Testimony of Katherine Hawkins, Senior Legal Analyst
The Constitution Project at the Project On Government Oversight
before the House Committee on Homeland Security
Subcommittee on Oversight, Management, and Accountability
On "Oversight of ICE Detention Facilities: Is DHS Doing Enough?"
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Chairwoman Torres Small, Ranking Member Crenshaw, and members of the Subcommittee, thank you for the opportunity to testify today on oversight of immigration detention centers.

I am Katherine Hawkins, a senior legal analyst for The Constitution Project at the Project On Government Oversight. The Project On Government Oversight (POGO) is a nonpartisan independent watchdog that investigates and exposes waste, corruption and abuse of power, and when the government fails to serve the public or silences those who report wrongdoing. We champion reforms to achieve a more effective, ethical, and accountable federal government that safeguards constitutional principles.

As part of that work, my colleagues and I have done a series of investigations into conditions in Immigration and Customs Enforcement (ICE) detention centers.[1] I will briefly explain our findings and suggest actions Congress can take to improve oversight of these facilities.

POGO's Investigations of ICE Detention Facilities

We found serious flaws in ICE's inspection and oversight system and inhumane conditions in ICE detention centers, including the Adelanto, Aurora, and Stewart facilities. Department of Homeland Security (DHS) and ICE documents reveal inadequate medical care, inadequate mental health care, and overuse of solitary confinement.

These problems are chronic, but they have grown worse with the rapid expansion of ICE detention over the last two and a half years. ICE is currently detaining over 52,000 people, in a

[1] Nick Schwellenbach, "Confidential Report Warned ICE of 'Inhumane' Use of Solitary Confinement," Project On Government Oversight, September 12, 2019. https://www.pogo.org/investigation/2019/09/confidential-report-warned-ice-of-inhumane-use-of-solitary-confinement/; Nick Schwellenbach, Mia Steinle, Katherine Hawkins, and Andrea Peterson, "Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months," Project On Government Oversight, August 14, 2019. https://www.pogo.org/investigation/2019/08/isolated-ice-confines-some-detainees-with-mental-illness-in-solitary-for-months/; Katherine Hawkins, "Medical Neglect at a Denver Immigration Jail," Project On Government Oversight, May 21, 2019. https://www.pogo.org/investigation/2019/05/medical-neglect-at-a-denver-immigration-jail/; Katherine Hawkins, "Outsourced Oversight," Project On Government Oversight, March 12, 2019. https://www.pogo.org/investigation/2019/03/outsourced-oversight/; Ken Silverstein, "Death Valley: Profit and Despair Inside California's Largest Immigrant Detention Camp," Project On Government Oversight, December 22, 2018. https://www.pogo.org/investigation/2018/12/death-valley-profit-and-despair-inside-californias-largest-immigrant-detention-camp/

patchwork of over 200 facilities across the country.[2] This is an increase of over 51% from an average daily population of 34,376 in fiscal year 2016.[3]

ICE detention facilities range in size from county jails that hold only a few immigration detainees at a time, to large facilities dedicated exclusively to immigration custody that hold well over 1,000 people. All facilities that hold over ten ICE detainees are subject to various forms of oversight by DHS. These include annual inspections by an ICE contractor, the Nakamoto Group; inspections by ICE's Office of Detention Oversight; reviews of detainee deaths by ICE's Office of Professional Responsibility; unannounced inspections by the DHS Office of Inspector General; and on-site investigations of detention conditions by DHS's Office for Civil Rights and Civil Liberties (CRCL).

While this may appear to be a rigorous system of inspection and oversight, the system is failing to adequately protect detainees or ensure that facilities comply with detention standards. The Nakamoto Group's inspections, which occur most frequently and can trigger loss of detention facility's contract with ICE, often fail to uncover serious violations. Other inspections are more thorough, but remain hidden from Congress and the public, and ICE fails to implement their recommendations.[4]

As a result, inhumane and unsafe conditions persist for years, sometimes with fatal consequences.

