OFFICE OF INSPECTOR GENERAL

Concerns about ICE Detainee Treatment and Care at Detention Facilities

Homeland Security

December 11, 2017

OIG-18-32

DHS OIG HIGHLIGHTS

Concerns about ICE Detainee Treatment and Care at Detention Facilities

December 11, 2017

Why We Did This Inspection

In response to concerns raised by immigrant rights groups and complaints to the Office of Inspector General (OIG) Hotline about conditions for detainees held in U.S. Immigration and Customs Enforcement (ICE) custody, we conducted unannounced inspections of five detention facilities to evaluate their compliance with ICE detention standards.

What We Recommend

We made one recommendation to improve ICE's oversight of detention facility management and operations.

For Further Information:
Contact our Office of Public Affairs at (202) 254-4100, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

Our inspections of five detention facilities raised concerns about the treatment and care of ICE detainees at four of the facilities visited. Overall, we identified problems that undermine the protection of detainees' rights, their humane treatment, and the provision of a safe and healthy environment. Although the climate and detention conditions varied among the facilities and not every problem was present at all of them, our observations, interviews with detainees and staff, and our review of documents revealed several issues. Upon entering some facilities, detainees were housed incorrectly based on their criminal history. Further, in violation of standards, all detainees entering one facility were strip searched. Available language services were not always used to facilitate communication with detainees. Some facility staff reportedly deterred detainees from filing grievances and did not thoroughly document resolution of grievances. Staff did not always treat detainees respectfully and professionally, and some facilities may have misused segregation. Finally, we observed potentially unsafe and unhealthy detention conditions.

ICE Response

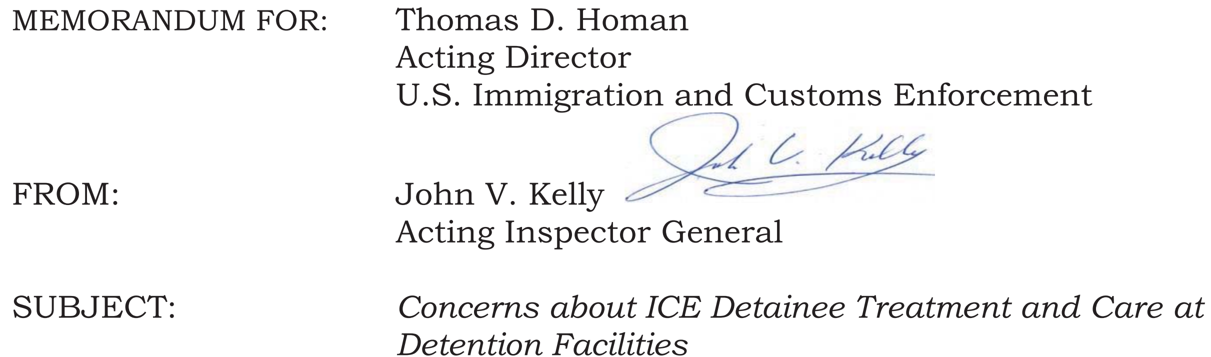
ICE concurred with the recommendation and has begun corrective action to address the findings in this report.

OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

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

December 11, 2017



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

FROM: John V. Kelly
Acting Inspector General

SUBJECT: *Concerns about ICE Detainee Treatment and Care at Detention Facilities*

For your action is our final report, *Concerns about ICE Detainee Treatment and Care at Detention Facilities*. We incorporated the formal comments provided by your office.

The report contains one recommendation aimed at improving ICE's detention operations. Your office concurred with the recommendation. Based on information provided in your response to the draft report, we consider recommendation 1 open and resolved. Once your office has fully implemented the recommendation, please submit a formal closeout letter to us within 30 days so that we may close the recommendation. The memorandum should be accompanied by evidence of completion of agreed-upon corrective actions. Please send your response or closure request to OIGInspectionsFollowup@oig.dhs.gov.

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 call me with any questions, or your staff may contact Jennifer L. Costello, Assistant Inspector General for Inspections and Evaluations, at (202) 254-4100.

Background

U.S. Immigration and Customs Enforcement (ICE) apprehends, detains, and removes aliens who are in the United States unlawfully. ICE Enforcement and Removal Operations (ERO) places apprehended aliens who require custodial supervision in detention facilities. ICE uses the following types of detention facilities for adults:

- Service processing centers – owned by ICE and operated by ICE and contract employees; dedicated exclusively to ICE detention.
- Contract detention facilities – owned and operated by private companies under contract with ICE; dedicated exclusively to ICE detention.
- Dedicated Intergovernmental Service Agreement (IGSA) facilities – state and local facilities operating under an agreement with ICE; hold only ICE detainees.
- Non-dedicated IGSA facilities – state and local facilities operating under an agreement with ICE; house ICE detainees in addition to other confined populations (i.e., inmates), either together or separately.

