provided.

Detainee 9 alleged that he was taking medication for chronic PTSD and nightmares prior to his detention, but was denied the medication at WTDF.

- This complaint is not substantiated. The file review reflected that the detainee did not report any mental health history, concern or trauma at intake and did not request mental health services at any time during his stay.

Concerns arising from the file reviews:

1. Documentation of mental health services was not always present and referrals were not always completed. Six detainees reported a history of mental health concerns but two had no follow-up appointments. One detainee reported experiencing hallucinations but no follow-up appointment was scheduled. A second detainee reported a history of PTSD and depression with medication but received no psychiatric follow-up appointment or care. This case is part of the complaints that resulted in this onsite.
2. Intake mental health assessments were not meaningful. While they were regularly conducted on the same day as arrival, file reviews indicated that the information obtained was unreliable. Of the 29 files reviewed, 23 showed no history of mental health concerns, however four of those were clearly inaccurate. In one case, the detainee was on psychotropic medications upon intake but the document showed no history of mental health concerns. In two other cases, the detainees reported no history of mental health concerns but were observed within hours exhibiting active symptoms of psychotic illness. In the final case, the detainee reported no mental health concerns but two weeks later

exhibited clear psychotic behavior requiring suicide watch and medical isolation with psychiatric medication. Efforts must be made to improve the intake process so that detainees with mental health concerns are adequately identified.

3. There is evidence that detainees placed into medical isolation for mental health purposes, or suicide watch remain in isolation for days after the risk of self-harm is reportedly allayed. In one case, the detainee was placed into medical observation on 6/24/2018 and remained there until 7/11/2018 when he was moved into medical observation. This occurred even though no suicidal ideation or behavior was noted after 6/25/2018. In another case the detainee was placed into suicide watch on 10/22/2017 after reporting being deported without her daughter. She remained on suicide watch in a suicide resistant gown for five days: three days after all thoughts of self-harm had dissipated. Efforts should be made to swiftly return detainees to their prior housing status, when they are no longer determined to be suicidal or have stopped exhibiting active symptoms of mental illness.

Summary of Recommendations

The 2000 NDS on Medical Care states, "All detainees shall have access to medical services that promote detainee health and general well-being." The following recommendations result from deficiencies in meeting the overarching standard. When relevant, I also include other portions of the NDS, as well as references to the Standards for Health Services in Jails and Standards of Mental Health Care, National Commission on Correctional Health Care (NCCHC).

1. **WTDF should remove the window coverings on the outside of the four cells located outside of the segregation unit to ensure appropriate monitoring of the detainees housed within.**

Rationale: 2000 NDS, Suicide Prevention and Intervention, § I. Policy states "All staff working with INS detainees in detention facilities will be trained to recognize signs and situations potentially indicating a suicide risk. Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainee will receive preventive supervision and treatment."

There are four restrictive housing cells located outside of the formal restricted housing unit. These cells are reportedly used for detainees who are placed into an isolated status – disciplinary segregation or administrative segregation – but who may require additional contact with medical staff or easier monitoring access than cells located within the segregation units proper due to a potential mental health concern or risk. Those four cells have window coverings that can be closed, blocking the view into the cell. One of those window-coverings was closed at the time of the onsite. If those cells are, indeed, used for their stated intent, those window coverings must be removed to reduce isolation of the detainee housed within and allow for ease of observation.

2. **WTDF should engage in comprehensive programmatic evaluation and physical improvements necessary to meet or exceed the 2000 NDS and the accreditation standards of the National Commission on Correctional Health Care.**

Rationale: 2000 NDS, Medical Care, §§ I. Policy states " Medical facilities in service processing centers and contract detention facilities will maintain current accreditation by the National Commission on Correctional Health Care."

WTDF medical services are not NCCHC accredited and do not approach the standards of accreditation for the majority of its mental health care service. Engaging in needed programmatic improvements and successfully attaining accreditation by NCCHC would satisfactorily address the majority of concerns related to mental health care noted in this report.

3. **Mental health evaluation and treatment should be conducted in private without risk of being overheard by other detainees.**
4. **WTDF should modify the intake space or process to allow for privacy during the initial officer screening of the detainee.**

Rationale: 2000 NDS, Medical Care, §§ I. Policy states, "All detainees shall have access to medical services that promote detainee health and general well-being."

NCCHC Standards for Mental Health Services (MH-A-09, an important standard) requires that "mental health services are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of services."

NCCHC Standards for Mental Health Services (MH-H-02, an essential standard) requires that "the confidentiality of a patent's written or electronic clinical record, as well as orally conveyed mental health information, is maintained."

The space used by staff to conduct initial interviews of arriving detainees allows for little privacy. Detainees are asked personal details about mental health needs, traumatic experiences, and sexual orientation, among others, while standing or sitting at a desk surrounded by other detainees or facility staff. The effectiveness of the intake process in gathering vital information for others to use in housing and treatment decisions is negatively impacted by the lack of privacy and may result in serious mental health needs of incoming detainees being missed at intake. Four of the twenty-three detainees who reported no mental health concerns during the intake assessment exhibited serious mental health concerns including psychosis soon after being placed into general population and required intervention. It is vital that every effort be made to encourage honest reporting during the intake process to ensure that the detainee receives the appropriate level of care.

WTDF routinely places detainees identified as having self-harm or suicidal ideation in suicide watch. Detainees isolated due to risk of self-harm or symptoms of serious mental illness do not participate in out of cell activities and receive daily rounds by mental health staff while standing at the cell door, which affords little privacy. Mental health rounds in segregation occur cell-front where other detainees may overhear, potentially reducing the likelihood that the detainee will be forthcoming with information vital to their well-being.

5. **WTDF should develop an adequate array of mental health services including individual, group, and psychoeducational opportunities for detainees who need them.**
6. **WTDF should develop an adequate array of mental health treatment to address the serious mental health needs of detainees housed in the special management unit.**
7. **WTDF should develop therapeutic treatment activities monitored through a formal treatment plan for detainees who are identified as at risk for suicide.**

Rationale: NCCHC Standards for Mental Health Services (MH-A-01, an essential standard) notes: "Inmates have access to care to meet their serious mental health needs." They continue: "The intent of this standard is to ensure that inmates can request and have access to care that meets their serious mental health needs and that a range of mental health services is available, adequate, accessible, and provided. It is the foundation on which all National Commission on Correctional Health Care standards are based."

NCCHC Standards for Mental Health Services (MH-G-01, an essential standard) requires that "a range of mental health services are available for all inmates who require them." "Outpatients receiving basic mental health services are seen as clinically indicated, but not less than every 90 days. Those with a chronic mental illness are seen as prescribed in their individual treatment plans." The intent of the standard is to ensure that a "range of mental health services are available to inmates with mental health problems so that they are able to maintain their best level of functioning. The immediate objective of mental health treatment is to alleviate symptoms of serious mental disorders and prevent relapses to sustain patient's ability to function safely in their environment."

NCCHC Standards for Mental Health Services (MH-G-03, an essential standard) expects that "mental health services are provided according to individual treatment plans" that "direct(s) the mental health services needed for every patient on the mental health caseload and includes the treatment goals and objectives."

Group mental health activities at WTDF are generally leisure focused including coloring, origami, discussing movies, and discussing Christian spiritual stories or bible characters. There are no commensurate activities for detainees of other faiths, further limiting their mental health programming opportunities. Short-term individual treatment is offered to general population detainees and is conducted with the aid of a security officer interpreter, which compromises the detainee's privacy. Services for segregated detainees are limited to word search, coloring, and other busywork. Individual services are reportedly offered but there is no evidence it is utilized and the HSA reported that detainees are not taken out of their cells for treatment.

There is no evidence of any treatment plans for services offered to detainees in segregation or suicide watch, or for group or individual services provided to detainees who request care.

Appendix 1 below provides recommendations reflective of best professional practice.

APPENDIX 1

Best Practice Recommendations

1. **Detainees with significant mental health concerns, history of suicidal ideation, or who are receiving complex psychiatric medications should not be placed at WTDF.**

Rationale: 2000 NDS, Medical Care, §§ III.A. states: "All facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatment for all detainees."

2000 NDS, Medical Care, §§ III.B. notes: "Adequate space and equipment will be furnished in all facilities so that all detainees may be provided basic health examinations and treatment in private."

NCCHC Standards for Mental Health Services (MH-A-01, an essential standard) notes: "Inmates have access to care to meet their serious mental health needs." They continue: "The intent of this standard is to ensure that inmates can request and have access to care that meets their serious mental health needs and that a range of mental health services is available, adequate, accessible, and provided. It is the foundation on which all National Commission on Correctional Health Care standards are based."

NCCHC Standards for Health Services in Jails (J-C-07, an important standard) notes: "A sufficient number of health staff of varying types provides inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care." NCCHC Standards for Mental Health Services (MH-C-07, an important standard) adds that there must be a "sufficient number of mental health staff" to provide appropriate levels of mental health care.

NCCHC Standards for Health Services (J-D-03, an important standard) requires: "Sufficient and suitable space, supplies, and equipment are available for the facility's medical, dental, and mental health services."

WTDF has inadequate staffing to accommodate the mental health needs of detainees. Psychiatric services are provided by a psychiatric nurse practitioner who provides service to the entire facility two days per week via teleconference. She consults with a psychiatrist in El Paso via telephone. The consultant psychiatrist, Dr. Gracia, does not come to the facility or do file reviews. The facility has one psychiatric nurse and one counselor to provide care to all detainees including both ICE and Marshall's detainees. The lack of adequate staff results in poor or untimely documentation, lack of follow up to mental health referrals, longer stays in suicide watch or medical isolation than warranted by the suicide assessment, minimal mental health treatment and no treatment planning, and lack of adequate privacy. Additionally, the geographical isolation of the facility results in difficult recruitment of professional staff.

