U.S. DEPARTMENT OF HOMELAND SECURITY

OFFICE OF INSPECTOR GENERAL

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FINAL REPORT

Summary of Unannounced Inspections of ICE Facilities Conducted in Fiscal Years 2020-2023

OFFICE OF INSPECTOR GENERAL

U.S. Department of Homeland Security

Washington, DC 20528 | www.oig.dhs.gov

September 24, 2024

MEMORANDUM FOR: Patrick J. Lechleitner
Senior Official Performing the Duties of Director
U.S. Immigration and Customs Enforcement

FROM: Joseph V. Cuffari, Ph.D.
Inspector General

GLENN SKLAR Digitally signed by GLENN E SKLAR Date: 2024.09.24 17:42:21 -04'00' "for"

SUBJECT: *Summary of Unannounced Inspections of ICE Facilities Conducted in Fiscal Years 2020–2023*

Attached is our final report, *Summary of Unannounced Inspections of ICE Facilities Conducted in Fiscal Years 2020–2023*. The report is for information purposes only and does not identify recommendations for ICE's action.

Consistent with our responsibility 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 report on our website for public dissemination.

Please contact me with any questions, or your staff may contact Thomas Kait, Deputy Inspector General at (202) 981-6000.

Attachment

DHS OIG HIGHLIGHTS

Summary of Unannounced Inspections of ICE Facilities Conducted in Fiscal Years 2020–2023

September 24, 2024

Why We Did This Summary

Our objective was to summarize the repeated findings from 17 reports and 1 management alert of ICE detention facilities, while analyzing facilities' and staff's compliance with PBNDS 2011 (2016) standards.

What We Recommend

While we do not provide any new recommendations in this report, we have provided a summary of ICE's corrective actions to close 74 relevant recommendations and the status of the remaining 11.

For Further Information:
Contact our Office of Public Affairs at (202) 981-6000, or email us at: DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

From fiscal years 2020 to 2023, we conducted 17 unannounced inspections at U.S. Immigration and Customs Enforcement (ICE) detention facilities across the United States (facility locations below), which resulted in 17 reports and 1 management alert.

ICE Facilities Inspected, FYs 2020-2023

In conducting these inspections, we found that ICE generally complied with *Performance-Based Detention Standards 2011* as revised in 2016, (PBNDS 2011) for the custody classification system, medical care, voluntary work program, and legal services. Conversely, we found ICE did not fully comply with all PBNDS 2011 standards related to environmental and health safety, special management units, staff-detainee communication, dental and chronic medical care, medical staffing, and the grievance system. Our analysis indicates that regardless of time, location, detainee population, and facility type, ICE and facility staff have struggled to comply with aspects of detention standards. In turn, this hindered their ability to maintain a safe and secure environment for staff and detainees. Further, we calculated that ICE paid approximately $160 million for unused bed space under guaranteed minimum contracts.

ICE Response

ICE management elected to forego a formal written response as we made no recommendations in the report.

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Abbreviations

CDF	Contract Detention Facility
DIGSA	Dedicated Intergovernmental Service Agreement
ERO	Enforcement and Removal Operations
ICE	U.S. Immigration and Customs Enforcement
IGSA	Intergovernmental Service Agreement
PBNDS 2011	*Performance-Based Detention Standards 2011*
SMU	special management unit

Background

U.S. Immigration and Customs Enforcement (ICE) houses detainees at roughly 110 facilities nationwide, and the conditions and practices at those facilities can vary greatly. ICE Enforcement and Removal Operations (ERO) oversees the detention facilities it manages with private contractors or state or local governments.[1] Facilities and staff must comply with ICE detention standards to provide a clean and safe environment and protect the health, safety, and rights of detainees.

As mandated by Congress,[2] we conduct unannounced inspections of ICE detention facilities to ensure compliance with applicable detention standards.[3] From fiscal years 2020 to 2023, we conducted 17 unannounced inspections at ICE detention facilities across the United States, which resulted in 17 reports and 1 management alert[4] (see Figure 1, next page, for facility locations).

For these inspections, we reviewed facility and staff compliance with *Performance-Based Detention Standards 2011*, as revised in 2016 (PBNDS 2011). PBNDS 2011 establishes consistent conditions of detention, program operations, and management expectations within ICE's detention system.

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[1] The types of facilities housing ICE/ERO detainees include Service Processing Centers, Contract Detention Facilities, and state or local government facilities used by ERO through Intergovernmental Service Agreements and Dedicated Intergovernmental Service Agreements. ICE owns Service Processing Centers, which contract detention staff generally operate. Under Contract Detention Facilities, private prison companies own and operate facilities and contract directly with ICE. Intergovernmental Service Agreements are contracts between local and county jails and ICE allowing for detention of individuals for immigration purposes within city or county jails. Dedicated Intergovernmental Service Agreements are contracts between local governments and ICE for facilities that house only individuals in ICE custody.

[2] *Consolidated Appropriations Act*, 2020, Pub. L. No. 116-93, Division D; *Department of Homeland Security Appropriations Act, 2020,* H.R. Rep. No. 116-180, at 17 (2019); S. Rep. No. 116-125, at 23 (2019). *Consolidated Appropriations Act, 2021,* Pub. L. No. 116-260, Division F; *Department of Homeland Security Appropriations Act, 2021*, H.R. Rep. No. 116-458 (2020). *Consolidated Appropriations Act, 2022,* Pub. L. No. 117-103, Division F*; Department of Homeland Security Appropriations Act, 2022,* H.R. Rep. No. 117-87 (2021). *Department of Homeland Security Appropriations Act, 2023,* H.R. Rep. No. 117-396 (2022).

[3] In addition to our congressionally mandated work, in FYs 2020 to 2023, we conducted ICE detention oversight as reported in the following: OIG-20-42, *Early Experiences with COVID-19 at ICE Detention Facilities*; OIG-21-58*, ICE's Management of COVID-19 in Its Detention Facilities Provides Lessons Learned for Future Pandemic Responses*; OIG-22-01, *ICE Needs to Improve Its Oversight of Segregation in Detention Facilities*; OIG-22-03, *Many Factors Hinder ICE's Ability to Maintain Adequate Medical Staffing at Detention Facilities*; OIG-22-14, *Medical Processes and Communication Protocols Need Improvement at Irwin County Detention Center*; OIG-23-12, *ICE and CBP Deaths in Custody During FY 2021*; OIG-24-16 *ICE Major Surgeries Were Not Always Properly Reviewed and Approved for Medical Necessity*.

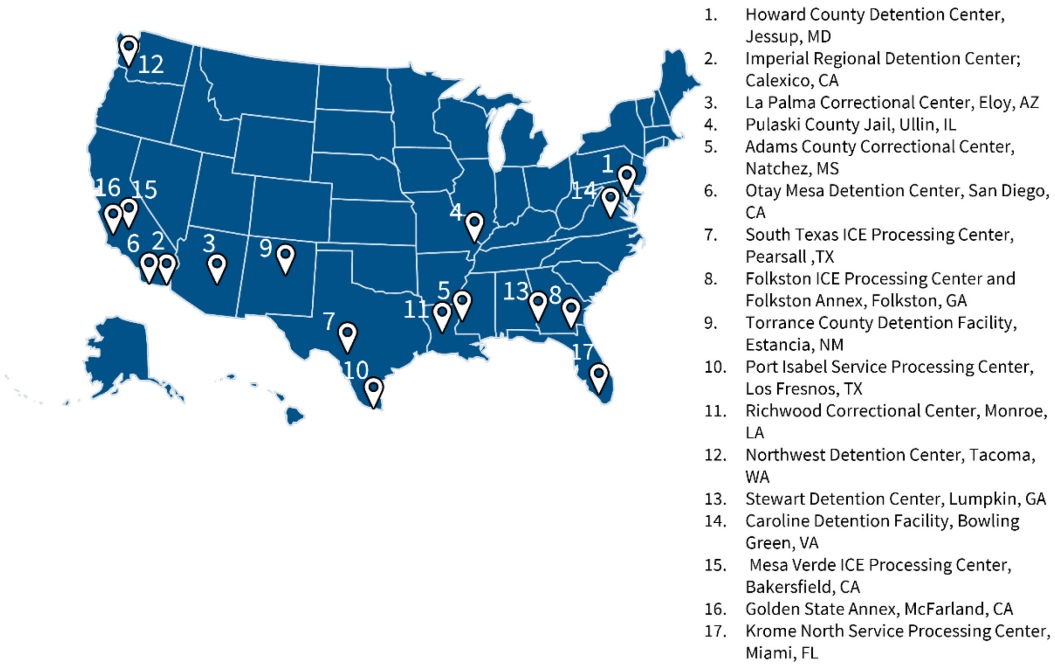
[4] From February 1, 2022, to February 3, 2022, we conducted an unannounced, in-person inspection of Torrance County Detention Facility in Estancia, New Mexico, which resulted in two published reports, OIG-22-31, *Management Alert—Immediate Removal of All Detainees from the Torrance County Detention Facility*, and OIG-22-75, *Violations of ICE Detention Standards at Torrance County Detention Facility.*