Contracts and agreements with facilities that hold ICE detainees require adherence to the 2000 National Detention Standards, ICE's *2008 Performance-Based National Detention Standards* (PBNDS), or the 2011 PBNDS. One facility we visited is operating under the 2000 National Detention Standards, one facility operates under the 2008 PBNDS, and three operate under the 2011 PBNDS.

According to ICE, the PBNDS establish consistent conditions of confinement, program operations, and management expectations within ICE's detention system. Among others, the PBNDS establish standards for environmental health and safety, including cleanliness, sanitation, security, admission into facilities, classification, searches of detainees, segregation (Special Management Units), and the disciplinary system. The PBNDS also contain standards for detainee care, including food service, medical care, and personal hygiene; activities, including religious practices, telephone access (e.g., to families, legal representatives, and embassies), visitation (e.g., by legal representatives); and a grievance system. The 2008 PBNDS and 2011 PBNDS have consistent requirements in the areas in which we identified issues.

All ICE detainees are held in civil, not criminal, custody, which is not supposed to be punitive. ICE confines detainees administratively to process and prepare them for deportation. Some detainees held at ICE detention facilities have been convicted of crimes, served their prison sentence, and have been transferred to the facility awaiting deportation by ICE or an immigration court hearing. Other

detainees have violated immigration laws and are in detention pending resolution of their cases. Prior to detention, ICE reviews each detainee's criminal record and assigns a risk level of high, medium/high, medium/low, or low. ICE bases its risk levels on the severity of past criminal charges and convictions.

ICE ERO has 24 Field Office Directors who are chiefly responsible for detention facilities in their assigned geographic area. ICE ERO oversees the confinement of detainees in nearly 250 detention facilities that it manages in conjunction with private contractors or state or local governments, as previously noted. ERO staff are responsible for monitoring conditions of confinement at these facilities.

When choosing the facilities to visit, we used our professional judgement and identified those of particular concern based on Office of Inspector General (OIG) Hotline complaints, reports from non-governmental organizations, and open source reporting. We made unannounced visits to six facilities: Hudson County Jail (mixed gender), Laredo Processing Center (female-only), Otero County Processing Center (male-only), Santa Ana City Jail (mixed gender), Stewart Detention Center (male-only), and Theo Lacy Facility (male-only).[1] The Laredo Processing Center, Otero County Processing Center, and Stewart Detention Center are dedicated IGSAs; Hudson County Jail, Santa Ana City Jail, and Theo Lacy are non-dedicated IGSA facilities.

At each facility, we examined the medical units; medical modular housing (for detainees requiring more medical attention); kitchen, including food preparation, food storage, and equipment cleaning areas; intake and out-processing areas; Special Management Units (segregation); and modular housing units, including individual cells. We also analyzed grievance procedures and evaluated staff-detainee communication practices. We interviewed detainees, ICE staff, and facility management staff at each facility. We followed up on issues by reviewing files and documents.

[1] On March 6, 2017, DHS OIG issued *Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California* (OIG-17-43-MA). This report focuses on our inspections of the other five detention facilities.

Results of Inspection

Our inspections of five detention facilities raised concerns about the treatment and care of ICE detainees at four facilities. Although the Laredo Processing Center modeled quality operations, during our inspections, we identified significant issues at the four other facilities. Overall, the problems we identified undermine the protection of detainees' rights, their humane treatment, and the provision of a safe and healthy environment. Although the climate and detention conditions varied among the facilities and not every problem was present at all of them, our observations, interviews with detainees and staff, and our review of documents revealed several issues. Upon entering some facilities, detainees were housed incorrectly based on their criminal history. Further, in violation of standards, all detainees entering one facility were strip searched. Available language services were not always used to facilitate communication with detainees. Some facility staff reportedly deterred detainees from filing grievances and did not thoroughly document resolution of grievances. Staff did not always treat detainees respectfully and professionally, and some facilities may have misused segregation. Finally, we observed potentially unsafe and unhealthy detention conditions.

