

# **Results of Office of Inspector General FY 2016 Spot Inspections of U.S. Immigration and Customs Enforcement Family Detention Facilities**





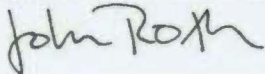
## OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Washington, DC 20528 / [www.oig.dhs.gov](http://www.oig.dhs.gov)

June 2, 2017

MEMORANDUM FOR: Thomas D. Homan  
Acting Assistant Secretary  
U.S. Immigration and Customs Enforcement

FROM: John Roth   
Inspector General

SUBJECT: *Results of Office of Inspector General FY 2016 Spot  
Inspections of U.S. Immigration and Customs  
Enforcement Family Detention Facilities*

Attached for your information is our report, *Results of Office of Inspector General FY 2016 Spot Inspections of U.S. Immigration and Customs Enforcement Family Detention Facilities*. As part of our ongoing oversight of detention conditions, we completed unannounced inspections of three U.S. Immigration and Customs Enforcement (ICE) family detention facilities. During these inspections, nothing came to our attention that warranted serious concerns about the health, safety, or welfare of the detained families. Specifically, we did not observe any conditions or actions that represented an immediate, unaddressed risk or an egregious violation of ICE's Family Residential Standards. The attached report contains details about the results of our inspections. We are making no recommendations in this report.

We received technical comments from ICE and the Office for Civil Rights and Civil Liberties; we incorporated these into the report as appropriate. Consistent with our responsibilities under the *Inspector General Act*, we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the final report on our website.

Please call me with any questions, or your staff may contact Andrew Oosterbaan, Assistant Inspector General for Investigations or Laurel Loomis Rimón, Acting Assistant Inspector General for Inspections and Evaluations, at (202) 254-4100.

Attachment



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### **Summary of Results**

During our July 2016 unannounced spot inspections of ICE's three family detention facilities, we observed conditions that generally met ICE's 2007 Family Residential Standards. The facilities were clean, well-organized, and efficiently run. Based on our observations, interviews, and document reviews, we concluded that, at all three facilities, ICE was satisfactorily addressing the inherent challenges of providing medical care and language services and ensuring the safety of families in detention.

We interviewed ICE and contractor staff at the three facilities to evaluate the level of training and awareness of appropriate procedures for handling allegations of sexual assault or abuse and child abuse, as well as complaints and grievances. The staff at all three facilities said they had received training, and all staff interviewed could identify the appropriate steps to take if they received such allegations, complaints, or grievances.

We also observed surveillance cameras and perimeter security at the three facilities. Staff at all three reported they store camera footage for at least 3 weeks. At one facility, staff reported that surveillance cameras cannot see certain spots in public areas. In addition, we observed that the facility perimeters may not prevent unauthorized intrusion.





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### Background

In 2001, ICE Enforcement and Removal Operations (ERO) opened the Berks Family Residential Center (Berks) in Leesport, Pennsylvania, to accommodate alien families in ICE detention. In 2007, ICE approved Family Residential Standards for families in administrative immigration proceedings<sup>1</sup> and subject to mandatory detention. ICE uses the Family Residential Standards to govern all aspects of family detention, including medical care, nutrition, legal access, educational services, and grievances. In 2014, following an increase in families apprehended on the southern U.S. border, ICE opened two additional facilities, the South Texas Family Residential Center (Dilley) in Dilley, Texas, and the Karnes County Residential Center (Karnes) in Karnes, Texas.



Figure 1. Recreation field at Karnes  
Source: Office of Inspector General (OIG)



Figure 2. Classroom at Berks  
Source: OIG

At the time of our site visit Berks had 77 detainees (capacity 96); Karnes had 466 detainees (capacity 830); and Dilley had 1,190 detainees (capacity 2,400). As of July 7, 2016, or about 2 weeks prior to our inspections, based on detainee data in ICE's detention database, families at Karnes and Dilley had been detained for an average of 1 week to complete their administrative immigration proceedings; 25 percent of the families had been detained longer than 10 days. As of July 7, 2016, most families in Berks were detained for more than 6 months; many of these families had cases on appeal in administrative immigration proceedings. At the time of our visit, all three facilities held only mothers and their children. ICE makes separate arrangements for single fathers traveling with children. Unaccompanied children are sheltered by the Department of Health and Human Services' Office of Refugee Resettlement.

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<sup>1</sup> ICE's Family Residential Standards govern the detention of families while awaiting the outcome of administrative immigration proceedings or return to home countries.