These standards set requirements in areas such as:

- environmental health and safety, including cleanliness, sanitation;
- security, including, detainee searches, special management units (SMU), and staff-detainee communication;
- order, such as disciplinary systems;
- detainee care, (e.g., food service, medical care, and personal hygiene);
- activities, including visitation and recreation; and
- justice, like legal rights, law libraries and the grievance system.

Our program of unannounced inspections of ICE detention facilities has identified and helped correct violations of these detention standards at facilities across the country.

Figure 1. ICE Facilities Inspected, FYs 2020–2023*[5]



1. Howard County Detention Center, Jessup, MD
2. Imperial Regional Detention Center; Calexico, CA
3. La Palma Correctional Center, Eloy, AZ
4. Pulaski County Jail, Ullin, IL
5. Adams County Correctional Center, Natchez, MS
6. Otay Mesa Detention Center, San Diego, CA
7. South Texas ICE Processing Center, Pearsall ,TX
8. Folkston ICE Processing Center and Folkston Annex, Folkston, GA
9. Torrance County Detention Facility, Estancia, NM
10. Port Isabel Service Processing Center, Los Fresnos, TX
11. Richwood Correctional Center, Monroe, LA
12. Northwest Detention Center, Tacoma, WA
13. Stewart Detention Center, Lumpkin, GA
14. Caroline Detention Facility, Bowling Green, VA
15. Mesa Verde ICE Processing Center, Bakersfield, CA
16. Golden State Annex, McFarland, CA
17. Krome North Service Processing Center, Miami, FL

Source: Department of Homeland Security Office of Inspector General Analysis
*Facilities listed in chronological order of inspection

[5] ICE has not housed detainees at the Howard County Detention Center since May 13, 2021.

Summary of Repeated Findings in Unannounced Inspections of ICE Facilities, Fiscal Years 2020-2023

In conducting these inspections from FYs 2020 to 2023, we found facilities and staff generally complied with the PBNDS 2011 standards of custody classification system, medical care, the voluntary work program, and legal services. Overall, staff properly classified detainees according to verifiable and documented data and did not co-mingle low or medium-low custody detainees with medium-high or high custody detainees. Medical staff mostly complied with standards of medical care, like providing daily sick calls, 24-hour nursing coverage, on-call physician coverage, and on-call mental health providers. In general, ICE facilities also complied with the voluntary work program. Specifically, detainee work schedules did not exceed 8 hours per day and 40 hours per week. Additionally, facilities generally complied with standards of legal services, like legal visitation occurring in person and in private rooms, or via live video streaming, and all detainees having access to law libraries.

Conversely, we found that facilities and staff did not fully comply with all PBNDS 2011 standards of environmental and health safety, SMUs, staff-detainee communication, dental and chronic care, medical staffing, and the grievance system (see Table 1). Further, we calculated ICE paid approximately $160 million for unused bed space under guaranteed minimum contracts.

Our analysis indicates that regardless of time, location, detainee population, and facility type, ICE and facility staff have struggled to comply with aspects of detention standards. In turn, this hindered their ability to maintain a safe and secure environment for staff and detainees. To ensure compliance, among other actions, they must guarantee facilities meet environmental and health safety standards, detainees in segregation receive required care and privileges, detainees receive dental and chronic medical care, staff responds to requests and grievances within the required timeframes and maintains complete logs and records, and guaranteed minimum contracts accurately reflect detainee populations.

Table 1. Summary of Areas of Non-compliance

	**Environmental Health and Safety:** Six of 17 (35 percent) facilities' living conditions violated PBNDS 2011 standards related to environmental health and safety, like sanitation of bathrooms and housing facilities.
	**Special Management Unit:** Staff at 12 of 17 (71 percent) facilities did not consistently provide required care for detainees in segregation, like access to recreation, commissary (administrative segregation), and laundry. Staff at some of these 12 facilities did not maintain accurate and complete logs, so we could not confirm whether they completed required wellness checks, provided medical care/daily health checks, and supplied the detainees with the required three meals a day.
	**Staff-Detainee Communication:** Staff at 14 of 17 (82 percent) facilities did not meet all standards for staff-detainee communication, like timely responses, logging requests in detainees' files, and communicating scheduled ICE visits. We also found a few facilities did not provide detainees with access to drop boxes, paper request forms, or writing instruments.
	**Dental and Chronic Care/Staffing Shortages**: At 10 of 17 (59 percent) facilities, we found instances of non-compliance with medical care standards, like dental and chronic care, and medical staffing.
	**Grievance System**: Staff at 13 of 17 (76 percent) facilities did not comply with all grievance system standards, like timely responses to grievances and responses in a language understood by detainees, complete detainee logs, and available paper grievance forms, drop boxes, or writing instruments.

Source: DHS OIG Analysis

Some Facilities Did Not Fully Comply with Standards of Environmental Health and Safety

PBNDS 2011 states, "facilities cleanliness and sanitation shall be maintained at the highest level."[6] Nevertheless, at 6[7] of 17 (35 percent) facilities inspected we found living conditions that violated PBNDS 2011 environmental health and safety standards. During our on-site inspections, we observed mold, rust, and peeling paint in showers as shown in Figures 1[8] and 2.[9] We also found bathrooms with clogged or inoperable toilets (Figure 3, next page),[10] broken sinks, and water leaking from toilets and sinks. We observed water leaks in housing units as shown in Figure 4, next page.[11]

Figures 1-2. Non-compliant Environmental Health and Safety Standards at ICE Detention Facilities

Source: DHS OIG photos

[6] PBNDS 2011 (2016), *Environmental Health and Safety*, Section 1.2.
[7] Facilities included: Imperial Regional Detention Center, Calexico, California; Folkston ICE Processing Center and Folkston Annex, Folkston, Georgia; Torrance County Detention Facility, Estancia, New Mexico; Port Isabel Service Processing Center, Los Fresnos, Texas; Richwood Correctional Center, Monroe, Louisiana; and Golden State Annex, McFarland, California.
[8] OIG-21-12, *ICE Needs to Address Prolonged Administrative Segregation and Other Violations at the Imperial Regional Detention Facility*, December 18, 2020, p.6.
[9] OIG-22-47, *Violations of ICE Detention Standards at Folkston ICE Processing Center and Folkston Annex*, June 30, 2022, p.8.
[10] OIG-23-13, *Violations of Detention Standards at ICE's Port Isabel Service Processing Center*, February 1, 2023, p.12.
[11] OIG-24-23, *Results of an Unannounced Inspection of ICE's Golden State Annex in McFarland, California*, April 18, 2024, p. 9.