The health services unit has limited treatment space and furniture that is in poor condition with peeling paint, torn furniture and mattresses, worn flooring, and is generally unclean. Staffs share

the limited space and there is adequate space to provide the most rudimentary of care, however the facility counselor is located in space outside of the health services unit, neither the medical director nor the consulting psychiatrist provide any service onsite, and all psychiatric care is accomplished via telemedicine. Some basic health services, including sick-call triage, occur on the open housing units, significantly limiting privacy.

It is vital that the mental health staff – and the space they occupy – be enhanced to ensure that adequate care is provided to detainees who present with mental health needs.

2. WTDF should develop a robust mental health quality improvement program.

Rationale: NCCHC Standards for Mental Health Services (MH-A-06, an essential standard) requires that "A continuous quality improvement (CQI) program monitors and improves mental health care delivered in the facility." They continue that in order to be compliant with the standard "the mental health care delivery system is systematically analyzed for needed improvement and, when found, that staff develop, implement, and monitor strategies for improvement." Specifically, "the CQI program for mental health services completes: an annual review of the effectiveness of the CQI program by reviewing CQI studies, minutes of administrative and staff meetings, results of mental health record reviews, or other pertinent written materials; at least one process quality improvement study and one outcome quality improvement study each year; and an annual review of deaths and serious incidents involving inmates with mental illness to identify trends and needed corrective actions."

There is a paucity of medical or mental health care quality improvement activities that could assist in identifying, correcting, and monitoring concerns noted in this report. There is no formal quality improvement committee, and no identifiable systematic quality assurance initiatives focused on mental health care. Additionally, what quality improvement activities that have occurred in the past have ceased as of April 2018.

A robust mental health quality assurance/quality improvement program including routine monitoring, targeted improvement studies, and case review would assist in identifying and addressing many of the issues noted in this onsite review.

3. Medical isolation and suicide watch should be used for the shortest duration necessary to ensure the safety of the detainee. WTDF should ensure that detainees who require isolation are returned to general population housing as soon as the clinical and medical staff identify that the suicide risk or active mental illness has abated.

Rationale: NCCHC Standards of Mental Health for Correctional Facilities (2001) state in Appendix D: Suicide Prevention Protocols: "To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary located close to staff. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on the decisions that heighten depersonalizing aspects of confinement" (p. 126).

File reviews suggest that some detainees who were placed into suicide watch or medical isolation appropriately for self-harm ideation or evidence of active mental illness remained in that isolated status many days after the behavior resulting in placement has resolved. Detainees also report concern that asking for assistance will result in placement in an isolated status. It is vital that detainees report self-harm ideation or mental health symptoms as soon as possible. Extended isolation with minimal property and little contact with others may act as a deterrent to honesty, which may result in unnecessary emotional harm to the detainee.

APPENDIX 2

List of Files Reviewed

(b)(6)

APPENDIX 3

List of Detainees Interviewed

(b)(6)

Conditions of Detention

Subject Matter Expert's Report

West Texas Detention Facility

This report is a general examination of conditions at the West Texas Detention Facility with a specific examination of the issues identified in the following complaints:

- **18-04-ICE-0139**
- **18-07-ICE-0282**
- **18-04-ICE-0322**
- **18-04-ICE-0312**
- **18-05-ICE-0318**
- **18-05-ICE-0317**
- **18-05-ICE-0320**
- **18-06-ICE-0156**
- **18-06-ICE-0321**

Prepared by:

(b) (6)

Lodi, CA

I. Summary of Review

The Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) received complaints alleging that U. S. Immigration and Customs Enforcement (ICE) has violated the civil rights and civil liberties of detainees at the West Texas Detention Facility (WTDF), located in Sierra Blanca, Texas. The complaints contained the following allegations which will be examined in this report:

- Detainees are served inadequate quantities and quality of food;
- Detainees incur telephone costs that are excessive;
- Facility housing units are overcrowded and toilets and showers are broken;
- Detainees are not provided with a clean change of clothing each week;[1]
- Outdoor recreation is denied or limited to one hour per week;
- ICE Deportation Officers do not adequately communicate or provide sufficient information to detainees and use coercion on detainees to sign documents they do not understand;
- Detainees are denied requests to communicate with consulates;
- Detainees are forced to clean without pay;
- Detainees are subjected to wrongful and excessive use of force, including the indiscriminate use of chemical agents;
- Detainees are subjected to wrongful and punitive use of segregation without good cause;
- WTDF Officers are using threats and intimidation, including racial slurs, threats by aiming firearms at detainees and threatening to spray detainees with chemical agents;
- Detainees are receiving inadequate medical care following use of force incidents;
- A detainee claims a sexual assault by WTDF staff;
- Detainee is denied religious accommodations; and
- Detainees receive delayed and inadequate medical and mental health care.[2]

In addition to the specific complaints identified, the following aspects of the WTDF facility operations were reviewed during the on-site investigation:

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[1] These first four issues relating to food services, telephones, the physical plant operations and facilities, and the laundry/clothing exchange will be addressed in a separate report by (b)(6) the environmental expert on the CRCL investigation team.

[2] The allegations related to medical and mental health care will be addressed in separate reports by CRCL team experts, (b)(6)

- Use of Force
- Segregation
- Sexual Abuse and Assault Prevention and Intervention (PREA/SAAPI)
- Detainee Grievances
- Visitation
- Recreation
- Mail
- Religious Practices
- Law Library

II. Facility Background and Population Demographics

On the first day of our on-site[3] the ICE detainee population at WTDF was 518.[4] WTDF is operated under an Intergovernmental Service Agreement between the U. S. Marshall's Service and Hudspeth County, Texas, which holds a contract with the LaSalle Corporation to operate the facility. WTDF is not an American Correctional Association (ACA) accredited facility and follows the 2000 National Detention Standards (NDS 2000).

The detainees at WTDF include all classification levels, low to high, which are housed in common dormitory-like housing units.[5] The general population housing units at WTDF are large open-bay dormitory style buildings, each building containing two housing units, one on either end of the four buildings.[6] The buildings containing the housing units are poorly constructed and in a state of disrepair.[7] The segregation unit is in the main facility where U. S. Marshall's inmates are housed. It contains 24 segregation cells and 12 medical isolation cells.

All meals are delivered to the housing units on carts from the main kitchen and are consumed by detainees while sitting at dayroom tables, sitting on beds or on the floor. Detainees are escorted to attend other programming, such as visitation, outdoor recreation and law library, which are provided outside the housing units in common areas. All common program areas are operated by schedule to ensure that U. S. Marshall's inmates and ICE detainees use the facilities at separate times and to prevent the intermingling of ICE detainees of different classification levels.

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[3] CRCL was on-site at WTDF August 14-16, 2018.

[4] The WTDF total population on August 14, 2018, was 1,153 (635 U. S. Marshall's inmates and 518 ICE detainees). Of the 518 ICE detainees, there were 388 male, 130 female.

[5] Low and low-medium classified detainees are housed together and high-medium and high classification level detainees are housed together in compliance with the NDS 2000.

[6] There are a total of eight housing units contained in the four buildings, each housing between 60-100 detainees. Female detainees are housed together in two of the eight dormitories.

[7] The condition of the housing unit structures will be addressed by the CRCL, environmental health expert, Diane Skipworth, in a separate report.

Throughout the on-site investigation, we toured WTDF areas, reviewed records, interviewed WTDF personnel and ICE officials as well as many ICE detainees. All general conditions of confinement were reviewed and considered while on-site.
Overall, we found the personnel to be professional, courteous and helpful. WTDF was generally in compliance with the NDS 2000, however, recommendations will be provided in this report to improve certain operational aspects. All opinions and recommendations contained herein are based on my background and experience in the correctional environment, ICE detention standards, and generally recognized correctional standards, including those of the ACA (American Correctional Association) and the AJA (American Jail Association).

III. Expert Professional Information

(b) (6)

IV. Relevant Standards

[8] At that time the inmate population in the CDCR was over 160,000 with approximately 120,000 parolees and 57,000 employees.

- **ICE Detention Standards**

The National Detention Standards (2000 NDS) apply to WTDF. These are the standards that were relied upon in looking at the specific allegations regarding this facility, as well as, the general review of operations.

- **Professional Best Practices**

In addition to the NDS 2000, this review is being conducted based on my correctional experience and nationally recognized best practices.

IV. Review Purpose and Methodology

The purpose of this review is to examine the specific complaint allegations and to observe overall WTDF operations as they relate to the care and treatment of the ICE detainees. For this review, I examined detainee records; WTDF policies and procedures; documentation kept on-site depicting such things as detainee grievances and law library usage; interviewed ICE detainees, ICE personnel, WTDF personnel; and, conducted an on-site tour of the WTDF facility with managers and supervisors. All WTDF and ICE personnel were professional, cordial and cooperative in facilitating our review, and a special thanks is due to Warden (b) (6) and his managers for the time spent ensuring that we were able to have unfettered access to the facility and the related information kept on-site.

Prior to the preparation of this report I specifically reviewed the following WTDF documents:

- Contract/Intergovernmental Services Agreement
- Detainee grievances and grievance logs
- Law library requests and Law library logs
- Detention Files
- Segregation records
- Incidents involving use of force and Force After-Action Reports[9]
- WTDF and ICE National Detainee handbooks in English and Spanish
- Assigned personnel roster
- WTDF Policies on the following:[10]

    1. Sexual Assault/PREA
    2. Detainee Classification
    3. Sanitation
    4. Detainee Hygiene
    5. Detainee Discipline
    6. Restricted Housing Unit Operations (segregation)

[9] There were thirteen uses of force at WTDF since November 2017.