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### Key Observations

At the time of our unannounced spot inspections, all three family detention facilities generally met ICE Family Residential Standards. Nothing came to our attention that represented an immediate, unaddressed risk or an egregious violation of the Family Residential Standards. In addition to compliance with the Family Residential Standards, we evaluated ICE and contract staff's familiarity with reporting procedures for allegations of sexual abuse or assault and child abuse, as well as complaints and grievances; the general operability of the facilities' surveillance cameras; and perimeter security.<sup>2</sup> Based on our observations, interviews, and reviews of hard copy and electronic documents, we concluded that ICE had a reasonable approach to addressing the challenges inherent to managing family detention. Specifically:

Medical Care: Medical care at all three facilities was readily available, followed up on as needed, and was well documented. We did not identify any egregious errors in maintaining privacy, documenting care, or responding to medical grievances. At two facilities, a few detainees raised some concerns about the quality or promptness of medical care. After meeting with medical staff, reviewing medical records, and following up with medical staff on a complex case, we determined the facility provided adequate medical care. Although the Family Residential Standards do not require an onsite pediatrician, the contracts for the two larger facilities with many children require one. One of these two facilities had onsite medical and mental health staff, including a family practitioner but did not yet have a pediatrician; even though the facilities contract had been modified in the fall of 2015 to require one. Staff at this facility said they had been trying to hire a pediatrician since 2015 and were continuing recruiting efforts, but given the remote location of the facility, it has been difficult to recruit a suitable candidate.



Figure 3. Exam room at Karnes  
Source: OIG



Figure 4. Dental chairs at Dilley  
Source: OIG

<sup>2</sup> Attachment A contains more information about our scope and methodology, as well as the facilities we visited.



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- Language Services: We did not observe deficiencies in translation or interpretation during our site visits. We observed examples of materials written in Spanish and English; materials enabled detainees to show facility staff what language they spoke; and language services by phone were available for communication on medical, detention, and immigration processing issues. Staff at one facility told us ICE has also produced an orientation video for detainees who speak an indigenous Central American language, Quiché, and was translating written materials into Quiché. According to staff at two facilities, it may take longer to identify an interpreter for uncommon languages than for a common language like Spanish. At one facility, staff said detainees were not using mental health services that required language interpretation by phone for fear of sharing personal information with interpreters.



Figure 5. Notifications at Karnes  
Source: OIG



Figure 6. Telephone room at Berks  
Source: OIG

- Safety Measures: ICE balanced the need for detainee safety with appropriate conditions of detention for children. At all three facilities, staff told us that some detainees questioned the need for some of ICE's safety measures, such as requiring parents to be with their children in the residential areas, leaving lights on at night, and conducting welfare checks during the night. Although these safety measures are reasonable, we were not able to evaluate how well ICE and contract staff communicated the need for these measures to detainees.
- Training: ICE employees and facility contractors said they had been trained on reporting procedures for allegations of sexual assault or abuse and child abuse and knew how to report and document complaints and grievances. At each facility, we questioned ICE employees and contract staff to gauge





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compliance with the *Prison Rape Elimination Act of 2003* (PREA) and the *Victims of Child Abuse Act of 1990* (VCAA), as well as staff's knowledge about reporting and documenting grievances and complaints. Staff at all three facilities said they had PREA and VCAA training, knew their duty to report, and knew how to report, any allegation, grievance, or complaint. Staff said they received in-person, as well as online training, on managing disclosures of child abuse or sexual assault and said the training prepared them to respond to and report such disclosures. All three facilities had Department of Homeland Security OIG Hotline, Keep Detention Safe, PREA, and other rights notification posters prominently displayed.