Figures 3-4. Non-compliant Environmental Health and Safety Standards at ICE Detention Facilities

Source: DHS OIG photos

The Majority of Facilities Did Not Consistently Comply with All Special Management Unit Standards

At 12[12] of 17 (71 percent) facilities inspected, we found that facilities did not consistently comply with all SMU[13] standards, like access to recreation and laundry. Additionally, staff at a few of the facilities inappropriately handcuffed detainees in disciplinary segregation, and staff at a few facilities did not maintain complete documentation and logs.

[12] Facilities included: Howard County Detention Center, Jessup, Maryland; Imperial Regional Detention Facility, Calexico, California; La Palma Correctional Center, Eloy, Arizona; Pulaski County Jail, Ullin, Illinois; Adams County Correctional Center, Natchez, Mississippi; Otay Mesa Detention Center, San Diego, California; South Texas ICE Processing Center, Pearsall, Texas; Folkston ICE Processing Center and Folkston Annex, Folkston, Georgia; Port Isabel Service Processing Center, Los Fresnos, Texas; Stewart Detention Center, Lumpkin, Georgia; Golden State Annex, McFarland, California; and Krome North Service Processing Center, Miami, Florida.

[13] PBNDS 2011 (2016), Standard 2.12, Special Management Units, Section (I). Facilities use the terms Restricted Housing Unit and segregation interchangeably with SMU. This report will use the PBNDS 2011 language of

PBNDS 2011 states that detainees in administrative segregation shall generally receive "the same privileges available to detainees in the general population," and "may be provided opportunities to spend time outside their cells (in addition to the required recreation periods), for such activities as socializing […]"[14] Our review of records and logs showed that staff at 6 of 12 facilities did not consistently provide detainees in administrative segregation with required recreation time outside their cell, or the recreation area did not fully comply with standards.[15]

PBDNS 2011 also asserts that detainees in SMU will have access to programs and services such as commissary for detainees in administrative segregation and basic services such as laundry for both detainees in administrative and disciplinary segregation.[16] We found staff at 3 of 12 facilities did not provide detainees in administrative segregation with access to commissary, and staff at 4 of 12 facilities did not provide detainees with laundry services for soiled bedding or clothing. Staff at 3 of 12 facilities had implemented their own policy of handcuffing detainees in disciplinary segregation, contradicting the PBNDS 2011 standard that placement in disciplinary segregation alone does not constitute a valid basis for using restraints.[17]

Further, while PBDNS 2011 states staff will record all activities of detainees in segregation via permanent logs and special management housing unit records,[18] we found staff at 5 of 12 facilities did not maintain accurate or complete logs and records, so we could not confirm whether they completed required health checks, provided medical care, or supplied the detainees with the required three meals a day.

SMU. Segregation is the process of separating certain detainees from the general population for disciplinary or administrative reasons. Detainees in disciplinary segregation can be held for no more than 30 days per incident, except in extraordinary circumstances. Detainees in disciplinary segregation are allowed out of their cells for 1 hour of recreation time at least 5 days a week. Detainees in administrative segregation can be held until their safety, and the safety of others, is no longer a concern. Detainees in administrative segregation are allowed out of their cells for up to 2 hours of recreation time and day room access each day, 7 days a week. Detainees in both disciplinary and administrative segregation are also allowed time out of their cells for showers, phone calls, use of the law library, visitation, and religious services when offered.

[14] PBNDS 2011 (2016), Special Management Units, Section 2.12.

[15] PBNDS 2011(2016), Recreation, Section 5.4.

[16] PBNDS 2011 (2016), *Special Management Units*, Section 2.12.

[17] *Id.*

[18] *Id.*

The Majority of Facilities Did Not Consistently Comply with All Staff-Detainee Communication Standards

At 14[19] of 17 (82 percent) facilities, we found deficiencies in staff-detainee communication practices, like delayed responses to detainees' requests, responses to requests in languages other than detainees' preferred languages, no logs of requests/missing requests in detainees' detention files, inconsistent visitation schedules, and absent request drop boxes for paper request forms.

Untimely Responses

PBNDS 2011 establishes procedures for detainees to submit written requests[20] to facilities and ICE staff and requires them to respond within 3 business days of receipt.[21] However, at 6 of 14 facilities, ICE did not respond to detainees' requests in the required time, and at 4 of 14 facilities, facility staff did not respond within 3 business days. Specifically, at 2 of 6 facilities, ICE took 10 business days or longer to respond, and at 4 of 14 facilities, ICE or facility staff did not respond at all to requests. Staff at 2 of 14 facilities also did not respond to requests in the detainees' preferred language, which does not comply with the PBNDS 2011 standard that staff should generally translate all written materials to Spanish.[22]

Incomplete Logbooks

Per PBNDS 2011, "[a]ll requests shall be recorded in a logbook (or electronic logbook) specifically designed for that purpose."[23] Nevertheless, we found ICE or facility staff at 9 of 14 facilities did not log or track detainees' paper and electronic requests or maintain a copy of the requests in detainees' detention files as required.

[19] Facilities included: Imperial Regional Detention Facility, Calexico, California; La Palma Correctional Center, Eloy, Arizona; Pulaski County Jail, Ullin, Illinois; Adams County Correctional Center, Natchez, Mississippi; Otay Mesa Detention Center, San Diego, California; South Texas ICE Processing Center, Pearsall, Texas; Folkston ICE Processing Center and Folkston Annex; Folkston, Georgia; Torrance County Detention Facility, Estancia, New Mexico; Port Isabel Service Processing Center, Los Fresnos, Texas; Richwood Correctional Center, Monroe, Louisiana; Stewart Detention Center, Lumpkin, Georgia; Caroline Detention Facility, Bowling Green, Virginia; Golden State Annex, McFarland, California; and Krome North Service Processing Center, Miami, Florida.

[20] A request is any detainee communication to staff in which a detainee makes a request or asks a question.

[21] PBNDS 2011 (2016), *Staff-Detainee Communication,* Section 2.13.

[22] *Id.*

[23] *Id.*

Inconsistent ICE Visits

PBNDS 2011 also requires ICE staff to visit detainees at the facility and post a schedule with the days and hours they will visit.[24] We found ICE staff at 7 of the 14 facilities did not provide sufficient communication to detainees on times deportation officers would be available on scheduled visitation days to address their concerns, or ICE staff infrequently visited the housing units.

Inconsistent Request Filing Practices

PBNDS 2011 also requires facilities to allow detainees to submit written questions, requests, grievances, or concerns to ICE staff using the detainee request form, local Intergovernmental Service Agreement form, or a sheet of paper.[25] Facilities must also provide a drop-box for ICE detainees to correspond directly with ICE management.[26] Facilities did not consistently comply with these standards; we observed the absence of drop boxes, writing instruments, or paper forms. We also observed sealed drop-boxes with unread forms as shown in Figures 5 and 6.[27] While several facilities used electronic tablets or kiosks for detainee requests, electronic devices at two of the facilities did not fully support detainees with limited English proficiency. While the device allowed detainees to initially choose from various languages, the system's sub-menus (like clothing, commissary, and mail) were only in English.

Figures 5 and 6. "Not-in-Use" Drop-Box with Visible Paper

Figure 5

Figure 6

Source: DHS OIG Photos

[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] OIG-23-13, *Violations of Detention Standards at ICE's Port Isabel Service Processing Center*, February 1, 2023, pp.16-17.

Some Facilities Did Not Comply with All Standards of Dental or Chronic Care or Did Not Meet Adequate Medical Staffing Levels

While facilities generally met standards related to medical care, at 10[28] of 17 (59 percent) facilities we found repeated instances of non-compliance with standards related to dental and chronic care, and medical staffing. For example, 4 of 10 facilities did not comply with all standards of dental care, and 4 facilities did not fully comply with all chronic care standards. Additionally, five facilities had medical staffing shortages, which potentially affected detainees' level of care.