[10] Because WTDF houses ICE detainees, as well as, U.S. Marshall's inmates, some policy/procedure documents refer to "inmate" rather than detainee and apply to both inmates and detainees.

7. Detainee Grievance Procedures
8. Use of Force
9. Critical Incident Reporting
10. Nondiscrimination Towards Residents/Detainees
11. Religious Programming
12. Detainee Legal Activities
13. Detainee Visitation
14. Voluntary Work Program
15. Inmate/Staff Communication

2000 NDS relevant to this review:

1. Admission and Release
2. Use of Force
3. Special Management Unit (Segregation)
4. Access to Legal Material
5. Detainee Grievance Procedures
6. Visitation
7. Correspondence and Other Mail
8. Recreation
9. Religious Practices
10. Sexual Abuse and Assault Prevention and Intervention (SAAPI)[11]

In addition to the above listed activities the on-site on August 14-16, 2018, included the following:

- Toured the Intake and Release area
- Toured the Housing Units
- Toured the Recreation yard(s)
- Toured the Law Library
- Toured the Restricted Housing Unit (Segregation)
- Toured the Medical Clinic
- Toured the Visitation area
- Toured the Mailroom
- Inspected all areas of detainee access for information postings
- Interviewed various personnel including command staff, supervisors and line staff[12]
- Interviewed various ICE detainees randomly selected

V. Findings, Analysis and Recommendations

[11] The SAAPI standard applied is the PBNDS 2011 standard which had not yet been created when the NDS 2000 standards were instituted.

[12] These interviews included, but were not limited to, the supervisors responsible for SAAPI, use of force accountability, segregated housing, detainee grievances, detainee classification/intake, detainee religious services, detainee visitation, detainee mail and detainee law library.

For this report the following definitions are being observed as they relate to the investigative "findings" relevant to the allegations:

- "Substantiated" describes an allegation that was investigated and determined to have occurred substantially, as alleged;
- "Not Substantiated" describes an allegation that was investigated and there was insufficient evidence to determine whether or not the allegation occurred[13]; and
- "Unfounded" describes an allegation that was investigated and determined not to have occurred.

Prior to making "findings," my analysis is provided to establish the evidence relied upon to make a finding. Any recommendations are assigned a "priority" that is tied to the NDS 2000 or to industry "best practices."

The complaints listed in this report have been specifically reviewed and analyzed, and a finding is opined. Some of the complaints are grouped together because they were either filed by the same detainee or the alleged issues are duplicative.

Complaint Nos. 18-04--ICE-0139; 18-07-ICE-0282

On January 31, 2018, and April 18, 2018, CRCL received email referrals from the OIG which contained inferior conditions of detention allegations made by Detainee # 1.[14] Specifically, Detainee # 1 alleged that he was forced to clean his housing unit without being paid and was placed in segregation as retaliation for refusing to clean on one occasion. He also alleged that detainees were not provided with sufficient amounts of food and that the food was of poor quality. Finally, he alleged that telephone calls were unreasonably expensive at WTDF.[15]

Analysis:

Detainee # 1 was removed in May 2018 and was not available for interview during the on-site. However, his complete detention file was reviewed and supervisors responsible for the detainee housing were interviewed. Other detainees were also interviewed with regards to the practices in the housing units related to how the common housing areas are cleaned, by whom they are cleaned and whether detainees are required by officers to conduct the cleaning.

Detainees randomly interviewed indicated that officers do not assign detainees to clean the housing units. The detainees determine whose turn it is to clean the housing unit showers, toilets, floors and common areas. The detainees described that they, without input from officers, take turns cleaning on a rotating schedule according to which bunk row they sleep in.

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[13] While "Unsubstantiated" can often be the finding because there simply is not enough tangible evidence to "Substantiate" an allegation, I may sometimes offer my expert opinion as to whether, based on other considerations and observations, it is more likely than not that the allegation either happened or did not happen.
[14] The identity of Detainee # 1 is contained in Appendix A.
[15] The allegations regarding the food and the telephones will be addressed in a separate report by the CRCL environmental expert, (b)(6)

Managers we interviewed indicated that all work by detainees is completely voluntary and that detainees are not assigned to work. However, the WTDF Voluntary Work Program policy indicates that, "each detainee will sign a volunteer to work form before being allowed to work." This clearly implies that detainees may be assigned to work, however they may only be assigned on a voluntary basis. It appears that the WTDF management has chosen not to follow the facility procedure for assigning work, even on a volunteer basis, and has left the determination about who will clean the housing units completely up to the detainees.

Review of the detention file for Detainee # 1 indicated that he was placed in restricted housing on segregation status for possession of a manufactured weapon. His file indicated that his behavior was non-compliant with officers and facility rules. He refused to follow the simplest rules like walking with hands behind the back during mass movements of detainees throughout the facility. He also received disciplinary charges for inciting other detainees to refuse food and to resist staff. While in segregation, he received a disciplinary infraction for banging on the cell door and disrupting the entire unit.

Findings:

- The allegations that Detainee # 1 was forced to clean without being paid is "**Not Substantiated**." There is no way to definitively determine if this detainee was "forced to clean." However, there was evidence that it is not the practice of housing unit officers to assign detainees to conduct the cleaning. It is even possible that Detainee # 1 was forced to clean by other detainees who felt it was his turn.
- The allegation that Detainee # 1 was placed in segregation as retaliation for refusing to clean on one occasion is "**Unfounded**." Not only is there evidence that officers would not have assigned Detainee # 1 to do the cleaning, but there is clear evidence that he was placed in segregation for possession of a manufactured weapon. His record reflects a detainee who was non-compliant and disruptive to facility operations and was justifiably placed in segregation.
- While the allegations in this complaint were not substantiated, the practice of leaving the cleaning decisions up to the detainee population is not advisable and is a practice that could potentially lead to some serious problems in the housing units. In the first place, the officers should be directing cleaning activities and ensuring quality control in the housing units so that proper hygiene is being maintained.[16] Secondly, and this is of serious concern, there is great potential for "stronger" detainees to pressure "weaker" detainees into doing the cleaning and to threaten them with bodily injury if they do not comply.

Recommendations:

- WTDF should discontinue the practice of requiring the detainees to determine who will clean the housing units and, instead, follow their written Voluntary Work Program

[16] We found that, not only were the housing dormitories in disrepair, but they were not clean. The environmental health expert on the CRCL team will address the issues of cleanliness and hygiene in separate report.

Procedure, which prescribes assigning detainees to work assignments on a volunteer basis. The officers should be supervising the cleaning of all housing areas. (**Best Practices**)

Complaint No. 18-04-ICE-0322

This complaint was received by CRCL by email referral on January 12, 2018, from the DHS Office of the Inspector General (OIG), alleging inferior conditions of detention by Detainee # 2.[17] Specifically, Detainee # 2 alleged that the facility housing unit 1-A was overcrowded; that detainees were forced to carry the bunk beds into the housing unit; that the showers and toilets were often broken; and, that recreation was either denied or limited to one hour per week.[18]

Analysis:

We reviewed the issue of detainees being asked to provide physical labor at WTDF by asking the officers how they would accomplish tasks such as reorganizing or reconfiguring the bunk beds in a housing unit. I was told that the facility has maintenance staff who assist with any activity related to the servicing or maintenance of supplies, equipment or furniture, the physical structure, or the related upkeep that is necessary to support the detention operations.

However, upon further inquiry, it was conceded that it would not be unlikely during a mass movement or reorganization of bunk beds from one dormitory to another, that the staff may ask detainees to assist on a voluntary basis. We were unable to find any evidence that there is a practice of "forcing" detainees to help the staff with physical labor. Detainees interviewed on-site were unaware of detainees ever being forced to work.

We also reviewed the recreation program at WTDF. There are two recreation officers who supervise the outdoor recreation program. There are two large "yard" areas where the detainees play soccer, and three smaller concrete exercise areas where the detainees play handball or basketball.[19] There are two canopies in the outdoor recreation areas to provide shade from the sun for detainees who want to be outside, but do not want to participate in games or activities. There is a separate outdoor exercise area that is adjacent to the Restricted Housing Unit, where detainees in segregation may exercise separately.

There is a recreation schedule posted each week that lists the time each dormitory is allowed to use the outdoor recreation areas. The schedule provides for each housing unit to use the outdoor recreation areas for one hour each day, seven days a week. The schedule rotates so that a housing unit that goes to the outside recreation in the morning one day, goes out in the afternoon the next day.

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[17] The identity of Detainee # 2 is contained in Appendix A.

[18] We will address the allegation regarding forcing the detainees to carry bunks and the allegation of restricted or denied access to recreation in this report. The other allegations in this complaint will be addressed in a separate report by the CRCL team environmental health expert,(b) (6) .

[19] The large yard areas are dirt with no grass or turf.

During our investigation, we observed the schedule being followed and detainees engaged in activity in the outdoor recreation areas in the mornings and afternoons. Detainees may refuse to participate in the outdoor recreation period each day when their housing unit is scheduled to use the outdoor recreation areas.

Findings:

- The allegation that Detainee # 2 was forced to carry bunk beds into the housing unit is "**Not Substantiated**." While there was evidence that detainees may be asked to voluntarily help with such tasks, there was no evidence that officers coerced detainees to work or help involuntarily. It is not possible to definitively determine that this allegation did not occur with a particular officer eight months ago. However, in my opinion, it is unlikely that this happened as alleged, based on current practices at WTDF.
- The allegation that recreation is either denied or limited to one hour per week is also "**Not Substantiated**." Again, while it is not possible to definitively rule out what may have happened eight months ago, the current recreation schedule of outdoor recreation, one hour a day, seven days a week, is being followed at WTDF.

Recommendations:

- None related to this complaint.