Insufficient Protection of Detainees' Basic Rights

Intake Issues That Could Affect Safety and Privacy

We observed some problems when detainees first arrive at facilities, which could have repercussions for their safety throughout detention, as well as the safety of facility staff. According to the 2011 PBNDS, upon admission (known as intake), facility staff are supposed to expeditiously classify detainees according to their crimes, based on "verifiable and documented information." Detainees' crimes may be felonies (classified as high-risk detainees), but may also have non-violent felony charges and convictions, which are considered low risk. Facilities are to use these classifications to ensure that detainees are housed with others of similar background and criminal history and that high- and low-risk detainees are separated. However, because criminal background information was not always available when the detainees arrived at the Stewart Detention Center, facility staff there had misclassified some detainees with high-risk criminal convictions and subsequently housed them with low-risk detainees. Staff at Stewart admitted they assigned some detainees to housing without having received criminal history reports.

We also received reports at the Stewart Detention Center of inadequate staffing at intake. As a result, according to staff, they did not have enough male

personnel to pat down detainees as required. Although staff used alternative measures, such as a magnetometer wand, to screen incoming detainees, these measures would not be sufficient to identify non-metallic items, drugs, or other contraband that could pose a security risk.

In contrast, at the Santa Ana City Jail, staff confirmed detainee reports of personnel strip searching all detainees upon admission, which they did not document in detainee files as required. This raises two concerns. First, according to the 2011 PBNDS, staff are not to routinely subject detainees to strip searches unless there is “reasonable suspicion” based on “specific and articulable facts that would lead a reasonable officer to believe that a specific detainee is in possession of contraband.” Second, without documentation, there is no way to ascertain whether these searches were justified or whether they infringed on the privacy and rights of detainees.

Language Barriers Hamper Communication and Understanding

Although the PBNDS specify that language assistance be provided to detainees, this was not always the case at the facilities we visited. The ensuing lack of communication and understanding creates barriers between facility staff and detainees. Consequently, this may cause confusion about facility rules and procedures and risks turning problems that could have been resolved through routine interaction into disciplinary issues. Ultimately, this lack of communication and understanding impacts the overall well-being of detainees and the security of the facility.

At some facilities, problems began at intake where facility staff failed to use interpretation services for detainees who did not speak English. Further, according to the PBNDS, when detainees arrive, they are supposed to receive the *ICE National Detainee Handbook* and a local facility detainee handbook. These handbooks cover essential information, such as the grievance system, services and programs, medical care, and access to legal counsel. At three facilities we inspected, detainees were not always given handbooks in a language they could understand. These language barriers could prevent detainees from fully comprehending basic facility rules and procedures. Using interpretation services would be a relatively simple way to improve interaction between staff and detainees and reduce misunderstandings.

At times, language barriers prevented detainees from understanding medical staff. Although it might have cleared up confusion, staff did not always use language translation services, which are available by phone, during medical exams of detainees. Some medical consent forms were not always available in Spanish, and staff did not always explain the English forms to non-English

speaking detainees. As a result, detainees may not have been providing enough information about their medical conditions to ensure adequate medical treatment while in detention.

Difficulties Resolving Issues through the Grievance System and Other Channels

The PBNDS establish procedures for detainees to file formal grievances, which are designed to protect detainees' rights and ensure detainees are treated fairly. However, resolution depends on facility staff properly handling and addressing grievances without deterrents, which we identified at several facilities. Specifically, some detainees reported that staff obstructed or delayed their grievances or intimidated them, through fear of retaliation, into not complaining. These deterrents may prevent detainees from filing grievances about serious concerns that should be addressed and resolved.

We reviewed a sample of grievances that were available at the facilities we visited. At the Stewart Detention Center, we found an inconsistent and insufficiently documented grievance resolution process. Many serious complaints from the sample at this facility included only cursory and uninformative explanations of the resolution. For one particularly troubling allegation of misconduct by facility staff, there was no clear documentation it had been investigated, only a note that it would be investigated. We were later able to verify that this allegation had been elevated and investigated by ICE, but this was not explicitly documented in the facility's grievance system.

According to the PBNDS, detainees may also seek help from ICE officials at facilities to resolve their complaints, but some detainees we interviewed reported that ICE personnel were not available to address their questions or concerns because they rarely visited their housing units. Some detainees also reported that ICE staff did not respond when contacted through written requests.

Detainees are supposed to have access to telephones and be able to make free calls to the Department of Homeland Security OIG. Yet, at the Otero County Processing Center we observed non-working telephones in detainee housing areas; at the Stewart Detention Center, when we called the OIG Hotline, we received a message that the number was restricted.