PBNDS 2011 is meant to ensure detainees have access to appropriate and necessary dental care.[29] It also states, "[d]etainees with chronic conditions shall receive care and treatment, as needed, that includes monitoring of medications, diagnostic testing and chronic care clinics," and requires facilities to provide medical staff and sufficient support personnel to meet standards.[30] We found instances of non-compliance with these standards (see Table 2).

Table 2. Summary of Non-compliant Standards of Medical Care

	Dental Care: Four of 10 facilities did not meet all dental care standards. Medical staff at two of four facilities did not conduct initial dental screenings during intake. Also, shortages of dentist/dental staff at three of four facilities caused delays in routine or advanced dental care for detainees.
	Chronic Care: Four of 10 facilities did not meet all chronic care standards, like updated chronic care protocols and guidelines, appropriate testing for chronic conditions, and appropriate medication refills.
	Staffing Shortages: Five of 10 facilities experienced staffing shortages potentially affecting timely sick call responses, medication refills, and the level of care detainees received for suicide watch, dental, optometry, and chronic care.

Source: DHS OIG Analysis

[28] Facilities included: La Palma Correctional Center, Eloy, Arizona; Pulaski County Jail, Ullin, Illinois; Folkston ICE Processing Center and Folkston Annex, Folkston, Georgia; Torrance County Detention Facility, Estancia, New Mexico; Northwest Processing Center, Tacoma, Washington; Stewart Detention Center, Lumpkin, Georgia; Caroline Detention Facility, Bowling Green, Virginia: Mesa Verde ICE Processing Center, Bakersfield, California; Golden State Annex, McFarland, California; and Krome North Service Processing Center, Miami, Florida.
[29] PBNDS 2011(2016), *Medical Care*, Section 4.3.
[30] *Id*.

The Majority of Facilities Did Not Consistently Comply with Grievance System Standards

We found that 13[31] of 17 (76 percent) facilities did not consistently comply with all grievance system standards,[32] like providing timely responses to detainees' grievances, consistently ensuring detainees could submit requests, inputting complete grievance logs in logbooks, and responding to grievances in detainees' preferred languages. Also, medical staff at some facilities improperly handled, filed, or logged medical grievances.

Untimely Responses

PBNDS 2011 establishes procedures for detainees to file grievances with facilities regarding aspects of their detention and requires facilities to respond within 5 days,[33] yet staff at 7 of 13 facilities failed to meet this standard. At these facilities, response times varied, some taking from 7 to 11 days or longer. We also found instances at 2 of 13 facilities where staff did not respond at all to some grievances. Three facilities had established and implemented a policy allowing staff to improperly issue extensions to grievance response times. This policy impermissibly allowed staff to unilaterally issue an extension of up to 15 days past the required time frame.

Inconsistent Grievance Filing Practices

PBNDS 2011 mandates that detainees can submit requests and grievances to facilities using paper forms.[34] We found housing units in one facility without paper grievance forms or writing instruments to fill out these forms. Further, staff at 2 of 13 facilities were no longer allowing detainees to submit grievances via paper forms; instead, detainees could only use electronic systems to submit grievances. Staff at one facility did not consistently communicate this to detainees; therefore, detainees still filed paper grievances, which staff were unaware of and not receiving.

[31] Facilities included: Howard County Detention Center, Jessup, Maryland; Imperial Regional, Calexico, California; La Palma Correctional Center, Eloy, Arizona; Adams County Correctional Center, Natchez, Mississippi, Otay Mesa Detention Center, San Diego, California; South Texas ICE Processing Center, Pearsall, Texas; Folkston ICE Processing Center and Folkston Annex, Folkston, Georgia; Port Isabel Service Processing Center; Los Fresnos, Texas; Richwood Correctional Center, Monroe, Louisiana; Northwest Detention Center, Tacoma, Washington; Stewart Detention Center; Lumpkin, Georgia; Caroline Detention Facility, Bowling Green, Virginia; and Krome North Service Processing Center, Miami, Florida.

[32] Per PBNDS 2011 (2016), a grievance is defined as "[a] complaint based on a circumstance or incident perceived as unjust."

[33] PBNDS 2011 (2016), *Grievance System*, Section 6.2.

[34] PBNDS 2011 (2016), *Staff-Detainee Communication,* Section 2.13.

Incomplete Logs

PBNDS 2011 requires facilities to record all requests and grievances in logbooks.[35] At 3 of 13 facilities we found incomplete logs[36] with erroneous filing dates or missing outcomes of adjudication. Based on this data, we assessed that the inconsistent filing practices as previously described appeared to affect staff's ability to maintain complete logs.

Language Discrepancies

PBNDS 2011 requires that all written materials, including facility grievance procedures, provided to detainees generally be translated into Spanish, and that facilities provide information and directions to detainees in a language or manner they can understand. Facilities must also provide a procedure for detainees to file both informal and formal grievances.[37] However, one facility did not provide detainees with limited English proficiency with a procedure to electronically submit grievances, as sub-menus of the electronic grievance system were only in English. We also found that staff at 2 of 13 facilities infrequently responded to grievances in detainees' preferred language or did not use the translate to feature available in the electronic grievance system.

Inconsistent Medical Grievance Processes

We found inconsistent filing and logging practices for medical grievances at 5 of 13 facilities. Two of five facilities terminated the electronic submission process for medical grievances because they felt the electronic system did not securely protect detainees' medical information; however, they either did not clearly communicate this, and/or they did not provide detainees with another way to submit grievances. We also found medical staff at two of five facilities did not always respond to medical grievances. At one of five facilities, staff only responded to 12 percent (10 of 82) of electronic medical grievances filed. Of those 82, detainees submitted 36 in a language other than English. Medical staff only responded to 8 of those 36, and all were in English. Medical staff at three of five facilities did not maintain complete and accurate logs, as required.[38]

[35] PBNDS 2011 (2016), *Grievance System*, Section 6.2.
[36] The grievance log must track how the facility processes each grievance, including the date of the grievance filing, name of the detainee filing the grievance, nature of the grievance, date the decision to provide to the detainee, and outcome of the adjudication.
[37] PBNDS 2011 (2016), *Grievance System*, Section 6.2.
[38] Id.

Facilities Paid Millions for Unused Bedspace Under a Guaranteed Minimum Contract

Eight[39] of 17 (47 percent) facilities paid for unused bedspace under a guaranteed minimum contract or agreement. Under these contracts or agreements, ICE guarantees minimum payments to detention facility contractors or state and local governments—paying for beds regardless of use. From FYs 2020 to 2023,[40] we found eight facilities inspected paid for unused bed space, paying approximately $160 million under contract (see Figure 7 next page).[41] [42] Although ICE must acquire and maintain enough bed space to satisfy demand for population surges and must adjust for health and safety requirements, it must also strive for balance to avoid wasting funds on empty beds.