Complaint Nos. 18-04-ICE-0312 and 18-050ICE-0318

These complaints were received by CRCL on January 30, 2018, and February 21, 2018 by email from the DHS OIG regarding allegations of inadequate medical care and inferior conditions of detention made by Detainee # 3.[20] Detainee # 3 specifically alleged that the medical care he was scheduled for at the El Paso Service Processing Center was not being provided to him at the WTDF.[21] He also alleged that telephone costs at WTDF were much higher than at other detention facilities and that detainees were not provided with a change of clean clothing during the week.[22] Lastly, Detainee # 3 alleged that the law library access at WTDF was inadequate.

Analysis:

While at the facility we reviewed the WTDF Detainee Legal Activities Procedure to determine the operational directives for detainee access to legal services and the law library. We also interviewed the legal activities officer and reviewed the law library logs which list names, dates and times when detainees accessed the law library.

The law library logs indicated that Detainee # 3 accessed the law library on a regular basis. The logs verified that between February 15, 2018 and April 5, 2018, while housed at WTDF, Detainee # 3 was in the law library every day, Monday through Friday for at least an hour each

[20] The identity of Detainee # 3 is contained in Appendix A.
[21] This allegation will be evaluated by the CRCL medical expert, (b)(6), in a separate report.
[22] These allegations will be addressed by (b)(6) CRCL environmental health expert, in a separate report.

day.[23] The law library log also indicated that approximately 25 – 30 detainees, on average, access the law library each day, Monday – Friday between 8:00 am and 12:00 pm. Documentation indicated that the ICE officials update the Lexus Nexus computerized legal material quarterly.

This was the only law library complaint we received or heard during this investigation and the law library appears to be functioning efficiently and effectively in providing access to legal material.

Findings:

- The allegation that Detainee # 3 did not receive adequate access to the law library at WTDF is "**Unfounded**." Sufficient evidence exists to determine that the detainee's allegation is without merit. He did in fact receive adequate access to the law library.

Recommendations:

- None related to this complaint

Complaint No. 17-05-ICE-0317 and 18-05-ICE-0320

These two complaints were received by CRCL from the OIG on February 20, 2018, in which Detainee # 1 and Detainee # 4 alleged that there was inadequate staff-detainee communications at WTDF. Specifically, they both alleged that their ICE Deportation Officers (DO) were not providing them with sufficient information regarding their cases.

Analysis:

In order to thoroughly investigate this allegation, we interviewed the ICE AFOD (acting), several WTDF managers and randomly selected detainees. We learned that the assignment of ICE DOs to the WTDF is not a permanent assignment. Apparently, when ICE officers are assigned to the WTDF it is considered a temporary, 45-day rotational assignment.

The detainees interviewed indicated that the WTDF staff are generally professional, helpful and respectful during staff/detainee interactions. However, most indicated that they did not know who their assigned DO was; that their assigned DO did not come to the facility and provide them any information; or, that when they did speak with their assigned DO, he was rude and disrespectful, even in some cases, telling them to "shut up."[24] There were no positive comments from the detainees about the ICE officers similar to the positive comments we received about the WTDF officers.

[23] The NDS 2000 requires access to the law library a minimum of five hours a week. Detainee # 2 greatly exceeded this minimum requirement and was in the law library for more than two hours on many days.

[24] We also noted that there was a disturbance between the detainees and staff at the facility last February that was sparked by a conflict between detainees and an ICE officer that led to the detainees assaulting the ICE officer by throwing objects at him.

WTDF managers indicated that the continued rotation of DOs presents a problem in continuity of services for the managers at WTDF, because they are unable to forge positive and productive consistency in their working relationships with the ICE employees. They also indicated that they too have been hearing complaints from the detainees about their assigned DO and that it would be easier to resolve issues for the detainees if the ICE DOs were not so often rotating in and out of the facility.

The acting ICE AFOD also acknowledged that the rotation of his DOs is problematic, and he would like to resolve it before the beginning of the 2019 calendar year.[25] The acting ICE AFOD indicated that he was aware of the concerns expressed by the facility staff and the tension between the detainees and his DOs.[26] The names of the DOs specifically named in the two complaints were given to the acting ICE AFOD.

In fairness to the DOs, by the time detainees are placed at the WTDF, most have already had their deportation hearings and are simply awaiting arrangements for removal. Accordingly, there may not be much information available that needs to be shared with these detainees for the most part, except to tell them that the specifics regarding their removal cannot be shared. However, we did speak with some detainees that had legitimate concerns regarding decisions pertaining to their asylum hearings and reunification with their children. These questions are legitimate, and providing some information about what to expect, or who to contact and the approximate timeframes for decisions, would go a long way to alleviate some of their anxiety and frustration. The ICE DOs are clearly not communicating appropriately with the detainee population at WTDF.

Findings:

- The allegation that there is inadequate communications between ICE DOs and the detainees at WTDF is "**Substantiated**." Based on the complaints, the serious incident involving the DO and the angry detainees, and the observations of the WTDF managers and the acting ICE AFOD, there is sufficient evidence to substantiate that communications between the DOs and the detainees is inadequate.

Recommendations:

- The ICE AFOD and the Warden should assess the manner in which the ICE officers interact and conduct business with the detainees at tables in the housing unit dayrooms and consider modifying the approach as to how, when and where the ICE officers meet with detainees to improve communications. The ERO should ensure that the ICE officers assigned to the WTDF are provided appropriate training and oversight regarding expectations for their interactions with detainees. (**NDS 2000, Staff-Detainee Communications Standard, III, A.**)

[25] Apparently, these assignments being temporary assignments is an issue that has been negotiated in the ICE officer union contract and must be renegotiated to make the assignment permanent like other assignments.
[26] We noted that the ICE officers conduct business with the detainees at dayroom tables in the housing units. This is not a good environment to conduct business and pass information among dozens of detainees simultaneously.

- The ICE AFOD should pursue making DO assignments to the WTDF a permanent assignment and assign officers who are willing to live and work in the area. (**Best Practices**)

Complaint No. 18-06-ICE-0156 and 18-06-ICE-0321[27]

This complaint was received by CRCL from the Texas A & M Law School and the University of Texas Law School on May 22, 2018, on behalf of 80 Somali National detainees. The complaint alleged several violations of civil rights and civil liberties for this group on 80 detainees, and contained very specific allegations attributed to specific detainees. Because this complaint is complex with many components, I separate the complaint into its component parts and address the allegations pertaining to each part, as follows:[28]

- Excessive use of force, including the indiscriminate use of OC spray
- Inadequate medical care following uses of force
- Wrongful segregation
- Staff-on-detainee sexual assault
- Threats, intimidation and verbal abuse by officers
- Denials of requests to communicate with the Consulate
- Coercion and due process

Analysis:

Excessive Use of Force and Inadequate Medical Care Following Uses of Force:
The Complaint alleged that WTDF officers indiscriminately used OC spray, used excessive and unnecessary force and did not provide adequate medical care following a use of force incident.

Analysis:

Between November 2017 and August 2018 there were thirteen uses of force at WTDF, which averages to 1.4 uses of force per month over the past 9 months.[29] This would at least imply on its face that WTDF staff do not rely heavily on using force to control or manage the detainee population.

The group of Somali National detainees represented in this complaint were housed at WTDF from February 23, 2018 through March 1, 2018: a period of one week. There were five

[27] Complaint No. 18-06-ICE-0321 is a complaint filed anonymously by a former detainee on March 14, 2018, alleging that there was an incident in which an officer sprayed him with "mace" and then denied him medical care. It is likely that this allegation arose out of the group incident that occurred on March 1, 2018, which will be addressed in the group complaint filed by the Law Schools of Texas A & M and University of Texas.
[28] In addition to the allegations listed, the additional allegations from this group included unsanitary conditions and denial of religious diet which will be addressed by the CRCL environmental expert, Diane Skipworth, in a separate report.
[29] This is less than might be expected in a facility with a population of over 500 detainees.

incidents in which force was used, four of which involved detainees named in this group complaint between February 23, and March 1, 2018. I thoroughly reviewed and evaluated each of these incidents by reading the reports, watching videos that captured events and interviewing available WTDF staff who were present and involved in the incidents.

For background, the WTDF staff and managers who were interviewed regarding the events of that week involving this group of detainees indicated that when this group of detainees arrived at WTDF they were angry, frustrated and agitated regarding their deportation status. The detainees were angry at ICE officers because they believed the information they were given was not accurate and they believed the ICE officers lied to them. Efforts by the WTDF staff and facility officers to calm their feelings were not effective and the detainees were uncooperative, causing disruption at every opportunity.

On February 23, 2018 there were three incidents involving use of force with detainees named in this complaint. The first of these involved Detainee # 5.[30] The incident occurred in a general population dormitory where Detainee # 5 was banging on the entrance door gate and demanding to speak with the officer. The officer opened the gate and Detainee # 5 charged the officer, assaulting him. The officer used force to subdue and restrain the angry detainee. I concluded that the force used was necessary in self-defense and to restrain the aggressive and assaultive detainee. The detainee was taken to medical for evaluation and the incident was well documented.

The second incident on February 23, 2018, involved a fight between Detainee # 6 and Detainee # 7.[31] When an officer witnessed Detainee # 6 strike Detainee # 7, he ordered them to step back and separate. Initially, the two detainees complied, then one detainee ran towards the other and the officer, grabbing the aggressive detainee by the arms and shoulders, restrained the detainee, bringing an end to the fight. I concluded that the force used was minimal to keep the one detainee from attacking the other detainee. The detainees were escorted to medical for evaluation and the incident was well documented.

