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November 18, 2019

The Honorable Joseph V. Cuffari
Inspector General
Department of Homeland Security
111 Massachusetts Avenue, N.W.
Washington, D.C. 20528

Dear Inspector General Cuffari:

I am writing to inform your office of findings from Committee staff visits to three Immigration and Customs Enforcement (ICE) detention facilities in Georgia and to request that your office conduct a review of these facilities. Committee staff conducted visits to the Stewart Detention Center, Irwin County Detention Center, and Folkston ICE Processing Center. The Committee's visits uncovered significant concerns with these facilities that would benefit from a thorough review by your office.

The Committee examined these facilities following a string of recent events at Stewart Detention Center, an expansive facility located in Lumpkin, Georgia, that currently houses approximately 1,900 detainees. Four immigrants have died at Stewart Detention Center in the last two years, and two of those deaths involved mentally ill men who committed suicide after being placed in solitary confinement.[1] During the staff visit, multiple detainees reported that another detainee attempted to commit suicide less than two weeks before the Committee staff's visit. Staff at the Stewart Detention Center did not inform Committee staff about the attempted suicide when asked about suicides at the facility and mental health care.

The Committee is concerned about the use of solitary confinement—also called "segregation" or the "Special Management Unit"—at Stewart Detention Center and other ICE detention facilities. Outside of the Intake and Processing Area at the Stewart Detention Center, a sign advises detainees that, "If found guilty of either fighting, assault or horse play you will serve up to 30 days in Segregation." This policy—which ICE appears to permit under the agency's

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[1] Immigration and Customs Enforcement, Department of Homeland Security, *ICE Detainee Passes Away at Georgia Hospital* (July 25, 2019) (online at www.ice.gov/news/releases/ice-detainee-passes-away-georgia-hospital-2); Immigration and Customs Enforcement, Department of Homeland Security, *ICE Detainee Passes Away at Georgia Hospital* (July 12, 2018) (online at www.ice.gov/news/releases/ice-detainee-passes-away-georgia-hospital-1); Immigration and Customs Enforcement, Department of Homeland Security, *ICE Detainee Passes Away* (Jan. 31, 2018) (online at www.ice.gov/news/releases/ice-detainee-passes-away); Immigration and Customs Enforcement, Department of Homeland Security, *ICE Detainee Passes Away at Georgia Hospital* (May 15, 2017) (online at www.ice.gov/news/releases/ice-detainee-passes-away-georgia-hospital-0).

Performance-Based National Detention Standards (PBNDS)[2]—is at odds with a growing national and international consensus that even limited periods of solitary confinement cause serious and long-lasting harm to detainees.

For example, Juan Méndez, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, has recommended that segregation in excess of 15 days should be prohibited because studies show lasting mental harm occurs after a few days of social isolation.[3] According to Mr. Méndez:

> Solitary confinement for shorter terms or for legitimate disciplinary reasons can amount to cruel, inhuman or degrading treatment or punishment in cases where the physical conditions of prisons, such as sanitation and access to food and water, violate the inherent dignity of the human person and cause severe mental and physical pain or suffering.[4]

Mr. Méndez has recommended that solitary confinement not be used for juveniles or individuals with mental disabilities.[5]

Both detainees who committed suicide at Stewart Detention Center in recent years had documented mental health conditions and were held in solitary confinement for more than 15 days.[6] When Committee staff visited Stewart Detention Center, they viewed a log of detainees in the Special Management Unit and saw that at least one detainee had been in segregation for 90 days. According to the PBNDS, a mental health provider must conduct a psychological review of an individual in segregation once every 30 days.[7] The detainee records on file at the facility should include further details regarding any detainee's length of disciplinary or administrative segregation.[8]

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[2] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011,* Appendix 3.1.A (I.) (II.) (2016) (online at www.ice.gov/detention-standards/2011).

[3] *Solitary Confinement Should be Banned in Most Cases, UN Expert Says*, United Nations News (Oct. 18, 2011) (online at https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says); United Nations, *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Aug. 5, 2011) (online at https://undocs.org/A/66/268).

[4] *Solitary Confinement Should Be Banned in Most Cases, UN Expert Says,* United Nations News (Oct. 18, 2011) (online at https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says).

[5] United Nations, *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Aug. 5, 2011) (online at https://undocs.org/A/66/268).

[6] *ICE Review Found Failures in Care of Mentally Ill Detainee Who Died by Suicide,* CBS News (Aug. 22, 2019) (online at www.cbsnews.com/news/jean-carlos-jimenez-joseph-ice-review-documented-failures-in-care-of-mentally-ill-detainee-who-died-by-suicide/).

[7] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 2.12 (V.)(P.) (2016) (online at www.ice.gov/detention-standards/2011).

[8] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 7.1 (V.)(C.)(5.) (2016) (online at www.ice.gov/detention-standards/2011).