Without an effective, compliant grievance process and access to ICE and other channels, facilities risk escalating or ignoring problems, which may lead to a failure to protect detainees' rights.

Improper Treatment of Detainees by Detention Facility Staff

We had concerns about a lack of professionalism and inappropriate treatment of detainees by facility staff, which fostered a culture of disrespect and disregard for detainees' basic rights. At the Laredo Processing Center, detainees we interviewed were generally positive about staff treating them with respect. In contrast, detainees at the other four facilities alleged poor treatment, which contributed to an overall negative climate.

At four facilities, detainees alleged in interviews that staff mistreated them, citing guards yelling at detainees, as well as using disrespectful and inappropriate language. For example, at the Santa Ana City Jail, multiple detainees corroborated an incident in which a guard yelled at detainees for several minutes, while threatening to lock down detainees at his discretion. We reviewed surveillance video footage of the incident, which confirmed detainee accounts, including a hostile and prolonged rant and threats of a lock-down. Some detainees at the Stewart Detention Center also reported that staff sometimes interrupted or delayed Muslim prayer times.

Potential Misuse of Segregation

Facility staff may separate detainees from the general population and place them in either disciplinary segregation or administrative segregation for a number of reasons, including violations of facility rules, risk of violence, or to protect them from other detainees. Most cases we reviewed involved administrative segregation, but some involved disciplinary segregation.

The Otero County Processing Center, Stewart Detention Center, and the Santa Ana City Jail were violating the PBNDS in the administration, justification, and documentation of segregation and lock-down of detainees. Staff did not always tell detainees why they were being segregated, nor did they always communicate detainees' rights in writing or provide appeal forms for those put in punitive lock-down or placed in segregation. In multiple instances, detainees were disciplined, including being segregated or locked down in their cells, without adequate documentation in the detainee's file to justify the disciplinary action. For example, one detainee reported being locked down for multiple days for sharing coffee with another detainee. We also identified detainees who were held in administrative segregation for extended periods of time without documented, periodic reviews that are required to justify continued segregation. Some detainees were locked down in their cells for violations of minor rules without required written notification of reasons for lock-down and

appeal options. Documentation of daily medical visits and meal records for detainees being held in segregation was also missing or incomplete. Some of these issues may simply be a matter of inadequate documentation, but they could also indicate more serious problems with potential misuse of segregation.[2]

Problems with Detainee Care and Facility Conditions

Medical Care May Have Been Delayed and Was Not Properly Documented

Although the facilities provided health care services, as required by PBNDS, some detainees at the Santa Ana City Jail and Stewart Detention Center reported long waits for the provision of medical care, including instances of detainees with painful conditions, such as infected teeth and a knee injury, waiting days for medical intervention. In addition, two detainees, one at the Hudson County Jail and another at the Santa Ana City Jail, waited several months for eyeglasses following a vision exam that confirmed a need for them. Finally, not all medical requests detainees claimed they submitted or the outcomes were documented in detainee files or facility medical files.

Lack of Cleanliness and Limited Hygienic Supplies

Although the 2011 PBDNS require maintaining "high facility standards of cleanliness and sanitation," at Otero County Processing Center and Stewart Detention Center we observed detainee bathrooms that were in poor condition, including mold and peeling paint on walls, floors, and showers. At the Stewart Detention Center, some detainee bathrooms had no hot water and some showers lacked cold water. Also, detainees reported water leaks in some housing areas.

Multiple detainees at the Hudson County Jail and Stewart Detention Center also complained that some of the basic hygienic supplies, such as toilet paper, shampoo, soap, lotion, and toothpaste, were not provided promptly or at all when detainees ran out of them. According to one detainee, when they used up their initial supply of certain personal care items, such as toothpaste, they were advised to purchase more at the facility commissary, contrary to the PBNDS, which specify that personal hygiene items should be replenished as needed.

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[2] On September 29, 2017, we issued *ICE Field Offices Need to Improve Compliance with Oversight Requirements for Segregation of Detainees with Mental Health Conditions* (OIG-17-119).

Potentially Unsafe Food Handling

We observed several problems with food handling and safety at four facilities, some of which did not comply with the PBNDS for food operations and could endanger the health of detainees. We observed spoiled, wilted, and moldy produce and other food in kitchen refrigerators, as well as food past its expiration date. We also found expired frozen food, including meat, and thawing meat without labels indicating when it had begun thawing or the date by which it must be used. Finally, at one facility, we observed food service workers not wearing required nets to cover facial hair to ensure food safety.