The third incident on February 23, 2018, involved Detainee # 8 and Detainee # 9 fighting in a crowded housing unit's dayroom.[32] Other detainees immediately joined in and began throwing punches. None of the detainees complied with officer orders to stop fighting and disperse. The lieutenant who was present in the housing unit then deployed OC to stop the fighting detainees and disperse the crowd. The fight stopped and the involved detainees were removed from the housing unit. I concluded that there was no physical force used by the officers as the detainees complied and stopped fighting once the OC was administered. Shortly thereafter, detainees were removed from the housing unit for decontamination of the area. Detainees were taken to medical for evaluation and the incident was well documented.

[30] The Identity of Detainee # 5 is contained in Appendix A.
[31] The identities of Detainee # 6 and Detainee # 7 are contained in Appendix A.
[32] The identities of Detainee # 8 and Detainee # 9 are contained in Appendix A.

The fourth incident involving force that occurred during the week in question, occurred on February 28, 2018, and involved Detainee # 10, a female detainee.[33] I concluded that physical force was used in this incident to place the uncooperative female detainee into a suicide smock in the medical unit, as ordered by mental health. The video of the incident clearly indicated that only minimal force was used to overcome the detainee's mostly passive resistance and there was no injury. The incident was well documented.

The fifth incident involving force during this period occurred on March 1, 2018, and involved several of the complainant detainees in a housing unit. Because this incident involved the use of OC, which was deployed toward a large group on detainees who were aggressive and refusing to follow orders to back away from the officers in the housing unit, it was difficult to determine exactly which detainees were immediately present and may have been affected by the OC. The incident may be described as follows:

> There was an ICE DO in a housing unit speaking with several angry Somali National detainees. The detainees became increasingly agitated and then began throwing items at the DO. The DO exited the dormitory and the Warden and the Captain entered the housing unit with a few other WTDF officers and began speaking with the detainees in an attempt to calm the group. They were unable to deescalate the group tension and the detainees were yelling and threatening the staff with physical violence. The Captain ordered the detainees to return to their bunks and after several refusals, deployed OC into the crowd of detainees to back them away from the WTDF staff who were present in the area. The detainees immediately dispersed and several were removed from the housing unit and decontaminated.

The video of the incident clearly depicts the scenario as reported by the WTDF officers present and there was no physical force used in this incident. It was unclear based on the incident report whether all detainees who may have been residually exposed to the OC were decontaminated and medically evaluated. Every detainee who is present in a housing unit at the time OC is deployed is potentially exposed to the chemical agent. Since detainees involved in this incident were not listed by name in the incident report, I was unable to determine if everyone who was potentially exposed was given the opportunity for decontamination.[34]

Findings:

The allegations that there is excessive use of force and indiscriminate use of OC spray at WTDF is "**Unfounded**" based on the following:

- There were four use of force incidents involving the complainants, all occurring between February 23, and March 1, 2018. I concluded that all of the uses of force

[33] The identity of Detainee # 10 is contained in Appendix A. This detainee was not one named in the group complaint being reviewed, but the incident was evaluated to determine the appropriateness of the force.
[34] Although, all the detainees in the dormitory did have access to running water to self-decontaminate if necessary, and we were advised the affected area was decontaminated.

were objectively reasonable and necessary to address the non-compliant, violent or aggressive behavior of the involved detainees.

- In each incident, where appropriate, the WTDF officers made reasonable efforts to deescalate the need to use force and only used the force necessary to overcome the resistance presented.
- There were only two incidents involving the complainant detainees in which OC was used. In both instances the use of the OC was necessary, appropriate and not excessive or indiscriminate.
- There were no significant injuries as a result of the force used.[35]
- Many of the specific complaint allegations were from detainees who were not directly involved in a use of force incident. For example, one detainee alleged that he was hit with a baton, however, he was not involved in a use of force incident at WTDF and the officers at WTDF do not carry batons. Batons are not utilized at the facility. Another detainee alleged that officers aimed firearms at his face, but the officers at WTDF do not have firearms.

The allegation that medical care following uses of force is inadequate is "**Not Substantiated**" based on the following:

- Medical follow-up evaluation was provided in each instance where detainees were specifically identified as being involved in the force, either physical force or from chemical agent exposure.
- Most of the detainees listed in this complaint that alleged lack of medical care following a use of force were not directly involved in any use of force incident.
- It was unclear based on the incident report of March 1, 2018, whether all the detainees who may have been residually exposed to the OC were decontaminated and medically evaluated. Every detainee in a housing unit at the time OC is deployed is *potentially* exposed to the chemical agent. Of course, not all are exposed. However, since detainees involved in this incident were not listed by name in the incident report, I was unable to determine if everyone who was potentially exposed was given the opportunity for decontamination.

Recommendations:

- WTDF should ensure that, if there are future incidents involving several detainees in which OC is deployed in an enclosed area such as a housing unit, all detainees who are potentially exposed to the OC are identified in the incident report and that decontamination is conducted and documented. (**Best Practices**)

[35] Use of Force Injury Reports indicated no injury in most instances and only minor bruises or abrasions in a few cases.

Wrongful Segregation:

The complaint filed on behalf of the Somali National detainees listed eight detainees who alleged that they were wrongfully segregated in the Restricted Housing Unit. The allegations included claims of being placed in segregation for requesting socks and underwear, for asking to be returned to Somalia, for complaining of pain, and for no valid reason.

Analysis:

Records were researched and managers interviewed to determine which of the eight detainees listed in the complaint were placed in segregation and, if placed, the reason for the placement. Records indicated that, of the eight detainees alleging placement in segregation, only one was actually placed in segregation during the week the group was at WTDF. The other seven detainees making the allegations were never placed in segregation and were housed in the general population during the entire week they were detained at WTDF.

The one detainee who was placed in segregation, Detainee # 5, alleged that he was placed in segregation without cause. In fact, the record indicates that Detainee # 5 was placed on segregated status in the Restricted Housing Unit because he assaulted staff on February 23, 2018.[36] Based on our review of the segregation records at WTDF we found no evidence to conclude that detainees were placed in segregated housing without justification and appropriate documentation.

Findings:

- The allegation that detainees were wrongfully placed in segregation is "**Unfounded.**" Seven of the eight who were allegedly wrongfully placed in segregation were, in fact, *never* placed in segregation. The one who was placed in segregation was placed there with good cause and appropriate documentation was completed.

Recommendations:

- None related to this element of the above complaint.

Staff-on-Detainee Sexual Assault:

The complaint alleged that Detainee # 11[37] was sexually assaulted "multiple times" by WTDF officers who fondled his penis and groin area over his clothing while pushing him against the wall.

Analysis:

While on-site at WTDF we interviewed the SAAPI Coordinator to determine if Detainee # 11 had filed a sexual assault allegation while at WTDF. There was no record demonstrating that

[36] The identity of Detainee # 5 is contained on Appendix A. This is the same detainee identified in the section above as assaulting an officer during the February 23, 2018 use of force incident.
[37] The identity of Detainee # 11 is contained in Appendix A.

Detainee # 11 ever reported his allegation to WTDF staff. Therefore, there has been no formal investigation of the allegation at the facility and no way to determine if, in fact, there was an incident or incidents that could be attributed to this allegation. However, based on the details provided in the allegation, it is possible that the allegation of sexual assault is related to the clothed body searches that are routinely performed on detainees in detention. The allegation stated the detainee was sexually assaulted "multiple times." Clothed body searches or "pat searches" may be conducted daily, sometimes multiple times daily, as detainees move from area to area within the detention setting. This is done to prevent the introduction or transportation of contraband throughout the facility. Pat searches necessarily involve contact between the officer's hand and the genital area of the person being searched.

Findings:

- The allegation that Detainee # 11 was sexually assaulted "multiple times" by WTDF officers is "**Not Substantiated**." Because there is no record of the complaint ever being made at the facility, I was unable to determine the circumstances related to the complaint or to determine what may or may not have happened.

Recommendations:

- None related to this element of the complaint.

Threats, Intimidation and Verbal Abuse by Officers:

The complaint alleged that WTDF officers threatened the named detainees with physical violence, in one case by holding scissors to the detainee's throat; in another case by threatening to stab the detainee with a handcuff key; and, in another case by aiming a firearm at the detainees and threatening to shoot everyone. The allegations also stated that officers were threatening detainees with OC spray and calling the detainees derogatory names, including "nigger," "monkey," "Stupid Motherfucker," "terrorist," and "animal."

Analysis:

In an effort to determine what evidence may exist to evaluate this element of the complaint, we attempted to examine the tenor and tone of the facility by interviewing some officers and dozens of detainees present at the facility during the on-site. The detainees nearly unanimously indicated that the relationship between the WTDF officers and the detainee population is respectful and helpful. Of course, some officers were described as kinder and more cordial than others, but the detainees had no complaints about ill treatment by the officers at WTDF. Most detainee comments regarding the facility officers were positive.

As indicated earlier in this report there are relatively few uses of force at WTDF and the attitude of the staff actually seems to demonstrate a desire to assist the detainees with their issues and concerns. The attitude and demeanor we observed was not punitive, rather, it was one more towards assisting the detainees where ever possible. Name-calling would seem out of character for the staff at WTDF based on what we observed on-site.

The nature of some of the allegations cast some serious doubt on their veracity because, for example, detention facilities do not normally have scissors in the facility and they most certainly do not have firearms. They do, of course, have OC and it is possible that an officer could point his/her OC canister at a detainee and threaten to spray them. I'm not sure what that would accomplish, but it is certainly possible.

Findings:

- The allegations that WTDF officers threatened detainees with physical violence, (OC, scissors, handcuff keys and firearms) and used derogatory racial slurs, is "**Not Substantiated**." While it is possible that officers acted inappropriately by making threats and using unprofessional language, we did not find evidence of that or that the environment at WTDF is conducive to that type of conduct.

Recommendations:

- None related to this element of the complaint.