This is not only wrong, but potentially unconstitutional. The Bill of Rights applies to everyone in the United States, not only to citizens. The Supreme Court has held that deliberate indifference to a prisoner's serious medical needs violates the Eighth Amendment's prohibition on cruel and unusual punishment, and circuit courts have held that excessive use of solitary confinement is cruel and unusual. ICE detention is civil, rather than criminal, which means that detainees cannot be subjected to any harmful treatment for the purpose of punishment.

The following are some examples from POGO's investigations of systemic failures in ICE's oversight of detention facilities.

Inadequate Inspections and Mental Health Care at Adelanto

This spring, POGO reported on a dispute between Nakamoto Group inspectors and the Department of Homeland Security inspector general regarding conditions at the Adelanto Detention Facility in California.[5]

In September 2018, the DHS inspector general released an alarming report about conditions uncovered at Adelanto during an unannounced inspection in May 2018. Inspectors found braided

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[2] Emily Kassie, "Detained: How the US built the world's largest immigrant detention system," *The Guardian*, September 24, 2019. https://www.theguardian.com/us-news/2019/sep/24/detained-us-largest-immigrant-detention-trump

[3] Kate Morrissey, "Operator moves to expand detention center for migrants in San Diego County," *Los Angeles Times*, June 24, 2018. https://www.latimes.com/local/lanow/la-me-ln-detention-center-expansion-20180624-story.html

[4] Department of Homeland Security Office of Inspector General, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements*, OIG-18-67 (June 26, 2018). https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf

[5] Hawkins, "Outsourced Oversight" [see note 1].

bedsheets, which they called "nooses," in 15 of the 20 cells they visited; seriously inadequate medical care; and improper use of solitary confinement.[6]

Weeks later, in October 2018, the Nakamoto Group conducted its own scheduled inspection of Adelanto. Nakamoto inspectors found that Adelanto was in compliance with 40 of 40 ICE detention standards, just as they had in 2017. They dismissed the nooses as a "housekeeping infraction," and accused the inspector general of writing an "erroneous" and "inflammatory"[7] report—although an Adelanto detainee had, in fact, used a bedsheet to hang himself in March 2017.[8]

Earlier this month, POGO reported on a third investigation of Adelanto, by the Office for Civil Rights and Civil Liberties, obtained through an ongoing Freedom of Information Act lawsuit.[9] That document was even more disturbing than the inspector general's report, because it demonstrated that violations at Adelanto had gone unaddressed for years.

CRCL reported that in November 2017, it had conducted an investigation into conditions at Adelanto as a follow-up to a prior investigation in December 2015. CRCL wrote,

> In 2015, CRCL clearly informed Adelanto that clinical leadership was not competent and that problematic medical care was occurring as a result. In 2017—two years since the 2015 onsite—the experts found no evidence that corrections were made to address this issue. The failure to hire an effective and qualified clinical leader contributed to the inadequate detainee medical care that resulted in medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees.[10]

CRCL recommended that until new medical leadership could be put in place, "at-risk detainees should immediately be removed from the facility and transferred to other facilities with well-functioning medical programs."[11]

CRCL made equally stark findings with regard to mental health care and the overuse of segregation, particularly for detainees with serious mental illness. CRCL's mental health expert wrote that "at the time of our on-site, 26 of the 50 detainees in segregation had serious mental disorders (such as Schizophrenia or other primary psychotic disorders)," and documented

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[6] Department of Homeland Security Office of Inspector General, *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California*, OIG-18-86 (September 27, 2018). https://www.oig.dhs.gov/sites/default/files/assets/2018-10/OIG-18-86-Sep18.pdf

[7] Memorandum from Lead Compliance Inspector, The Nakamoto Group, Inc., to Assistant Director for Detention Management, about "Annual Detention Inspection of the Adelanto ICE Processing Center East," October 11, 2018, 2-3. https://www.ice.gov/doclib/facilityInspections/adelantoEastCa_CL_10_11_2018.pdf

[8] Hawkins, "Outsourced Oversight" [see note 1].