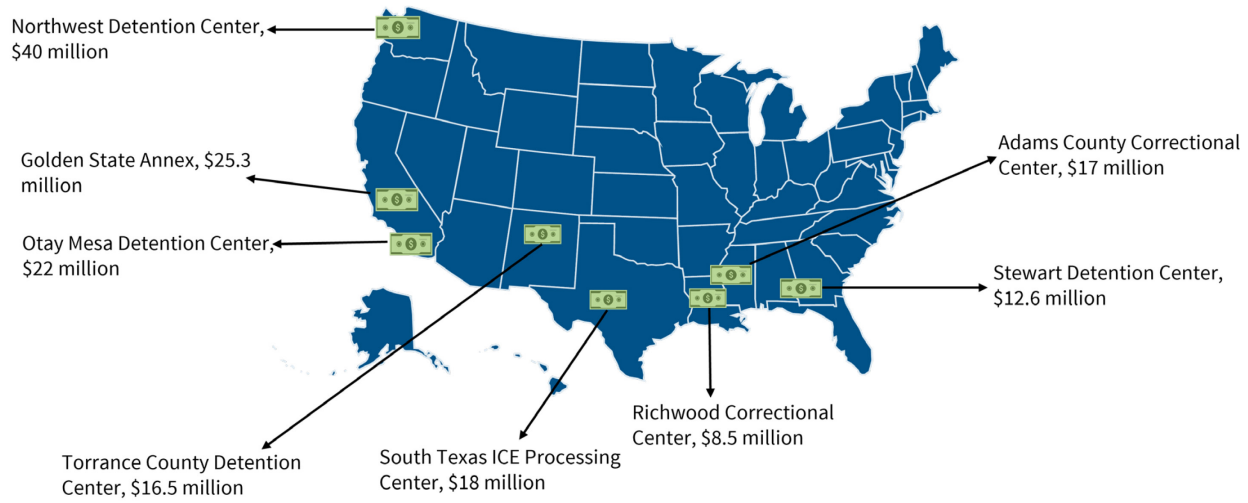
[39] Facilities included: Adams County Correctional Center, Natchez, Mississippi; Otay Mesa Detention Center, San Diego, California; South Texas ICE Processing Center, Pearsall, Texas; Torrance County Detention Facility, Estancia, New Mexico; Richwood Correctional Center, Monroe, Louisiana; Northwest Detention Center, Tacoma, Washington; Stewart Detention Center, Lumpkin, Georgia; and Golden State Annex, McFarland, California.

[40] In April 2020, ICE released *The U.S. Immigration and Customs Enforcement and Removal Operations Coronavirus Disease 2019 Pandemic Response Requirements,* which set forth expectations and assisted ICE detention facility operators in sustaining detention operations while mitigating risk to the safety and wellbeing of detainees, staff, contractors, visitors, and stakeholders due to COVID-19. It specifically stated, "[e]fforts should be made to reduce the population to approximately 75 percent of capacity."

[41] Contracts include, contract detention facility (CDF), an intergovernmental service agreement (IGSA), or dedicated intergovernmental service agreement (DIGSA).

[42] South Texas ICE Processing Center, Northwest Detention Center, and Golden State Annex are CDFs owned and operated by The Geo Group, Inc. Core Civic owns and operates Adams County Correctional Center, whereas ICE contracts with Adams County under a DIGSA. Otay Mesa Detention Center is a CDF owned and operated by Core Civic. Core Civic owns and operates Torrance County Detention Facility, whereas ICE contracts with Torrance County under an IGSA. Core Civic owns and operates Stewart Detention Center, whereas ICE contracts with Stewart County under a DIGSA. La Salle Corrections owns and operates Richwood Correctional Center, whereas ICE contracts with Richwood County under a DIGSA.

Figure 7. Breakdown of Amount Paid for Unused Bed Space by Facility



Source: DHS OIG analysis

Conclusion

From FYs 2020 to 2023, we conducted 17 unannounced inspections at ICE facilities across the United States. These unannounced inspections resulted in 17 reports and 1 management alert. While the locations and conditions varied at each facility, we found facilities and staff generally complied with PBNDS 2011 standards of custody classification system, medical care, voluntarily work program, and legal services. We found repeated instances of non-compliance in the areas of environmental and safety conditions, SMUs, staff-detainee communication, medical specialty and chronic care, medical staffing shortages, and the grievance system. Furthermore, eight facilities paid for unused bedspace under guaranteed minimum contracts and agreements. Our findings indicated that regardless of time, location, detainee population, facility types, other variables, ICE and facility staff have struggled to ensure facilities meet environmental and health safety standards, detainees in segregation receive required care and privileges, detainees receive dental and chronic medical care, staff responds to requests and grievances within the required timeframes and maintains complete logs and records, and guaranteed minimum contracts accurately reflect detainee populations.

Overview of Previously Issued Recommendations

From FYs 2020 to 2023, we issued 128 recommendations for the 17 reports and 1 management alert summarized in this report. As of June 30, 2024, ICE has closed 112 of those recommendations; 16 remain open. Of the 128 recommendations, 85[43] (66 percent) relate to the findings summarized in this report.[44] ICE has closed 74 of those 85 (87 percent); 11 remain open. The following section summarizes ICE's actions to resolve these recommendations, closed recommendations, and the recommendations' official date of closure.

Recommendations Related to Environmental Health and Safety

ICE has resolved and closed six of seven (86 percent) environmental health and safety-based recommendations; one[45] remains resolved and open. To resolve recommendations, ICE:

- established databases to track repair status;
- provided maintenance schedules; and
- documented repairs with photographic evidence and provided them to OIG.

Closed recommendations:

Report No.	Recommendation	Date Closed
OIG-21-12	[Imperial Regional Detention Facility (IRDF)] Review the IRDF facility conditions we identified as deficient to ensure corrective action in compliance with 2011 PBNDS requirements.	5/4/21
OIG-22-47	[Folkston ICE Processing Center and Folkston Annex] Ensure the Folkston facility conditions we identified as deficient are corrected and in compliance with 2011 PBNDS requirements.	6/30/22
OIG-22-75	[Torrance County Detention Facility] Ensure repairs identified are completed to provide a clean and safe living environment.	9/28/22
OIG-23-13	[Port Isabel Detention Facility] Ensure all unaddressed facility conditions that we identified as deficient (torn bedding and plumbing issues) are corrected.	6/1/23
OIG-23-18	[Richwood Correctional Center] Ensure facility conditions we identified as deficient (rusted bunks, shower water pressure, and detainee clothing) are corrected and provide proof of scheduled renovations.	1/29/24

[43] Some recommendations correlate to two different areas but are counted as one recommendation in this number, hence why the addition of each section does not equate to 85.
[44] Recommendations not related to the areas discussed in this summary include, but are not limited to, those on commingling of detainees, use of force, food services, and sick calls.
[45] Recommendation 1, OIG-22-31, *Management Alert: Immediate Removal of all Detainees from the Torrance County Detention Facility*, resolved and open May 1, 2024.

OIG-24-23	[Golden State Annex] Make necessary and permanent repairs to the roof leak described and depicted in this report.	4/18/24

Recommendations Related to Special Management Units

ICE has resolved and closed 17 of 18 (94 percent) SMU-based recommendations; 1[46] remains resolved and open.

To resolve recommendations, ICE:

- established guidance for properly documenting detainees' actions in segregation;
- ensured staff and volunteers received annual training on Security Procedures and Regulations, specifically related to 2011 PBNDS, section 7.02;
- revised the SMU confinement card to now include a line for the unit officer to initial and confirm medical staff completed medical rounds daily for each detainee in segregation; and
- purchased permanent recreation equipment for the SMU recreational area.

Closed Recommendations:

Report No.	Recommendation	Date Closed
OIG-21-03	[Howard County Detention Center] Establish a process for routine oversight of HCDC to ensure it: a) provides, and records that detainees in segregation receive, three nutritionally balanced meals per day; b) completes and records daily medical visits for segregated detainees; and c) establishes and maintains a separate medical grievance log, per PBNDS requirements.	4/23/21
OIG-21-12	[Imperial Regional Detention Facility] Review IRDF's use of prolonged administrative segregation and seek alternative housing when appropriate.	5/4/21
OIG-21-12	[Imperial Regional Detention Facility] Ensure that, for detainees in administrative segregation, IRDF provides outdoor recreation and access to privileges similar to those offered to detainees in the general population, in compliance with 2011 PBNDS requirements.	5/4/21
OIG-21-12	[Imperial Regional Detention Facility] Require IRDF staff to complete daily face-to-face medical visits with detainees in administrative segregation to ensure detainee welfare]	5/4/21
OIG-21-30	[La Palma Correctional Center (LPCC)] Ensure that, for detainees in segregation, LPCC provides access to laundry, legal materials, haircuts,	7/19/21

[46] Recommendation 6, OIG-24-21, *Results of an Unannounced Inspection of ICE's Krome North Service Processing Center in Miami, Florida*, resolved and open, April 16, 2024.