Denial of Requests to Communicate with the Consulate:

The complaint included allegations from two detainees who stated that calls to the Somali Embassy were "cut off after 60 seconds" and that the number provided by the facility did not connect to the embassy.

Analysis:

While on-site we inspected housing unit postings and we interviewed the WTDF officer who supervises legal phone call requests. The phone numbers for the consulates were listed on ICE posters attached to the bulletin boards inside the housing units. The detainees were able to call the consulate of their choice from the telephones in the dormitories. Facility staff stated that they had not heard detainees complain that the consulate phone numbers malfunctioned or that detainees had difficulty contacting consulates using the numbers provided on the ICE posters.

The WTDF officer in the legal services area where legal calls and attorney visits take place indicated that she did not get requests to call the consulates because the detainees were able to contact consulates from the phones inside the housing units. She was not aware of any problems getting through to the consulate via the facility telephones.

Findings:

- The allegations that calls to the Somali Embassy were "cut off after 60 seconds," and that the number provided by the facility doesn't connect with the embassy is "**Not Substantiated**." While the two detainees who alleged this problem may have had a problem getting through to the consulate by telephone on a given occasion, there was no evidence of that or of on-going difficulties making phone contact with the consulates.

Recommendations:

- None related to this element of the complaint.

Coercion and Due Process:

The complaint included an allegation from Detainee # 12 that ICE DOs "pressured" him to sign documents without explaining what they were and did not provide him with needed translation. He alleged that he would never have signed the documents had he known their purpose.

Analysis:

While this group complaint provided the name of the detainee making the allegation, it did not provide sufficient detail to effectively determine if the alleged incident, in fact, happened.[38] However, throughout this on-site investigation we looked into the manner in which the ICE DOs conducted business with, and interacted with, the detainees. Additionally, we were provided with information that suggests that the WTDF staff generally use the language line when translation is needed in such instances as the provision of medical care or during intake processing. However, having heard many detainee complaints about the manner in which the ICE officers interacted with detainees at tables in the open dayroom areas of the housing units, I conclude that it is highly unlikely that the ICE officers are using the language line for detainee translation needs in that setting. Accordingly, it is possible that Detainee # 12 did not understand what he was signing.

On the other hand, it is unclear how an ICE officer could "pressure" a detainee into signing something he did not understand, particularly if a language barrier prevents the two from effectively communicating. It would be difficult to pressure someone using the English or Spanish language if that person did not understand the language being spoken. Accordingly, it is difficult to determine exactly how this may have happened.

Findings:

- The allegation that ICE officers "pressured" Detainee # 12 into signing documents without explaining what they were and did not provide him with needed translation is "**Not Substantiated**." There is no way to definitively determine if or how this may have occurred. However, if this detainee indeed needed language translation, it is unlikely that it was provided.

Recommendations:

- The AFOD and Warden should review and assess the process used by the ICE DOs to conduct business with detainees at tables in the housing unit dayrooms and consider modifying the approach to how, when and where the DOs meet with detainees, in

[38] For example, the name of the ICE DO alleged to have "pressured" the detainee into signing documents without explaining what they were was not provided to CRCL

an effort to improve communications. (**NDS 2000, Staff-Detainee Communications Standard, III, A.**)

VII. Additional Review and Findings:

In addition to the specific complaint issues we reviewed, we also reviewed the following issues and facility operational areas generally. These areas of WTDF operations and my observations of each are discussed below:

- Use of Force
- Restricted Housing Unit (RHU) (Segregated Housing)
- Sexual Abuse and Assault Prevention and Intervention (SAAPI)
- Detainee Grievance System
- Visitation
- Recreation Program
- Mail Services
- Religious Services
- Legal Library Services

Use of Force

The NDS 2000, Use of Force standard requires that, "Staff shall prepare detailed documentation of all incidents involving the use of force...Written procedures shall govern the use of force incident review...The review is to assess the reasonableness of the actions taken." The NDS also requires that, "the OIC (Warden), the Assistant OIC (Assistant Warden), the CDEO (AFOD) and the Health Services Administrator shall conduct the after-action review. This four-member After-Action Review Team shall convene on the workday after the incident. The After-Action Review Team shall gather relevant information, determine whether policy was followed and complete an after-action report, recording the nature of the review and findings."[39]

Analysis:

As previously indicated in the complaint investigation discussion regarding the use of force at WTDF, there have been 13 incidents in which some level of force was used during the past 9 months.[40] We reviewed all 13 of the incident reports to get a good understanding of each circumstance in which force was used, the reporting and documentation of the force and the after-action review process employed by WTDF management.[41] Our general impression is that the documentation of force is thoroughly prepared and properly evaluated by the Warden. In each incident package, all personnel who either used or observed force prepared a report to document their involvement.

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[39] INS 200, Use of Force, II, Applicability; and, III, K, After-Action Review of Use of Force and Application of Restraints.

[40] Four of those incidents of force were involving a single group of detainees during a seven day period of time in February 2018.

[41] Our review of force incidents also included the review of video footage in the incidents in which video was taken.

In reviewing the force incidents it was apparent that most of the force used was related to detainees resisting restraint or escort, or to stop detainees from fighting. There were no force incidents that resulted in serious injury and the level of force used appeared to be consistent with the level of resistance encountered.

In reviewing force incident reports, it was apparent that each WTDF officer observing or using force documents his/her actions and observations in a written report and submits that report before leaving shift. In reviewing the officers force reports, we determined that some staff training is needed to ensure that insufficient outcome-oriented phrases in the reports such as, "we placed him on the floor," or, "I secured the detainee's right arm," or, "I gained control of the detainee," must be accompanied by language that *specifically describes* the forceful actions taken or the specific force applied. It is more important to describe the actual actions taken and the level of force exerted to overcome resistance, rather than to leave it to the reader to imagine how much force was used to "place him on the floor," or to, "gain control of the detainee."[42]

It is difficult to accurately evaluate the appropriateness of a use of force if the specific actions of involved staff are not descriptive. The threat perceived, efforts made to temper the force response, the need to use force, the amount of force necessary to overcome resistance, and the extent of any injury are difficult to determine and judge without reports that accurately depict the detailed actions of each participant.[43] This was discussed with the Warden and Assistant Warden, who indicated that they intend to follow-up with officer training on this issue.

All force incidents that we reviewed at WTDF had after-action review documentation indicating that the incidents were reviewed and evaluated by the Warden. In evaluating the after-action review process, it was apparent that the Warden reviews all written documentation, including any clinical personnel involvement, and any available video recordings for each incident.

While the NDS 2000 only specifically requires the Service Processing Centers (SPCs) and Contract Detention Facilities (CDFs) to conduct after-action reviews with a team comprised of the Warden, the Health Care Administrator and the AFOD, it also requires that, if IGSA facilities such as WTDF choose to "adopt, adapt or establish alternatives to the procedures specified for SPCs/CDFs, they must meet or exceed the objective represented by the standard."[44] Clearly, the review conducted by the Warden, without the participation and input from the other facility managers, does not meet or exceed the standard. Input and evaluation by all stake-holder administrators provides great value in ensuring that the different disciplines are working together and effectively supporting each other in the effort to provide accountability and oversight for use of force.

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[42] While the reports have enough detail to determine the officers' actions generally, (and the videos support the level of force used), the use of the outcome-oriented phrases detracts from the specificity and professionalism of the reports.

[43] These standards are outlined in the US Supreme Court Case, Hudson V. McMillan (503 U. S. 1, 112 S. Ct. 995).

[44] NDS 2000, Use of Force, II, Applicability.

The reviews by the Warden were timely but were not documented as thoroughly as should be expected. In the after-action review, the Warden uses a check-the-box form to document and verify that force incidents are reviewed and evaluated. None of the after-action reviews included any narrative of issues considered by the Warden or any description of recommended follow-up with the involved personnel.[45] While these discussions and considerations may be taking place, there is no way of knowing that without documentation.

In my experience reviewing thousands of force incidents, it is common to have discussions about the appropriateness of actions taken in response to different scenarios presented in force incidents and recommendations for possible alternative actions that may be implemented in future similar situations. While my interviews and discussions with the Warden leads me to believe that his reviews include this higher level of scrutiny and evaluation, the after-action review documentation does not reflect it.

Recommendations:

- WTDF should employ the NDS 2000 standard for an After-Action Review Committee, including at a minimum, the Facility Administrator (Warden), the Health Services Administrator and the AFOD. **(NDS 2000, Use of Force, II, Applicability, and III, K, After-Action Review of Use of Force and Application of Restraints Incidents.)**
- WTDF should provide training to the facility officers to ensure use of force reports include language that specifically describes the forceful actions taken. Specific actions taken to overcome resistance must be described in a good use of force report. **(Best Practices)**
- WTDF should expand the check-the-box, After-Action Review Form to include the reviewers' considerations or discussions of the force incident and tactics, and any follow-up considerations for each incident reviewed. A description of the issues discussed and evaluated should be included in "comments" on the After-Action Review Form to memorialize the review and any actions to be taken. **(Best Practices)**

Restricted Housing Unit (RHU) (Segregation)

The NDS 2000, Special Housing Unit, requires that, "Each facility will establish a Special Management Unit that will isolate certain detainees from the general population...separation from the general population (is) used when the continued presence of the detainee in the general population would pose a danger to self, staff, other detainees, property or the security and orderly operation of the facility." It also requires that, "A written order shall be completed

[45] Many times in force reviews training issues are identified or tactics are considered such as, techniques for early intervention or force avoidance that may mitigate the need to use force. While the Warden indicated he did this, it was not documented on the After-Action Report.

and approved by a supervisory officer before a detainee is placed in administrative segregation..."[46]

Analysis:

It appears that the RHU at WTDF is utilized very sparingly and as a last resort for the safety of detainees and the facility staff. At the time of our on-site there were three detainees in the RHU.[47]

Segregation Orders are completed when a decision is made to place a detainee in administrative segregation. Reviews of administrative segregation placements are being conducted within appropriate timeframes and access to recreation, showers, phones, law library, etc., are provided per the NDS 2000. All services and activities are logged on the segregation forms kept for each detainee in the RHU.