Conclusion

Treatment and care of detainees at facilities can be challenging. For example, personnel at one facility reported staffing shortages, and, according to officials, it can be difficult for remote facilities to provide medical care to detainees. Nevertheless, complying with the PBNDS and establishing an environment that protects the rights, health, and safety of detainees are crucial to detention. ICE could mitigate and resolve many of these issues through increased engagement and interaction with the facilities and their operations.

Recommendation

We recommend that the Acting Director of U.S. Immigration and Customs Enforcement ensure that Enforcement and Removal Operations field offices that oversee the detention facilities covered in this report develop a process for ICE field offices to conduct specific reviews of these areas of operations: detainee classification, use of language services, use of segregation and disciplinary actions, compliance with grievance procedures, and detainee care including facility conditions. The process should include deficiency and corrective action reporting to Enforcement and Removal Operations headquarters to ensure deficiencies are corrected.

Management Comments and OIG Analysis

We evaluated ICE's written comments and changed the report where we deemed appropriate. A summary of the written response to the report recommendation and our analysis of the response follows. Appendix B includes ICE's response in its entirety. In addition, we incorporated ICE's technical comments into the report, as appropriate.

ICE acknowledged the importance of and challenges with detainee treatment and care in detention facilities. ICE reported it discontinued the contract with the Santa Ana City Jail in early 2017 and will no longer house detainees in this facility.

ICE Response: Concur. The ICE Director and ERO field office leadership will advise compliance personnel in the ICE facilities identified by OIG to fully integrate special assessments of the below operational areas into their existing auditing and compliance efforts: (1) detainee classification, (2) use of language services, (3) use of segregation and disciplinary actions, (4) compliance with grievance procedures, and (5) detainee care, including facility conditions. Special emphasis in these areas will strengthen ICE's existing system of oversight and compliance and improve overall conditions of detention.

According to ICE senior officials, ICE maintains a rigorous and multi-faceted inspection schedule for its detention facilities, and local field management is responsible for the areas identified in the recommendation. ICE's detention operations are governed by national detention standards and are overseen by field office personnel, inspections by the ICE Office of Professional Responsibility, and other programmatic oversight and inspections by the Detention Standards Compliance Unit, which includes the facility inspection contract and the Detention Management Compliance Program. ICE headquarters, particularly the Detention Management Compliance Unit, works on a daily basis with the ERO field offices, the Office of Detention Policy and Planning, and the DHS Office for Civil Rights and Civil Liberties to ensure that facilities comply with ICE detention standards or take the necessary corrective action to address problems and concerns.

OIG Analysis: ICE's response to this recommendation addresses the intent of the recommendation. In ICE's corrective actions, we will look specifically at the newly established or revised processes used to advise personnel and complete special assessments for the operational areas outlined in the report. This recommendation is resolved and will remain open until ICE provides evidence it has integrated special assessments of the operational areas identified as concerns. Once completed, ICE should provide a copy of the completed reviews identifying the process developed to ensure deficiencies were corrected and facilities are complying with standards.

Appendix A
Objective, Scope, and Methodology

DHS OIG was established by the *Homeland Security Act of 2002*, Pub. L. No. 107−296, 116 Stat. 2135, which amended the *Inspector General Act of 1978*.

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

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

- OIG Hotline complaints
- ICE *Performance-Based National Detention Standards*
- DHS Office for Civil Rights and Civil Liberties reports
- ICE Office of Detention Oversight reports
- Information from non-governmental organizations

During the inspections we:

- visited six facilities: Hudson County Jail, Laredo Processing Center, Otero County Processing Center, Santa Ana City Jail, Stewart Detention Center, and Theo Lacy Facility (previously reported);
- 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; recreational facilities; and barber shops;
- reviewed facilities' compliance with key health, safety, and welfare requirements of the PBNDS for classification and searches, segregation, use of force and restraints, medical care, mental health care, staffing, training, medical and nonmedical grievances, and access to translation and interpretation;

- interviewed ICE and detention facility staff members, including key ICE operational and detention facility oversight staff, detention facility wardens or equivalent, and detention facility medical, classification, grievance and compliance officers;
- interviewed detainees held at the detention facilities to evaluate compliance with PBNDS grievance procedures and grievance resolution; and
- reviewed documentary evidence, including electronic and paper medical files and grievance logs and files.

We conducted this review 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.