	required recreation time outside their cells, and (for those in administrative segregation) the commissary.	
OIG-21-30	[La Palma Correctional Center] Require LPCC staff to complete and document medication administration and daily face-to-face medical visits with detainees in segregation to ensure detainee health and welfare.	3/30/21
OIG-21-32	[Pulaski County Jail] Ensure Pulaski staff complete and record the results of visual welfare checks for detainees in segregation once every 30 minutes.	7/9/21
OIG-21-46	[Adams County Correctional Center] Ensure Adams provides detainees in segregation access to laundry, legal materials, mail, required recreation time outside their cells, the commissary (for those in administrative segregation), ICE request forms, and secure drop-boxes.	7/14/21
OIG-21-61	[Otay Mesa Detention Center] Provide detainees in segregation access to laundry, legal materials, mail, required recreation time outside their cell, and the commissary (for those in administrative segregation).	1/11/22
OIG-22-40	[South Texas ICE Processing Center] Ensure compliance with segregation standards, including the use of restraints, access to recreation, legal calls, laundry services for bedding and clothing, mail, legal materials, and the law library.	8/22/22
OIG-22-47	[Folkston ICE Processing Center] Require Folkston staff to complete daily medical monitoring of detainees in administrative segregation.	6/30/22
OIG-22-47	[Folkston ICE Processing Center] Provide detainees in segregation at Folkston IPC access to recreation, legal calls, laundry services for bedding and clothing, mail, legal materials, law library, and commissary.	6/30/22
OIG-22-47	[Folkston ICE Processing Center] We recommend the Executive Associate Director of Enforcement and Removal Operations direct the Atlanta ERO Field Office Director responsible for Folkston to: Ensure Folkston segregation practices related to handcuffing comply with 2011 PBNDS requirements.	6/30/22
OIG-23-13	[Port Isabel Detention Facility] We recommend the Executive Associate Director of Enforcement and Removal Operations direct the Harlingen ERO Field Office responsible for Port Isabel to: Discontinue use of the building housing the segregation unit.	6/1/23
OIG-23-13	[Port Isabel Detention Facility] Ensure compliance with segregation standards, including having a basis for use of restraints and providing access to recreation, library, mail, and religious services.	6/1/23
OIG-23-38	[Stewart Detention Center] Document in special management unit records the reason detainees refuse to return to general population to ensure facility staff do not use disciplinary segregation as a punitive measure for detainees who require protection	10/17/23
OIG-24-23	[Golden State Annex] Provide SMU detainees access to commensurate recreational areas as are available to detainees housed in general population, specifically areas that include exercise opportunities and equipment.	4/18/24

Recommendations Related to Staff-Detainee Communication

ICE has resolved and closed 20 of 23 (87 percent) staff-detainee communication-based recommendations; 3[47] remain resolved and open.

To resolve recommendations, ICE:

- assigned a dedicated Detention Service Manager to assist with visiting detainees and addressing any issues or concerns regarding the facility;
- conducted initial and refresher training regarding staff-detainee communication policies;
- placed hanging wall pockets in all housing units to maintain an adequate supply of detainee request forms;
- posted visitation schedules—the time, duration, and location for facility visits—in all housing unit pods; and
- provided training on the language line translation services to both detention facility and medical staff.

Closed Recommendations:

Report No.	Recommendation	Date Closed
OIG-21-12	[Imperial Regional Detention Facility] More clearly identify time, duration, and location for facility visits to ensure detainees' regular access to assigned ICE ERO deportation officers.	5/4/21
OIG-21-30	[La Palma Correctional Center] Ensure LPCC records and maintains a detainee request log and properly files detainee requests.	1/14/22
OIG-21-30	[La Palma Correctional Center] Ensure detainees consistent and appropriate access to ICE ERO deportation officers by identifying time, duration, and location of ICE facility visits.	7/19/21
OIG-21-32	[Pulaksi County Jail] Ensure detainees have consistent and appropriate access to ICE ERO deportation officers and include identifying time, duration, and location of ICE facility visits.	4/29/21
OIG-21-46	[Adams County Correctional Facility] Establish a system to ensure timely ICE responses to requests.	1/11/22
OIG-21-61	[Otay Mesa Detention Center] Provide detainees full access to a secure drop-box for ICE requests and verify that ICE responds timely to such requests.	1/11/22

[47] Recommendation 5, OIG-23-18, *Violations of ICE Detention Standards at Richwood Correctional Center in Monroe, Louisiana*, resolved and open, March 25, 2024; Recommendation 5, OIG-24-23, *Results of an Unannounced Inspection of ICE's Golden State Annex in McFarland, California,* resolved and open, April 18,2024; Recommendation 8, OIG-24-21, *Results of an Unannounced Inspection of ICE's Krome North Service Processing Center in Miami, Florida*, resolved and open, April 16, 2024.

OIG-21-61	[Otay Mesa Detention Center] Ensure detainees have consistent and appropriate access to ICE ERO deportation officers, including identifying time, duration, and location of ICE facility visits.	1/11/22
OIG-22-40	[South Texas ICE Processing Center] Establish a request tracking system to ensure timely responses to all detainee requests filed at South Texas, with a complete request log.	4/22/22
OIG-22-47	[Folkston ICE Processing Center and Folkston Annex] Establish a requests tracking system to ensure timely and complete responses to all detainee requests filed at Folkston.	6/30/22
OIG-22-47	[Folkston ICE Processing Center and Folkston Annex] Provide ICE visitation schedules, including the time, duration, and location for housing unit visits, to ensure Folkston detainees are aware of their regular access to assigned ICE ERO deportation officers.	6/30/22
OIG-22-47	[Folkston ICE Processing Center and Folkston Annex] Ensure ICE provides copies of ICE request forms and secure drop boxes in all Folkston housing units.	6/30/22
OIG-22-75	[Torrance County Detention Facility] Provide timely responses to detainee requests and keep a log of detainee requests submitted via paper forms.	1/25/23
OIG-23-13	[Port Isabel Detention Center] Ensure paper forms for facility requests are available, collected, logged, and responded to within 3 business days of receipt.	6/1/23
OIG-23-13	[Port Isabel Detention Center] Ensure electronic request and grievance logs are available for inspection, as required.	6/1/23
OIG-23-18	[Richwood Correctional Center] Provide training and guidance for facility staff on the use of language line translation services.	2/28/23
OIG-23-18	[Richwood Correctional Center] Establish a request tracking system to ensure timely responses to all detainee request files at Richwood, with a complete request log.	3/25/24
OIG-23-38	[Stewart Detention Center] Comply with the PBNDS 2011 staff-detainee communication standard by: a. responding to detainee requests within the required timeframes; b. ensuring detainees have frequent opportunities for informal contact with ICE ERO field office staff, including by requiring ICE ERO to post and adhere to a visitation schedule; c. ensuring responses to detainees are in a language they can understand; d. establishing a request tracking system for paper requests to ensure timely responses, with a complete request log; and e. maintaining copies of each completed detainee request in detainees' detention files.	3/25/24
OIG-23-51	[Caroline Detention Facility] Ensure detainee detention files include all submitted requests.	12/18/23

OIG-23-51	[Caroline Detention Facility] Ensure ICE personnel provide frequent opportunities for informal contact with detainees by adhering to the weekly visitation schedule posted in the housing units and by recording their visits in the appropriate logs.	12/18/23

Recommendations Related to Dental, Specialty, and Chronic Medical Care/Medical Staffing

Dental, Specialty, and Chronic Medical Care

ICE has resolved and closed 10 of 13 (77 percent) dental-/chronic care-based recommendations; 3[48] remain resolved and open.

To resolve recommendations, ICE:

- completed enrollment and onboarding of an additional dental provider;
- enhanced its medical care in emergency care guidelines;
- drafted a local operating procedure to outline and describe the procedures for the continuation of care; and
- updated guidelines to ensure they are current and reflect the Department of Justice's Federal Bureau of Prisons' Chronic Care Guidelines.