[9] Schwellenbach, "Confidential Report Warned ICE of 'Inhumane' Use of Solitary Confinement" [see note 1].

[10] Memorandum from Veronica Venture and Dana Salvan-Dunn, Office for Civil Rights and Civil Liberties, to Enforcement and Removal Operation Executive Associate Director Matthew Albence, about Adelanto Correctional Facility Complaints, April 25, 2018, 2. https://www.pogo.org/document/2019/09/dhs-office-for-civil-rights-and-civil-liberties-review-of-adelanto-sent-to-ice-in-april-2018/

[11] Memorandum from Veronica Venture and Dana Salvan-Dunn about Adelanto Correctional Facility Complaints, 2. [see note 10].

"shockingly high" lengths of stays in segregation. These included one detainee who cumulatively spent over 904 days in solitary.[12]

ICE did not respond to our request for comment on the CRCL report. An ICE spokesperson told another reporter that ICE "disagreed with much of" CRCL's review, citing Nakamoto's October 2018 inspection.[13] Moreover, we cannot find evidence that any of the problems with medical and mental health care at Adelanto have been corrected.

Excessive Use of Solitary Confinement

Adelanto is not the only immigration detention facility that has used solitary confinement as a substitute for adequate treatment of detainees suffering from severe mental illness. In August, POGO published a report that examined records of over 6,500 solitary confinement placements across the ICE detention system, from January 2016 to May 2018. We found that "about 40 percent of the records show detainees placed in solitary have mental illness. At some detention centers, the percentage is much higher."[14]

Placing detainees with severe mental illness in segregation instead of providing adequate treatment can have fatal consequences, as illustrated by two recent suicides at the Stewart Detention Center in Lumpkin, Georgia. As POGO reported in August:

> Jean Jimenez-Joseph was taken into ICE custody around the beginning of March 2017. In the months before, he had been involuntarily hospitalized multiple times for schizophrenia and psychosis, and made repeated threats of and attempts at suicide. Jimenez-Joseph's family has alleged in a lawsuit that contrary to agency policies, when ICE officers took custody of him, initially at a county jail, they did not transfer over his "prior detention records, medical records, and his vitally necessary prescription medication for schizophrenia and psychosis."
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> He was transported to ICE's Stewart Detention Center. There, according to the lawsuit, Jimenez-Joseph eventually did receive an antipsychotic medication but he repeatedly requested that the dosage be increased because "the voices in his head were getting worse."
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> But due to "systemic, chronic understaffing" at Stewart, the lawsuit states, particularly for medical and mental health positions, this never occurred. Instead, he was placed in solitary confinement multiple times as his psychiatric symptoms worsened, including for the 20 days before he died. Jimenez-Joseph hanged himself shortly after midnight on May 15, 2017. According to the lawsuit,

[12] *On-Site Investigation Report - Adelanto Correctional Facility, November 2017*, 3, enclosed in Memorandum from Veronica Venture and Dana Salvan-Dunn about Adelanto Correctional Facility Complaints [see note 10].

[13] Schwellenbach, "Confidential Report Warned ICE of 'Inhumane' Use of Solitary Confinement" [see note 1].

[14] Schwellenbach et al., "Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months" [see note 1].

> on the eve of his death, there were ample warnings that his psychological state was dire. The lawsuit states, "Jean had written 'Hallelujah The Grave Cometh' in large, dark letters on the wall" of his solitary confinement cell.
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> Efraín De La Rosa, another detainee with a history of severe schizophrenia and psychosis, hanged himself in solitary confinement at Stewart in July 2018. An employee of ICE's Health Service Corps wrote in an email to agency leadership later that year that De La Rosa "could have been saved" if ICE had responded adequately to "a total of 12 SEN [Significant Event Notifications] reports prior to his death, depicting suicidal ideation and psychosis."[15]

The official ICE review of Jimenez-Joseph's death corroborates his attorney's allegations.[16] De La Rosa's death review still has not been made public.