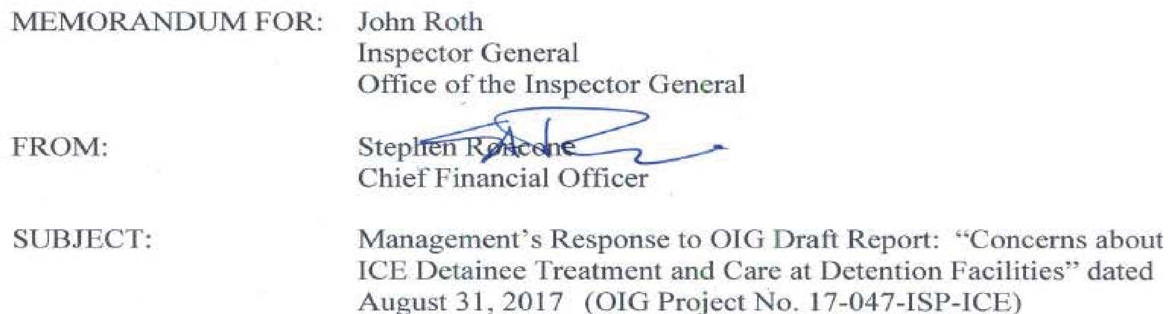
Appendix B
ICE Comments to the Draft Report

Office of the Chief Financial Officer

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

October 18, 2017



MEMORANDUM FOR: John Roth
Inspector General
Office of the Inspector General

FROM: Stephen Roncone
Chief Financial Officer

SUBJECT: Management's Response to OIG Draft Report: "Concerns about ICE Detainee Treatment and Care at Detention Facilities" dated August 31, 2017 (OIG Project No. 17-047-ISP-ICE)

Thank you for the opportunity to review and comment on this draft report. U.S. Immigration and Customs Enforcement (ICE) appreciates the Office of Inspector General's (OIG) work in planning and conducting its review and issuing this report.

ICE appreciates that the OIG acknowledges that treatment and care of detainees can be challenging. ICE maintains a rigorous and multi-faceted inspection schedule for its detention facilities, and local field management is responsible for the aforementioned areas identified in the recommendation. ICE's detention operations are governed by national detention standards and are overseen by field office personnel, inspections by the ICE Office of Professional Responsibility, and other programmatic oversight and inspections by ICE Enforcement and Removal Operations (ERO). ICE works on a daily basis with the ERO field offices, the Office of Detention Policy and Planning, and the DHS Office for Civil Rights and Civil Liberties to ensure that facilities comply with ICE detention standards or take the necessary corrective action to address problems and concerns.

The draft report contained one recommendation with which ICE concurs. Attached find our detailed response for the recommendation.

Again, thank you for the opportunity to review and comment on this draft report. Technical Comments were previously provided under separate cover. Please feel free to contact us if you have any questions. We look forward to working with you in the future.

Attachment

www.ice.gov

OIG recommended that the Acting Director of ICE:

Recommendation 1: Ensure that Enforcement and Removal Operations (ERO) field offices that oversee the detention facilities covered in this report develop a process for ICE field offices to conduct specific reviews of these areas of operations: detainee classification, use of language services, use of segregation and disciplinary actions, compliance with grievance procedures, and detainee care including facility conditions. The process should include deficiency and corrective action reporting to Enforcement and Removal Operations headquarters to ensure deficiencies are corrected.

Response: Concur. The ICE Director and ERO Field Office leadership will advise compliance personnel in the ICE facilities identified by OIG to fully integrate special assessments of the below operational areas into their existing auditing and compliance efforts: (1) detainee classification, (2) use of language services, (3) use of segregation and disciplinary actions, (4) compliance with grievance procedures, and (5) detainee care including facility conditions. Special emphasis in these areas will only strengthen ICE's existing system of oversight and compliance and improve overall conditions of detention.

As previously noted, ICE maintains a rigorous and multi-faceted inspection schedule for its detention facilities, and local field management is responsible for the aforementioned areas identified in the recommendation. ICE's detention operations are governed by national detention standards and are overseen by field office personnel, inspections by the ICE Office of Professional Responsibility, and other programmatic oversight and inspections by the Detention Standards Compliance Unit, which includes the facility inspection contract and the Detention Management Compliance Program. ICE headquarters, particularly the Detention Management Compliance Unit, works on a daily basis with the ERO field offices, the Office of Detention Policy and Planning, and the DHS Office for Civil Rights and Civil Liberties to ensure that facilities comply with ICE detention standards or take the necessary corrective action to address problems and concerns.

We respectfully request that the OIG close this recommendation.

Appendix C
Office of Inspections Major Contributors to This Report

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Appendix D
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