Closed Recommendations:

Report No.	Recommendation	Date Closed
OIG-21-32	[Pulaski County Jail] Ensure the Pulaski Medical Unit develops chronic care guidelines and provides routine and emergency dental care.	9/24/21
OIG-21-46	[Adams County Correctional Center] Ensure the Adams Medical Unit develops emergency care guidelines, documents patient treatment during sick call encounters, and documents interpretation and medical care provided based on laboratory testing results.	7/14/21
OIG-22-47	[Folkston ICE Processing Center/Folkston Annex] Establish coordination of medical care for detainees moved between	6/30/22

[48] Recommendation 1, OIG-23-51, *Results of an Unannounced Inspection of ICE's Caroline Detention Facility in Bowling Green, Virginia*, resolved and open, Feb. 20, 2024; Recommendation 1, OIG-24-23, *Results of an Unannounced Inspection of ICE's Golden State Annex in McFarland, California,* resolved and open, April 18, 2024; Recommendation 3, OIG 24-21, *Results of an Unannounced Inspection of ICE's Krome North Service Processing Center*, resolved and open, April 16, 2024.

	Folkston IPC and Folkston Annex and ensure timely access to specialty care.	
OIG-22-75	[Torrance County Detention Facility] Ensure the chronic care guidelines are evaluated and updated to include the most current medical community standards. The guidelines should also be readily accessible to medical department staff and easy to find and use.	9/28/22
OIG-22-75	[Torrance County Detention Facility] Ensure each detainee receives both an intake dental screening as well as an initial dental screening.	9/28/23
OIG-22-75	[Torrance County Detention Facility] Evaluate and amend the dental referral process to ensure a timely response for dental pain cases, including timely evaluation of quarantined patients by dentists.	9/28/23
OIG-22-75	[Torrance County Detention Facility] Ensure our other medical observations are addressed, including that: • detainees have access to water and restrooms while they are in the medical waiting area; • appropriate testing is provided for all asthma patients; • medical evaluations match complaints submitted by detainees; • appropriate medication is provided to detainees with high cholesterol; and • expired medication is disposed of according to the disposition schedule and in a timely manner.	9/28/23
OIG-23-38	[Stewart Detention Center] Establish and enforce a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including dental and mental health services) provided by a physician or other qualified medical staff in a clinical setting by ensuring medical staff receives all detainee sick call requests in a timely manner.	4/25/24
OIG-23-51	[Caroline Detention Facility] Ensure the Caroline facility medical staff are using the most current treatment guidance for chronic illnesses.	12/18/23
OIG-24-03	[Mesa Verde] Establish and implement a plan to reduce wait times for optometry appointments at Mesa Verde.	2/2/24

Medical Staffing

ICE has resolved and closed two of four (50 percent) medical staffing shortages-based recommendations; two[49] remain resolved and open.

To resolve these recommendations, ICE:

- hired additional medical staff to conduct telehealth or in-person visits; and
- allocated federal clinical positions and posted multiple job announcement on USA Jobs.

Closed Recommendations:

Report No.	Recommendation	Date Closed
OIG-22-47	[Folkston ICE Processing Center/Folkston Annex] Address medical staffing issues at Folkston IPC to ensure adequate mental health care for detainees.	6/30/22
OIG-23-26	[Northwest ICE Processing Center] Ensure the facility has a plan to fill medical vacancies.	9/7/23

Recommendations related to Grievance Systems

ICE has resolved and closed 15 of 16 (94 percent) grievance system-based recommendations; one[50] remains resolved and open.

To resolve recommendations, ICE:

- assigned a backup grievance officer to assist with monitoring the existing grievance tracking system and secure drop-box;
- placed hanging wall pockets in all housing units to maintain an adequate supply of grievance forms;
- provided copies of grievance logs demonstrating timely response to grievances; and
- established a dedicated compliance supervisory detention and deportation officer position who ensures all requests and grievances are responded to on the date of submittal or the following day and follow up on grievances not translated into a detainee's preferred language.

[49] Recommendation 1, OIG-22-75, *Violations of ICE Detention Standards at Torrance County Detention Facility*, resolved and open, Jan. 25, 2023; Recommendation 3, OIG-24-21, *Results of an Unannounced Inspection of ICE's Krome North Service Processing Center*, resolved and open, April 16, 2024.
[50] Recommendation 4, OIG-24-21, *Results of an Unannounced Inspection of ICE's Krome North Service Processing Center*, resolved and open, April 16, 2024.

Closed Recommendations:

Report No.	Recommendation	Date Closed
OIG-21-12	[Imperial Regional Detention Facility] Require the IRDF staff to provide written responses to medical grievances and provide copies to the detainees who filed the grievances.	5/4/21
OIG-21-30	[La Palma Correctional Center] Review LPCC's grievance policy, processes, and procedures to ensure adherence with requirements.	1/14/22
OIG-21-46	[Adams County Correctional Center] Ensure Adams establishes a grievance tracking system to ensure timely responses to grievances.	7/14/21
OIG-21-61	[Otay Mesa Detention Center] Establish a grievance tracking system to ensure timely responses to all grievances filed at Otay Mesa.	1/11/22
OIG-21-61	[Otay Mesa] We recommend the Executive Associate Director of Enforcement and Removal Operations direct the San Diego Enforcement and Removal Field Office responsible for Otay Mesa to: Ensure Otay Mesa forwards all staff misconduct complaints to ICE ERO, as required.	1/11/22
OIG-22-40	[South Texas ICE Processing Center] Establish a grievance tracking system to ensure timely responses to all detainee grievances filed at South Texas, with a complete grievance log.	8/22/22
OIG-22-47	[Folkston ICE Processing Center/Folkston Annex] Establish a grievance and facility request tracking system to ensure timely and complete responses to all detainee requests filed at Folkston.	6/30/22
OIG-23-13	[Port Isabel Service Processing Center] Ensure paper forms for facility and medical grievances are available, collected, logged, and responded to by staff within 5 working days of receipt, where practicable.	6/1/23
OIG-23-13	[Port Isabel Service Processing Center] Ensure electronic request and grievance logs are available for inspection, as required.	6/1/23
OIG-23-18	[Richwood Correctional Center] Comply with the PBNDS 2011 grievance standard by: a. ensuring detainees have access to paper grievance forms, including medical grievance forms, and can submit paper or electronic grievances; b. ensuring detainees can submit medical grievances directly to medical staff; c. establishing a grievance appeals board; d. updating the facility handbook to accurately reflect grievance process; and e. conducting training for the facility grievance officer and other department leads on processes for all grievances (including informal, formal, medical, and emergency), grievance appeals, and appellate review.	1/29/24

OIG-23-18	[Richwood Correctional Center] Establish a grievance tracking system to ensure timely responses to all detainee grievances filed at Richwood.	1/29/24
OIG-23-26	[Northwest ICE Processing Center] Ensure response to grievances occur within 5 days.	9/7/23
OIG-23-26	[Northwest ICE Processing Center] Ensure responses to requests and grievances are in a language understood by the detainee.	9/7/23
OIG-23-38	[Stewart Detention Center] Comply with the PBNDS 2011 grievance standard by: a. responding to detainee grievances within the required timeframes. b. designating alternative staff who are responsible for responding to grievances, when necessary, to ensure the subject of a grievance is not the same as the person responding to the grievance. c. conducting training for the facility grievance officer and other officials responsible for responding to grievances on what constitutes an appropriate grievance response. d. ensuring detainees can submit medical grievances directly to medical staff and no other staff can access detainee electronic medical grievance information; and e. ensuring responses to grievances are in a language detainees can understand.	4/25/24
OIG-23-51	[Caroline Detention Facility] We recommend the Executive Associate Director of Enforcement and Removal Operations direct the Washington Field Office, responsible for Caroline, to: Ensure that all detainee grievances receive responses within the required 5 days and the grievances log is accurate.	12/18/2023

Recommendations related to Guaranteed Minimum

ICE has resolved and closed six of seven (86 percent) guaranteed minimum-based recommendations; one[51] remains resolved and open.