On July 24, 2019, more than a month before the Committee's visit to Stewart Detention Center, Pedro Arriago-Santoya, a Mexican man waiting to be deported, died of "cardiopulmonary arrest" at the facility.[9] Despite his death, the warden at Stewart Detention Center—who is employed by CoreCivic, a for-profit contractor—informed Committee staff that his company had determined that it was not necessary to have defibrillators throughout the facility because they were available on the two crash carts located in the medical care unit. ICE standards require Stewart Detention Center to have a defibrillator that is "accessible to staff," but given the size of the facility, the Committee is concerned that Stewart Detention Center staff may not be able to access defibrillators in a timely manner to respond to emergencies.[10] In addition, detainees reported that facility officers were often asleep on duty and that the distress buttons in their units either did not work or were ignored.

Many detainees told Committee staff they had experienced trauma related to extreme fear of returning to the countries from which they fled. Detainees expressed feelings of hopelessness and uncertainty regarding their current circumstances. Committee staff heard reports of numerous individuals who have remained in detention for months after receiving orders of removal. Detainees told Committee staff that the uncertainty regarding their cases, paired with frustration regarding mistreatment at the facilities, amounted to "psychological torture." From Committee staff observations, none of the three facilities appear to be adequately equipped to appropriately treat or manage the trauma and ongoing duress experienced by these individuals.

During the Committee staff's visit to Stewart Detention Center, a group of Cuban detainees told staff that some men had been engaging in hunger strikes to send a message regarding what they believed to be discriminatory treatment toward Cuban immigrants in the immigration process and at Stewart.

On September 12, 2019, ICE informed Committee staff that on the evening of the staff's September 11 visit to the Stewart facility, between 60 and 70 detainees, including Cuban immigrants, staged a protest by refusing to come inside from the recreation yard. The detainees remained outside through the night and were forcibly removed by detention officers the following day. The ICE official who informed Committee staff about the event acknowledged that a series of events—particularly the recent deaths at Stewart Detention Center and mounting frustration among detainees—led to the protest. He also noted the recent deportation of 120 Cuban immigrants, which was described by ICE as "the largest group of Cuban nationals to be removed on a single flight in recent years."[11]

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[9] Immigration and Customs Enforcement, Department of Homeland Security, *ICE Detainee Passes Away at Georgia Hospital* (July 25, 2019) (online at www.ice.gov/news/releases/ice-detainee-passes-away-georgia-hospital-2).

[10] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 4.3 (V.)(T.)(C.)(1.) (2016) (online at www.ice.gov/detention-standards/2011).

[11] Immigration and Customs Enforcement, Department of Homeland Security, *ICE ERO Removes 120 Cuban Nationals via ICE ERO Air Operations Charter to Havana* (Sept. 4, 2019) (online at www.ice.gov/news/releases/ice-ero-removes-120-cuban-nationals-ice-air-operations-charter-havana).

Numerous detainees at the three facilities described inhumane or unsanitary conditions. For example, some detainees at Folkston ICE Processing Center reported filthy showers that had been cleaned only for the purpose of the visit by Committee staff. Detainees reported that more than 60 individuals are forced to share one or two toilets, and detention officers provide the entire group a total of only five minutes at a time to go to the bathroom. ICE's standards require that toilets be provided at a minimum ratio of one for every twelve male detainees.[12] Multiple detainees at Folkston ICE Processing Center described not being allowed by some detention officers to cover their bodies with their blankets at night. ICE standards state that, at a minimum, bedding should include one mattress, one blanket, and one pillow and that "additional blankets shall be issued, based on local indoor-outdoor temperatures."[13]

Several detainees at the Irwin County Detention Center reported concerns with sleep deprivation caused by repeated counts of detainees during the night, lights not being dimmed until midnight on weekdays and 2 a.m. on weekends, and a wake-up time to eat breakfast at 4 a.m. ICE standards require that formal counts be conducted "at least once every eight hours" and that "counts shall be scheduled to achieve full accountability with minimal interference."[14] Current schedules at the Georgia facilities indicate counts during typical sleeping hours are occurring around three times per night. For example, the warden at Stewart told Committee staff that there are counts at 11 p.m., 1 a.m., and 3:30 a.m. Detainees said these counts are conducted in a manner that disrupts their sleep, often by shaking them awake or banging on their door or bunk.

Detainees said that some facility officers are verbally abusive. Across facilities, detainees said that animals are treated better than they are and that guards use harsh language toward detainees, such as "f--k you" and "motherf--ker." Multiple individuals reported that treatment can be especially harsh for detainees who do not speak English. Detainees who do not understand instructions are sometimes punished, including through restrictions on activities, denials of health care, and—in one incident reported to Committee staff—the use of force against a detainee who failed to follow instructions of facility officers spoken in English that were not understood.