Nakamoto Group inspectors found that Stewart was in compliance with 39 of 39 applicable detention standards in both 2017 and 2018.[17]

Inadequate Medical Care at Aurora

In May, POGO published an investigation of inadequate medical care at the Aurora Contract Detention Center in Colorado, which a government source alleged had contributed to the death of Kamyar Samimi in December 2017.[18] Soon after we published our report, ICE released its internal review of Samimi's death, which confirmed our source's account.[19]

Samimi, an Iranian citizen who received a U.S. green card in 1979, was arrested by ICE in November 2017 based on a 12-year-old drug possession conviction.[20] He had been prescribed methadone treatment for opioid addiction for years. In ICE custody, he was abruptly cut off from the drug, and began experiencing increasingly severe withdrawal symptoms. According to the internal review of Samimi's death, medical staff at Aurora never physically examined Samimi, nor did they evaluate his symptoms using a standard medical assessment for opioid withdrawal. They also dismissed his increasing and eventually fatal physical and mental deterioration—including "tremors, pain and weakness, nausea and vomiting, refusing meals, inability to sit up in

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[15] Schwellenbach et al., "Isolated: ICE Confines Some Detainees with Mental Illness in Solitary for Months" [see note 1].

[16] Erin Donaghue, "ICE review found failures in care of mentally ill detainee who died by suicide," CBS News, August 22, 2019. https://www.cbsnews.com/news/jean-carlos-jimenez-joseph-ice-review-documented-failures-in-care-of-mentally-ill-detainee-who-died-by-suicide/

[17] Memorandum from Lead Compliance Inspector of The Nakamoto Group, Inc., to Assistant Director for Detention Management about "Annual Detention Inspection of the Stewart Detention Center," May 3, 2018, 2. https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA_CL_05_03_2018.pdf

[18] Hawkins, "Medical Neglect at a Denver Immigration Jail" [see note 1].

[19] ICE Office of Professional Responsibility, *Detainee Death Review - Kamyar Samimi*, May 22, 2018. https://www.documentcloud.org/documents/6019213-Samimi-Death-Review.html

[20] ICE Office of Professional Responsibility, *Detainee Death Review - Kamyar Samimi*, 1-2 [7-8 in PDF][see note 19].

bed or in a wheelchair, incontinence and signs of dehydration"—as "malingering and seeking drugs."[21] Multiple detention officers told investigators they did not believe Samimi was faking his symptoms, and that "all officers were troubled by what they perceived was a lack of care and concern for Samimi."[22]

We found numerous other credible reports of inadequate medical care at Aurora, including one case in which a detainee's untreated bedsores became so severely infected that his leg had to be amputated.[23]

Nakamoto Group inspectors found that Aurora was in compliance with 41 of 41 applicable detention standards in both 2017 and 2018.[24]

Recommendations

In closing, POGO offers a non-exhaustive set of recommendations for improved oversight of ICE detention facilities.

1. As previously recommended by the inspector general's office, DHS should revise its methodology for annual inspections to ensure that the inspection procedures are adequate to evaluate actual conditions at facilities.[25] DHS should consider whether to replace its annual contract inspections with increased resources for in-house inspections by the Office of Detention Oversight. Finally, DHS should impose financial penalties for violations of detention standards regardless of whether they are uncovered by CRCL experts, spot checks by the inspector general, detainee death reviews, or annual inspections.

2. Given ICE's pattern of providing inadequate mental health and medical care to individuals in custody, Congress should reinstitute and codify the Department of Homeland Security's previous policy limiting detention of individuals:

> who are known to be suffering from serious physical or mental illness, who are disabled, elderly, pregnant, or nursing, who demonstrate that they are primary caretakers of children or an infirm person, or whose detention is otherwise not in the public

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[21] Memorandum from Office of Professional Responsibility Assistant Director Jennifer Fenton to Enforcement and Removal Operations Executive Associate Director Matthew Albence, about "Findings - Death of ICE Detainee Kamyar Samimi, May 22, 2018. .https://www.documentcloud.org/documents/6019213-Samimi-Death-Review.html

[22] Creative Corrections, *Detainee Death Review: Kamyar Samimi Healthcare and Security Compliance Review*, March 6, 2018, 58-9 [103-4 in PDF]. https://www.documentcloud.org/documents/6019213-Samimi-Death-Review.html

[23] Hawkins, "Medical Neglect at a Denver Immigration Jail" [see note 1].