Documentation for retention hearings and disciplinary hearings is completed and placed in the detainee files. Security checks are conducted every 30 minutes in the RHU, unless medical or mental health clinicians determine checks are to be done more frequently. The operation of the RHU at WTDF is in compliance with the NDS 2000.

The required documentation for placement into the RHU is completed by entering the detainee's name, identification number and reason for placement on the Administrative Segregation Order Form. Reviews of the segregation placement are also documented on the form.[48] If a disciplinary rule infraction is the basis for the placement, a disciplinary report is issued to the detainee and a disciplinary hearing is held within three days.

However, although the segregation form requires that the reason(s) for placement be documented on the form, the form does not have a place to document the reason(s) for release; it only requires a signature of the official making the decision to release the detainee. Specifically, with protective custody placements in segregation, it is important to briefly describe not only the circumstances as to why the protective custody placement is necessary, but also, why it is appropriate to release a detainee back to the general population. The forms should be modified to provide for a space to give the brief description of circumstances that make release from protective custody status appropriate. In this manner the considerations or circumstances that led to the decision to release and individual are documented.

Recommendations:

- WTDF should revise the segregation forms to require a brief narrative regarding the reason(s) or reasoning for release from segregated housing. (**Best Practices**)

[46] INS Detention Standard I., and III, B.

[47] Three detainees in segregated housing is less than might be expected out of a population of approximately 500 detainees in the facility (less than 1 % of the population).

[48] Segregation placement reviews are conducted by the third day, and if retained in RHU, every seven days thereafter until released.

Sexual Abuse and Assault Prevention and Intervention (SAAPI)

The NDS 2000 is silent on SAAPI and does not establish standards that must be followed. The PBNDS 2011 SAAPI standards contain a multitude of specific requirements that must be implemented to ensure compliance. Understanding that, while WTDF is not being held to the letter of the PBNDS 2011, there are certainly requirements and obligations under the National Standards to Prevent, Detect and Respond to Prison Rape as published by the USDOJ. The CRCL team reviewed and evaluated the process used by WTDF to respond to allegations of sexual abuse or assault in light of these standards.

Analysis:

Based on our on-site investigation, it was apparent that the WTDF management posted appropriate notifications throughout the facility, making detainees and employees aware of the zero tolerance policy for sexual abuse and assault. A SAAPI pre-screening process is in place and utilized during the detainee intake and classification process. The standard intake process includes the risk assessment tool necessary to determine vulnerability and is included in every detainee intake file.

The SAAPI Coordinator was interviewed and described the prescribed process when an allegation of sexual assault or abuse is made:

- When allegations of sexual abuse or assault are made, the involved detainees are separated and medically examined; the detainees are moved to appropriate and safe housing; any possible crime scene is secured and processed; the detainees are interviewed by a medical and mental health clinician; and all required notifications are made to ICE. The SAAPI coordinator is to be immediately notified, and they subsequently notify the local county Sheriff.
- The Sheriff decides whether his office will conduct a criminal investigation based on the allegation(s). If, based on the allegation(s), the Sheriff declines to investigate, the case is assigned to a trained shift supervisor for investigation. The completed investigation is provided to the SAAPI Coordinator, who determines the findings as substantiated, not substantiated, or unfounded.

While the SAAPI Coordinator at WTDF was able to articulate the processes to be utilized when an allegation of sexual abuse or assault is made, she indicated that she has not managed any allegations since being placed in the Coordinator position.[49] She indicated that she has received training. However, because there have been no allegations at WTDF since her assignment, she is inexperienced with the process and suggested that she would benefit from spending some time with the experienced SAAPI Coordinator at the El Paso Service Processing Center. We agree.

[49] She indicated that there has been only one case in the past year, but it involved a detainee at WTDF that made an allegation regarding an occurrence at the El Paso Service Processing Center that did not involve WTDF.

In response to the CRCL request for records, the ICE ERO provided a SAAPI log indicating there were nine (9) SAAPI allegations at WTDF in the past year; six (6) in 2018. This, of course, was not consistent with what we were told by the WTDF SAAPI Coordinator. When inquiry was made with ICE ERO requesting the nine investigations, we were told that the log provided was from the EL Paso AOR and did not specifically pertain to the WTDF. Accordingly, we have no SAAPI allegation investigations to evaluate at this time for tracking or evaluating investigative quality.

The WTDF SAAPI Coordinator has a logging and tracking system to account for the SAAPI process if and when an allegation occurs. The log for tracking the SAAPI allegations is inadequate and does not include all the information necessary to ensure compliance to the required SAAPI standards.[50] In our judgement, she is not currently well-prepared to oversee SAAPI allegations and would benefit greatly from additional and immediate training from an experienced SAAPI Coordinator.

Recommendations:

- WTDF should send the assigned SAAPI Coordinator to El Paso Service Processing Center as soon as possible, to spend some time on temporary assignment, to observe the SAAPI tracking system and train with the SAAPI Coordinator at that facility. This will enable her to get familiar with SAAPI investigative reports and establish an adequate tracking process for WTDF. (**Best Practices**)

Detainee Grievance System

NDS 2000, Detainee Grievance Procedures, requires that, "Every facility will develop and implement standard operating procedures that address detainee grievances...providing written responses to detainees who file formal grievances, including the basis for the decision." The standard includes additional specific requirements that must be met for compliance, including that, "Each facility will devise a method for documenting detainee grievances. At a minimum, the facility will maintain a Detainee Grievance Log."[51]

Analysis:

We verified that grievance forms for both WTDF and ICE are available in each housing unit in both the Spanish and English language. During our on-site investigation, officers in the housing units were able to provide grievance forms upon request.

We noted that there was only one grievance filed with the WTDF in the past year. However, there were hundreds of grievances filed with ICE during the same time period. In an effort to

[50] The current SAAPI tracking log includes only the date and time of the allegation, the level (1, 2 or 3), the nature of the incident, (e.g. detainee on detainee), and report number. An adequate tracking log would include the ability to track the date and time of every required activity in terms of the notifications to facility and ICE managers, the assigned investigator, the investigation completion date, investigative findings, and etc.

[51] INS Detention Standard, Detainee Grievance Procedures, III, E.

determine why there were so few grievances filed with WTDF compared to so many with ICE, we interviewed case managers and detainees, and identified three possible reasons. First, most of the detainees arrive at WTDF after they have already had a deportation hearing and are awaiting removal. Accordingly, the average length of stay is very short in most cases. The short period of time at WTDF may be one reason for the lack of grievances.

Many detainees at WTDF told us that their most important issue was to learn when they were being removed. When we reviewed the stacks of grievances sent to ICE in the past year, we found that most were, in fact, asking when they were leaving the U.S.[52] Several of those ICE grievances were also complaining about the deportation process in general.

After our detainee group interviews, we also determined that detainee grievances may be few in number due to the constant contact that case managers have with detainees. Both the detainees and the case managers described how they are responsive to the detainees' needs and concerns. Without that amount and detainee contact and responsiveness, issues that may have otherwise been grieved, were being quickly being addressed by the case managers. However, also during detainee interviews, we learned that detainees did not understand the difference between "requests" and grievances, and when it was appropriate to file one rather than the other. It is possible that because detainee requests, including verbal requests, are quickly responded to in an appropriate manner by the case managers, the need to file a grievance is greatly reduced. Even so, it is important for detainees to understand the difference between the two processes. At the time of the CRCL onsite, they did not.

The single grievance logged at WTDF made it difficult to assess the grievance process, but the one grievance was appropriately handled. We neither received nor heard complaints regarding the grievance process while on-site.

Recommendations:

- Detainees at WTDF should be regularly instructed on the differences between grievances and requests, the grievance and request process, and how to file the corresponding forms for each. **(Best Practice)**

Visitation

NDS 2000, Visitation, requires that, "Facilities holding INS detainees shall permit authorized persons to visit detainees, within security and operational constraints."[53]

Analysis:

We interviewed the Visitation and Legal Services Coordinators. WTDF allows visitation for family and friends for male detainees on Friday and Saturday, 8:00 am – 5:00 pm; and, for

[52] The WTDF staff do not know when deportation removals are scheduled until they happen.
[53] INS Detention Standard, Visitation, I.

female detainees on Sunday and Monday, 8:00 am – 5:00 pm. Special visits may be scheduled on different days upon request to accommodate those visitors who are traveling long distances. All visits are non-contact and are limited to two adults and three children at any given time. Visits are routinely scheduled for 30 minutes each, but may be extended to 90 minutes to accommodate those traveling long distances. There are few visits at WTDF due to its remote location and the limited amount of time that most detainees remain at WTDF. We heard no detainee complaints about the general visitation program.

Legal visitation for attorneys operates Monday – Friday, 8:00 am – 5:00 pm. Attorneys may schedule a visit ahead or drop in for an unscheduled visit. Attorney visits may also be scheduled after hours or on weekends by appointment only. There are five attorney visitation booths where attorneys may visit detainees face-to-face through glass. Contact visits are allowed in private rooms if approved by ICE. There are approximately two to three attorney visits per week, on average.

The WTDF officer in charge of Legal Services is also responsible for attorney phone calls. There are 10 private booths for attorney phone calls that are located in the attorney visitation area. Detainees make a request to the Legal Services Officer, she brings them to the Legal Services area, and allows them to conduct the attorney call in private. There are approximately 20 attorney phone calls conducted weekly. There were no detainee complaints regarding attorney visitation or phone calls.[54]

Recommendations:

- None related to this process.