The Committee is also concerned about reports of ICE personnel and contractors using aggressive force. Committee staff understand from local advocates that severe anti-riot tactics may have been used to end the protest at Stewart Detention Center, and public reports indicate similar uses of force to quell protests at ICE detention centers in Pine Prairie and Bossier, Louisiana, including widespread use of pepper spray on detainees.[15] During a visit to Pine

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[12] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 4.5 (V.)(E.)(1.) (2016) (online at www.ice.gov/detention-standards/2011).

[13] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 4.5 (V.)(G.)(1.) (2016) (online at www.ice.gov/detention-standards/2011).

[14] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 2.8 (V.)(A.)(1.) (2016) (online at www.ice.gov/detention-standards/2011).

[15] *More Than 100 Immigrants On Hunger Strike At ICE Facility Allegedly Pepper-Sprayed, Shot at With Rubber Bullets and Blocked from Contacting Families*, Newsweek (Aug.7, 2019) (online at www.newsweek.com/ice-detainees-hunger-strike-pepper-sprayed-excessive-force-1452953); *Dozens of ICE*

Prairie on August 22, 2019, Committee staff were barred from speaking to detainees and were not informed about an incident involving pepper spray that occurred less than three weeks earlier. Although GEO Group staff at Pine Prairie committed to provide information on use-of-force incidents after the visit, the Committee has not received it. Instead, the Committee has received only general statistical information from ICE.

Detainees stated that they feared retaliation for meeting with Committee staff and that some individuals did not volunteer to speak with staff due to fears of retaliation. Retaliation against detainees for filing an informal or formal complaint or grievance is prohibited in the Performance-Based National Detention Standards.[16] Committee staff received information regarding a potential retaliatory transfer of a detainee after the Committee visit to one Georgia facility. At another facility, a detainee expressed concern regarding harassment for speaking with staff. More broadly, detainees in multiple states, across Customs and Border Patrol and ICE facilities, have expressed concerns regarding potential retaliation for having spoken with Committee staff.

I respectfully request that your office reviews any instances of retaliation against detainees at Stewart, Irwin, and Folkston detention facilities for speaking with Committee staff. Please also review any instances of retaliation at the other detention facilities that Committee staff have visited. A list of these facilities is enclosed. Any filed grievances or complaints should be contained in the detainee files at the respective facilities.[17] As part of this review, please detail any instances of retaliation and the steps taken at the respective facilities to prevent and respond to the reported retaliation.

Your office has previously performed inspections of the ICE detention facilities in Georgia. Given the findings during recent Committee staff visits—which occurred with significant notice to ICE and the facilities—I urge you to initiate a review of these concerns as well as a review of compliance with previous recommendations by your office. Thank you for your prompt assistance in this matter.

Sincerely,

Carolyn B. Maloney
M.C

Carolyn B. Maloney
Acting Chairwoman

cc: The Honorable Jim Jordan, Ranking Member

Detainees Were Pepper-Sprayed by Guards for Protesting at a Louisiana Jail, Mother Jones (Aug. 2, 2019) (online at www.motherjones.com/politics/2019/08/immigrant-detention-ice-bossier-louisiana-pepper-spray/).

[16] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 6.2 (V.)(G.) (2016) (online at www.ice.gov/detention-standards/2011).

[17] Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011*, 7.1 (V.)(C.)(4.) (2016) (online at www.ice.gov/detention-standards/2011).

APPENDIX

Department of Homeland Security Immigration Facilities Visited by Oversight and Reform Committee Staff August—September 2019

U.S. Immigration and Customs Enforcement Detention Facilities

1. Adams County Correctional Center, Natchez, MS
2. Catahoula Correctional Center, Harrisonburg, LA
3. Pine Prairie ICE Processing Center, Pine Prairie, LA
4. Otay Mesa Detention Center, San Diego, CA
5. Port Isabel Detention Center, Los Fresnos, TX
6. T. Don Hutto Residential Center, Taylor, TX
7. South Texas Family Residential Center, Dilley, TX
8. South Texas Detention Complex, Pearsall, TX
9. ICE Processing Center, El Paso, TX
10. Stewart Detention Center, Lumpkin, GA
11. Irwin County Detention Center, Ocilla, GA
12. Folkston ICE Processing Center, Folkston, GA

U.S. Customs and Border Protection Facilities

1. Yuma, AZ Border Patrol Station
2. El Centro, CA Border Patrol Station
3. Chula Vista, CA Border Patrol Station
4. Imperial Beach, CA Border Patrol Station
5. Weslaco, TX Border Patrol Station
6. Fort Brown, TX Border Patrol Station
7. Donna, TX Holding Facility
8. Calexico, CA Port of Entry
9. San Ysidro, CA Port of Entry
10. Brownsville, TX Port of Entry