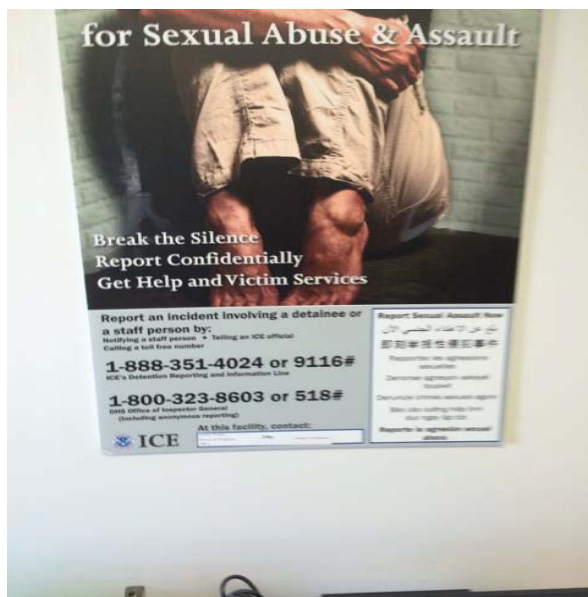


Figure 7. Report abuse poster at Dilley  
Source: OIG



Figure 8. Grievance box at Karnes  
Source: OIG

- Security Cameras and Perimeter Security: Security cameras and measures at facilities were adequate, but perimeter security may not be adequate. All three facilities had security cameras; staff reported they store footage for at least 3 weeks and save footage related to any incidents and allegations. As appropriate, at no facility were cameras focused on or able to view areas, such as showers and toilets, where detainees had a reasonable expectation of privacy. However, at one facility, staff reported there are spots in public areas that the cameras cannot view. Facility staff members are aware of this issue and said they patrol these areas in pairs to avoid the possibility of misconduct and allegations of misconduct. One facility did not have physical barriers protecting it, and at the remaining two, the physical barriers were incomplete; these conditions could leave detainees and staff vulnerable to unauthorized intrusion.



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Figure 9. Security fence at Dilley  
Source: OIG



Figure 10. Entrance gate at Berks  
Source: OIG





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### Attachment A

#### Objective, Scope, and Methodology

DHS OIG initiated this inspection program in response to concerns raised by immigrant rights groups and complaints to the DHS OIG Hotline regarding conditions for aliens in U.S. and Customs and Border Protection and ICE custody. We generally limited our scope to the ICE Family Residential Standards for health, safety, medical care, mental health care, educational services, grievances, classification and searches, use of force, language access, and staff training. We focused on elements of these standards that could be observed and evaluated without specialized training in medical, mental health, education, or corrections. Our visits to these facilities were unannounced so we could observe normal conditions and operations.

Prior to our inspections, we reviewed relevant background information, including:

- ICE Family Residential Standards
- OIG Hotline complaints from October 1, 2012, to June 17, 2016
- DHS Office for Civil Rights and Civil Liberties reports
- An ICE Office of Detention Oversight report
- Information from nongovernmental organizations
- Material related to ICE's implementation of the August 21, 2015, *Flores v. Lynch* order<sup>3</sup>
- Information in ICE's detention database on detainees currently housed in the three family detention facilities

During the inspections we performed the following activities:

- Inspected areas used by detainees, including intake processing areas; medical facilities; kitchens and dining facilities; residential areas, including sleeping, showering, and toilet facilities; legal services areas, including law libraries, immigration proceedings, and rights presentations; classrooms; recreational facilities; day care; and barber shops.
- Reviewed facilities' compliance with key health, safety, and welfare requirements of ICE's Family Residential Standards on classification and searches, use of force and restraints, medical care, mental health care, educational services, staffing, training, medical and nonmedical grievances, and access to translation and interpretation.

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<sup>3</sup> *Flores v. Lynch*, No. 85-4544 (C.D. Cal. Filed July 11, 1985), August 21, 2015



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- Reviewed the welfare of a sample of detainees in ICE's detention database who appeared potentially vulnerable, based on the mother's or child's age, length of detention, or country of origin.
- Reviewed detention, medical, and educational staff training on and compliance with PREA and VCAA, as well as staff's knowledge about reporting and documenting procedures for allegations, grievances, and complaints.
- Evaluated facility and perimeter security, including the operation of cameras and capacity for video storage.
- Reviewed documentary evidence, including electronic and paper medical files, educational files, and grievance logs and files.

We also interviewed ICE officers, medical staff, educational staff, chaplains, social workers, contract guards, and other contract personnel. We informally interviewed detainees who agreed to speak with us. We conducted these staff and detainee interviews to evaluate compliance with ICE's Family Residential Standards, grievance procedures, and grievance resolution.

Our inspection results are limited by the scope and methodology we employed; we used surprise visits to observe normal conditions and operations, but these observations represent a single point in time and cannot be used to verify past conditions or predict ICE's actions in the future. Our inspection results therefore should not be more broadly interpreted or generalized.

Our inspection results complement, and do not replace, essential family detention oversight conducted by the DHS Office for Civil Rights and Civil Liberties and ICE's Office of Detention Oversight. Our inspection teams did not include experts in specialized fields, such as medical and mental health care, education, or nutrition.

We conducted these inspections in July 2016, as part of our ongoing oversight of detention conditions. We conducted the inspections under the authority of the *Inspector General Act of 1978*, as amended, and according to the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

## ADDITIONAL INFORMATION AND COPIES

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Department of Homeland Security  
Office of Inspector General, Mail Stop 0305  
Attention: Hotline  
245 Murray Drive, SW  
Washington, DC 20528-0305