To resolve recommendations, ICE:

- Provided documentation showing trends of increased daily population; and
- Maintained the daily population over or at the guaranteed minimum.

[51] Recommendation 7, OIG-24-23, *Results of an Unannounced Inspection of ICE's Golden State Annex in McFarland, California,* resolved and open, April 18, 2024.

Closed Recommendations:

Report No.	Recommendation	Date Closed
OIG-21-46	[Adams County Correctional Center] Update ICE's contract with Adams to better identify requirements for detainee housing.	1/11/22
OIG-21-61	[Otay Mesa Detention Center] Update ICE's contract with Otay Mesa to better identify housing requirements and determine if guaranteed minimums are necessary.	1/11/22
OIG-22-40	[South Texas ICE Processing Center] Determine ICE housing requirements based on COVID-19 protocols and guaranteed minimums outlined in the contract.	4/22/22
OIG-23-18	[Richwood Correctional Center] Immediately modify the Richwood contract to decrease the guaranteed minimum to only pay for available bed space while the facility is unable to meet the contractual minimum. Then, review and update ICE's contract with Richwood by better identifying housing requirements and determining whether guaranteed minimums are necessary.	1/29/24
OIG-23-26	[Northwest ICE Processing Center] Review and update ICE's contract with the facility by better identifying housing requirements and determining an appropriate guaranteed minimum.	6/24/24
OIG-23-38	[Stewart Detention Center] Review and update ICE's contract with Stewart by better identifying housing requirements and determining whether guaranteed minimums are necessary.	2/27/2024

Management Comments and OIG Analysis

We received technical comments from ICE and incorporated them in the report where appropriate. ICE management elected to forego a formal written response as we made no recommendations in the report.

Appendix A:
Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General was established by the *Homeland Security Act of 2002* (Pub. L. No. 107−296) by amendment to the *Inspector General Act of 1978*.

This report summarizes repeated findings from 17 reports and 1 management alert of ICE detention facilities from OIG's FYs 2020 to 2023 unannounced inspections of ICE facilities. To deduce repeated findings, we reviewed all 17 reports and 1 management alert against PBNDS 2011 standards.

The 17 facilities inspected, dates of inspection, associated management and type of contract follow:

Facility	Location	Dates of Inspection[52]	Associated Management/Type of Agreement or Contract
Howard County Detention Center	Jessup, MD	12/17-12/18/2019	Howard County Department of Corrections/IGSA
Imperial Regional Detention Center	Calexico, CA	2/25-2/27/2020	Management Training Corporation/CDF
La Palma Correctional Center	Eloy, AZ	8/25-11/2020	CoreCivic/IGSA
Pulaski County Jail	Ullin, IL	11/16/20-1/5/2021	Pulaski County/IGSA
Adams County Correctional Center	Natchez, MS	1/11-2/26/2021	CoreCivic/DIGSA
Otay Mesa Detention Center	San Diego, CA	2/22-4/30/2021	CoreCivic/CDF
South Texas ICE Processing Center	Pearsall, TX	9/13-10/29/2021	Geo Group, Inc./CDF
Folkston Processing Center and Annex	Folkston, GA	11/16-11/18/2021	Geo Group, Inc./DIGSA
Torrance County Detention Facility	Estancia, NM	2/1-2/3/2022	CoreCivic/IGSA
Port Isabel Service Processing Center	Los Fresnos, TX	4/26-4/28/2022	ICE; Ahtna Support and Training Services; LLC; ICE Health Services Corp./SPC
Richwood Correctional Center	Monroe, LA	6/28-6/30/2022	LaSalle Corrections/DIGSA

[52] Note that from August 2020 to October 2021, teams conducted all onsite inspections virtually.

Northwest Detention Center	Tacoma, WA	8/30-9/1/2022	Geo Group, Inc./CDF
Stewart Detention Center	Lumpkin, GA	11/8-11/10/2022	Core Civic/DIGSA
Caroline Detention Facility	Bowling Green, VA	1/24-1/26/2023	Caroline County/DIGSA
Mesa Verde ICE Processing Center	Bakersfield, CA	4/18-4/19/2023	Geo Group, Inc./CDF
Golden State Annex	McFarland, CA	4/18-4/20/2023	Geo Group, Inc./CDF
Krome North Service Processing Center	Miami, FL	6/13-6/15/2023	Akima Global, LLC/SPC

We conducted these inspections under the authority of the *Inspector General Act of 1978*, 5 United States Code §§ 401–424, and according to the *Quality Standards for Inspections and Evaluations*, issued by the Council of the Inspectors General on Integrity and Efficiency. At 14 of 17 facilities inspected, we contracted with a team of qualified medical professionals to conduct a comprehensive evaluation of detainee medical care at detention facilities. We incorporated information provided by the medical contractors in our findings and made recommendations based on those findings.

For this summary, when characterizing percentages as adjectives, we used the following guidelines:

All	100%	**Some**	26-49%
Most	79-99%	**Few**	1-25%
Majority	50-79%	**None**	0%

DHS OIG's Access to DHS Information

For this summary report, we did not request information from ICE.

Appendix B:
ICE Comments on the Draft Report

ICE management elected to forego a formal written response as we made no recommendations in the report.

Appendix C:
Inspection Reports Referenced in Summary

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1. *ICE Needs to Address Concerns About Detainee Care and Treatment at Howard County Detention Center*, OIG-21-03, October 28, 2020.
2. *ICE Needs to Address Prolonged Administrative Segregation and Other Violations at the Imperial Regional Detention Facility*, OIG-21-12, December 18, 2020.
3. *Violation of Detention Standards Amidst COVID-19 Outbreak at La Palma Correctional Center in Eloy, AZ*, OIG-21-30, March 30, 2021.
4. *Violations of ICE Detention Standards at Pulaski County Jail,* OIG-21-32, April 29, 2021.
5. *Violations of ICE Detention Standards at Adams County Correctional Center*, OIG-21-46, July 14, 2021.
6. *Violations of ICE Detention Standards at Otay Mesa Detention Center*, OIG-21-61, September 14, 2021.
7. *Management Alert-Immediate Removal of All Detainees from the Torrance County Detention Facility,* OIG-22-31, March 16, 2022.
8. *Violations of ICE Detention Standards at South Texas ICE Processing Center,* OIG-22-40, April 22, 2022.
9. *Violations of ICE Detention Standards at Folkston Processing Center and Folkston Annex*, OIG-22-47, June 30, 2022.
10. *Violations of ICE Detention Standards at Torrance County Detention Facility,* OIG-22-75, September 28, 2022.
11. *Violations of Detention Standards at ICE's Port Isabel Service Processing Center*, OIG-23-13, February 1, 2023.
12. *Violations of ICE Detention Standards at Richwood Correctional Center in Monroe, Louisiana*, OIG-23-18, February 28, 2023.
13. *Results of an Unannounced Inspection of Northwest Processing Center in Tacoma, Washington*, OIG-23-26, May 22, 2023.
14. *Results of an Unannounced Inspection of ICE's Stewart Detention Center in Lumpkin, Georgia*, OIG-23-38, July 27, 2023.
15. *Results of an Unannounced Inspection of ICE's Caroline Detention Facility in Bowling Green, Virginia*, OIG-23-51, September 15, 2023.
16. *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, California*, OIG-24-03, October 30, 2023.
17. *Results of an Unannounced Inspection of ICE's Krome North Service Processing Center in Miami, Florida*, OIG-24-21, April 16, 2024.
18. *Results of an Unannounced Inspection of ICE's Golden State Annex in McFarland, California,* OIG-24-23, April 18, 2024.

Appendix D:
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Appendix E:
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