Recreation

NDS 2000, Recreation, requires that, "All facilities shall provide (INS) detainees with access to recreational programs and activities, under conditions of security and supervision that protect their safety and welfare."[55]

Analysis:

The recreation program at WTDF operates seven days a week. As indicated earlier in this report, there is a recreation schedule posted each week that indicates the time each housing unit may use the outdoor recreation areas. The schedule allows each housing unit to use the outdoor recreation areas for one hour each day, seven days a week. The schedule rotates so that a housing unit scheduled for outside recreation in the morning on one day, goes out in the afternoon on the next day.

[54] It is likely that there are so many more attorney phone calls than attorney visits each week because of the remote location of this facility.
[55] INS Detention Standard, Recreation, I.

During the on-site, we observed the schedule being followed and observed detainees engaged in activity in the outdoor recreation areas during the mornings and afternoons. Detainees may refuse to participate in the scheduled outdoor recreation period.

Indoor recreation is also available in the housing unit dayroom areas in the form of playing cards and board games. These activities are allowed during all programming time throughout the day and evening until lights out.

The NDS 2000 requires that outdoor recreation be available a minimum of one hour a day, five days a week, weather permitting. Our observation is that the recreation program at WTDF meets the requirements.

Recommendation:

- None related to this process.

Mail

NDS 2000, Correspondence and Other Mail, requires that, "All facilities will ensure that detainees send and receive correspondence in a timely manner, subject to limitations required for safety, security and orderly operation of the facility."[56]

Analysis:

We interviewed the Mailroom Supervisor. Outgoing mail is placed by detainees in locked boxes inside each housing unit. The mailroom staff picks up the mail daily, logs it in the mail log, ensures it is stamped or metered with postage and takes it to the local U. S. Post Office. The facility pays for postage for three personal letters per week and unlimited legal correspondence for indigent detainees. Detainees with funds may buy postage in the commissary. The mail log is kept for all mail, personal and legal, to verify that it was sent.

The incoming mail is picked up by mailroom staff at the local U. S. Post Office, logged into the mail log, sorted according to housing unit, opened to check for contraband and money orders, then delivered to the housing units and handed out to the detainees by the housing officers each evening.[57] Legal mail is opened in front of the detainee and searched for contraband, but is not read by the officers. Detainees are required to sign the legal mail log verifying that they have received the legal correspondence. The process used at WTDF is sound and we heard no complaints about the handling or processing of the mail.

Recommendations:

- None related to this process.

[56] INS Detention Standard, Correspondence and other Mail, I.

[57] If a check or money order is found in the mail, it is removed and placed on the detainee's account. The detainee is notified when funds are received.

Religious Services

NDS 2000, Religious Practices, requires that, "detainees of different religious beliefs will be provided reasonable and equitable opportunities to participate in the practices of their respective faiths. Opportunities will only be constrained by concerns about safety, security, the orderly operation of the facility, or extraordinary costs associated with a specific practice."[58]

Analysis:

We interviewed the WTDF Religious Services Coordinator. Christian and Catholic services are offered on a regular schedule each week by religious volunteers.[59] Services are held in housing unit dayrooms or in a multipurpose room. Muslims and Jewish services are also scheduled each week, however, the Religious Services Coordinator has been unable to locate a Muslim Imam or Jewish Rabbi to conduct the services. Accordingly, the Muslim and Jewish prayer services are self-led by the detainees when they wish to participate. Both religious groups are provided a scheduled time and place for the self-led services. All detainees are approved and welcome to participate in the weekly services.

Publications, such as Bibles and Qurans, are provided in English, Spanish and Arabic upon request. Detainees may make requests to the Religious Services Coordinator and she provides the publications. The library also has religious publications available to the detainees.

When detainees enter the ICE detention process they are asked to designate their religious preference. This is recorded on the initial intake forms during detainee processing. When a detainee requests a special diet, the Religious Services Coordinator refers to the intake record to determine if the request for a religious diet is consistent with the detainees' religious preference. The special diet request is also reviewed by Health Services to ensure that the requested religious diet is not contraindicated by any health problems the detainee may have.[60] In our interviews with detainees, we heard several complaints about the food in general, but did not hear complaints specifically regarding the religious diet accommodations.

Recommendations:

- None related to this process.

Law Library

[58] INS Detention Standard, Religious Practices, I.

[59] WTDF currently has sixteen religious volunteers who come to the facility on a regular schedule and provide services.

[60] The religious diets offered will be reviewed and assessed in detail in separate report by the CRCL environmental health expert, Diane Skipworth, as she conducts the review of the food services department at WTDF.

NDS 2000, Access to Legal Material, requires that, "Facilities holding INS detainees shall permit detainees access to a law library and provide legal materials, facilities, equipment and document copying privileges and the opportunity to prepare legal documents."[61]

Analysis:

We interviewed the Law Library Officer. The Law Library is in operation five days a week and is located in a common area and available to all the detainees at WTDF. There are six (6) computers programmed with the Lexus Nexus legal research program for detainees to use. These programs are available in several languages for non-English speaking detainees and are updated by ICE quarterly. The Law Library operates between 8:00 am and 12:00 pm daily for the ICE detainee population. Copies of legal materials are made for detainees upon request.

The Law Library Officer goes to each housing unit each morning and identifies the detainees who would like to use the law library. She then escorts them to the library and supervises the session. Sessions are most often limited to two hours each, but can be extended upon request when detainees have a deadline or time sensitive matter to address.

In reviewing the Law Library logs, it appeared that the average daily attendance was approximately 25 – 30 detainees. Detainees sign in and out for each session they attend. Logs of Law Library attendance were well kept and provided a good record of the time being utilized by each detainee.

None of the detainees interviewed indicated that law library access, availability or legal materials are deficient or inadequate.

Recommendations:

- None related to this process.

General Observations:

WTDF operates under the National Detention Standards established in September 2000. These standards have been revised several times over the past decade, with the newer versions including many specific requirements that WTDF is not required to follow. During our investigation, the leadership at WTDF, both the LaSalle management team and the ICE leadership, expressed their willingness to adopt some of the newer standards outlined in PBNDS 2011. For example, the composition of the Use of Force After-Action Review Committee as required by PBNDS 2011 that is currently not in effect at WTDF would be an improvement in force accountability. It is commendable that the Warden and AFOD are open to improving this process and we would encourage the continued movement towards the newer standards.

[61] INS Detention Standard, Access to Legal Material, I.

The personnel in leadership at WTDF are for the most part knowledgeable and professional. The tenor and tone of the facility was generally good and the interaction between detainees and officers appeared to be healthy. However, as pointed out to the WTDF leadership on site, the facility is not up to standards in terms of cleanliness and physical plant maintenance. I am certain there will be findings and recommendations from Diane Skipworth regarding the maintenance needs of the plant overall and the need for some major cleaning.

We sincerely appreciate the manner in which we were welcomed and assisted in our investigation by both the WTDF leadership team and the ICE AFOD and his team. Finding only a few NDS violation,[62] we hope our best practices recommendations will be sincerely considered in improving the facility operation.

Summary of Recommendations

The following is a summary of the WTDF recommendations made throughout the body of this report:

- The ICE AFOD and the Warden should assess the manner in which the ICE officers interact and conduct business with the detainees at tables in the housing unit dayrooms and consider modifying the approach as to how, when and where the ICE officers meet with detainees to improve communications. The ERO should ensure that the ICE officers assigned to the WTDF are provided appropriate training and oversight regarding expectations for their interactions with detainees.(**NDS 2000, Staff-Detainee Communications Standard, III, A.**)
- WTDF should employ the NDS 2000 standard for an After-Action Review Committee, including at a minimum, the Facility Administrator (Warden), the Health Services Administrator and the AFOD. **(NDS 2000, Use of Force, II, Applicability, and III, K, After-Action Review of Use of Force and Application of Restraints Incidents.)**
- WTDF should discontinue the practice of requiring the detainees to determine who will clean the housing units and follow their written Voluntary Work Program Procedure, assigning detainees to work assignments on a volunteer basis. The officers should be supervising the cleaning of the housing areas. (**Best Practice**)
- The ICE AFOD should pursue making ICE officers' assignments to the WTDF a permanent assignment and assign officers who wish to work in the area whenever possible. (**Best Practice**)
- WTDF should ensure that if there are future incidents involving several detainees in which OC is deployed in an enclosed area such as a dormitory that all detainees who are potentially exposed to the OC are identified in the incident report and that appropriate decontamination is conducted and documented. (**Best Practice**)

[62] This finding relates to the Development of a Use of Force After-Action Review Committee.

- WTDF should provide training to the officers to ensure use of force reports include language that specifically describes the forceful actions taken. Good use of force reports always describe specific descriptions of actions taken to overcome resistance. (**Best Practice**)

- WTDF should employ the PBNDS 2011 standard for an After-Action Review Committee, including the Facility Administrator (Warden), the Health Services Administrator and the AFOD. (**Best Practice)**

- WTDF should expand the check-the-box, After-Action Review Form to include the reviewers' considerations or discussions of the force incident and tactics, and any follow-up considerations for each incident reviewed. A description of the issues discussed and evaluated should be included in "comments" on the After-Action Review Form to memorialize the review and any actions to be taken. (**Best Practice**)

- WTDF should consider revising the segregation forms to require a brief narrative regarding the reason(s) or reasoning for release from segregated housing. (**Best Practice**)

- Detainees at WTDF should be regularly instructed on the differences between grievances and requests, the grievance and request process, and how to file the corresponding forms for each. (**Best Practice**)

APPENDIX A

- (b)(6)