[24] Memorandum from Lead Compliance Inspector, The Nakamoto Group, Inc., to Assistant Director for Detention Management about "Annual Inspection of the Aurora Ice Processing Center," October 4, 2018, 2. https://www.ice.gov/doclib/facilityInspections/denverCdfCo_CL_10_04_2018.pdf

[25] Department of Homeland Security Office of Inspector General, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements*, 15 [see note 4].

interest.[26]

3. Congress should place binding restrictions on DHS's ability to transfer funds in order to expand ICE detention capacity. ICE has increased the number of people it detains by over 50% percent in the last two and a half years. It is detaining over 10,000 more people than its appropriated budget allows,[27] an expansion that has clearly outstripped the agency's capacity to provide adequate oversight of detention conditions.

4. Congress should strengthen the authority of the Department of Homeland Security's Office for Civil Rights and Civil Liberties to maximize its effectiveness and transparency. POGO would be happy to provide more detailed recommendations for increasing CRCL's effectiveness to Members of Congress and their staffs upon request.

5. Congress should ensure that the DHS Office of Inspector General has sufficient resources to continue its unannounced inspections of ICE and Customs and Border Protection detention facilities.

6. Members of Congress and their staffs should visit detention facilities, and these visits should include interviews with detainees.

7. Congress should pass legislation ensuring that Members cannot be denied access to immigration detention facilities.

8. Congress should request, by subpoena if necessary, and publicly release copies of
   - Reports from on-site investigations by the Office for Civil Rights and Civil Liberties, including recommendations by the office's subject matter experts; and
   - Detainee death reviews by the ICE Office of Professional Responsibility and the ICE Health Service Corps.

9. Congress should require ICE to conduct investigations and publicly release death reviews for individuals who are released from immigration custody during or shortly before their final hospitalization. Congress should seek information about previous cases of detainees who died soon after their release from ICE custody, including Teka Gulema, Mariee Juárez, Jose Luis Ibarra Bucio, and Johana Medina León.[28]

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[26] Memorandum from Secretary of Homeland Security Jeh Charles Johnson to Acting Director of Immigration and Customs Enforcement Thomas S. Winkowski et al., about "Policies for the Apprehension, Detention and Removal of Undocumented Immigrants," November 20, 2014, 5. https://www.dhs.gov/sites/default/files/publications/14_1120_memo_prosecutorial_discretion.pdf

[27] Letter from Senator Chris Van Hollen et al. to Senator Mitch McConnell et al. about diversion of DHS funds, September 13, 2019. https://www.vanhollen.senate.gov/imo/media/doc/Van_Hollen_CR_and_ICE-CPB_Transfers%20_Letter_to_Leadership.pdf

[28] Tina Vasquez, "Report: In-Custody Deaths of Immigrants Were 'Preventable,'" *Rewire News*, March 2, 2016. https://rewire.news/article/2016/03/02/report-custody-deaths-immigrants-preventable/; Joel Rose, "A Toddler's Death Adds To Concerns About Migrant Detention," *NPR*, August 28, 2018. https://www.npr.org/2018/08/28/642738732/a-toddlers-death-adds-to-concerns-about-migrant-detention; Amy Taxin, "Family seeks answers in immigrant's death after detention," Associated Press, April 10, 2019.

10. Congress should pass legislation to ensure that the private corporations that participate in the ICE detention system are subject to Freedom of Information Act requests.

Thank you again for the opportunity to testify. I am happy to take your questions.

https://www.apnews.com/8775303f79ee4d44a5959c34a8f3d99d; Sam Levin, "Trans woman who died after illness in US custody had asked to be deported, family says," *The Guardian*, June 12, 2019. https://www.theguardian.com/us-news/2019/jun/12/trans-woman-death-us-custody-ice-deportation