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Office of Professional Responsibility Inspections and
Detention Oversight Division
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Office of Detention Oversight Compliance Inspection

Enforcement and Removal Operations ERO Denver Field Office Denver Contract Detention Facility Aurora, Colorado

April 16-18, 2019

COMPLIANCE INSPECTION
of the
DENVER CONTRACT DETENTION FACILITY
Aurora, Colorado

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FACILITY OVERVIEW

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR) Office of Detention Oversight (ODO) conducted a compliance inspection of the Denver Contract Detention Facility (DCDF) in Aurora, Colorado, from April 16-18, 2019.[1] The facility opened in February 1997 and began housing ICE detainees in July 2010. The facility is owned and operated by The GEO Group, Inc. (GEO). The facility is a medium security facility with an average length of stay of 36 days. The facility operates under the ICE Performance-Based National Detention Standards (PBNDS) 2011, as revised in 2016.

ICE Office of Enforcement and Removal Operations (ERO) personnel are assigned to the facility on a full-time basis, including a Detention Service Manager (DSM). However, at the time of the inspection, the DSM position was vacant. The Warden of the facility handles daily facility operations and is supported by (b)(7)(E) personnel. GEO provides medical and food services, and Keefe Commissary Network provides commissary services. The Assistant Warden of Operations of GEO has been acting as the designated Health Services Administrator (HSA). The facility is accredited by the National Commission on Correctional Health Care and the American Correctional Association.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	1540
Average ICE Detainee Population[3]	925
Male Detainee Population (as of 04/16/2019)	1,139
Female Detainee Population (as of 04/16/2019)	183

This is ODO's fifth inspection of the facility. In fiscal year (FY) 2016, ODO conducted an inspection of the DCDF under the ICE PBNDS 2011. ODO reviewed the facility's compliance with 16 standards and found the facility compliant with seven standards. ODO found 24 deficiencies in the remaining nine standards, six of which were priority components and one of which was a repeat deficiency.

[1] This facility holds male and female detainees with low, medium, and high security classification levels for periods greater than 72 hours, in addition to U.S. Marshals inmates.
[2] Data Source: ERO Facility List dated March 18, 2019.
[3] *Ibid.*

FINDINGS BY PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 2011 MAJOR CATEGORIES

PBNDS 2011 STANDARDS INSPECTED[4]	DEFICIENCIES
Part 1 – Safety	
Environmental Health and Safety	1
Sub-Total	**1**
Part 2 – Security	
Admission and Release	3
Custody Classification System	1
Facility Security and Control[5]	1
Funds and Personal Property	0
Sexual Abuse and Assault Prevention and Intervention	0
Special Management Units	3
Staff-Detainee Communication	0
Use of Force and Restraints	1
Sub-Total	**9**
Part 4 – Care	
Food Service	3
Medical Care	3
Medical Care (Women)	2
Significant Self-harm and Suicide Prevention and Intervention	1
Disability, Identification, Assessment, and Accommodation	1
Sub-Total	**10**
Part 5 – Activities	
Recreation	0
Religious Practices	0
Telephone Access	1
Sub-Total	**1**
Part 6 – Justice	
Detainee Handbook	0
Grievance System	0
Law Libraries and Legal Materials	0
Sub-Total	**0**
Total Deficiencies	**21**

[4] For greater detail on ODO's findings, see the *Compliance Inspection Findings* section of this report.
[5] This standard is not part of the core standards of ODO's review. *See* Footnote 12.

COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population greater than ten, and where detainees are housed for over 72 hours, to assess compliance with ICE national detention standards. These inspections focus solely on facility compliance with detention standards that directly affect detainee life, health, safety, and/or well-being.[6] ODO identifies violations outlined in ICE detention standards, ICE policies, or operational procedures, as "deficiencies."

For facilities governed by either the PBNDS 2008 or 2011, ODO specifically notes deficiencies related to ICE-designated "priority components," which are considered critical to facility security and the legal and civil rights of detainees. ODO also highlights instances when the facility resolves deficiencies prior to completion of the ODO inspection. Where applicable, these corrective actions are annotated with "C" under the Compliance Inspection Findings section of this report.

Upon completion of each inspection, ODO conducts a closeout briefing with facility and local ERO officials to discuss preliminary findings. A summary of these findings is also shared with ERO management officials. Thereafter, ODO provides ICE leadership with a final compliance inspection report to: (i) assist ERO in developing and initiating corrective action plans; and (ii) provide senior executives with an independent assessment of facility operations. Additionally, ODO's findings inform ICE executive management in order to aid in the decision-making processes to better allocate resources across the agency's entire detention inventory.

[6] ODO reviews the facility's compliance with selected standards in their entirety.

DETAINEE RELATIONS

ODO interviewed 35 detainees who each voluntarily agreed to participate. None of the detainees made allegations of discrimination, mistreatment, or abuse. Most detainees reported satisfaction with facility services, except for the concerns listed below.

Medical Care: The following detainees expressed concerns about medical care:

One male detainee stated he was in a vehicle accident prior to his ICE detention and complained that although he was treated by medical staff for head pain, the pain persisted.

- Action Taken: ODO reviewed the detainee's medical file and discussed the issue with medical staff. The detainee arrived at DCDF on May 8, 2018, and upon arrival he informed medical staff that he was involved in motor vehicle accident on May 17, 2017. On July 12, 2018, the detainee was referred to a neurologist and underwent a computerized tomography (CT) scan. The CT scan showed traumatic brain injury. On July 30, 2018, the detainee was evaluated by a neurologist, who ordered medications to manage the pain. The detainee's medical record shows he refused to take his medications on September 18, 2018, and September 22, 2018, and was referred back to the neurologist on September 22, 2018. The detainee's record shows that he continued to refuse medications until March 5, 2019, after which he took his medications consistently.

One male detainee stated he complained about stomach pain but received no response from medical staff.

- Action Taken: ODO reviewed the detainee's medical record and discussed the issue with medical staff. The detainee's record revealed that he was seen by a nurse during sick call on five occasions between June 7, 2018 and the week of ODO's inspection. On June 7, 2018, he was seen for stomach pain and was given Mylanta; on June 10, 2018, he was again seen for stomach pain and offered a rectal examination, which he refused; on June 20, 2018, he was seen and treated for an upper respiratory infection; on October 24, 2018, he was seen for stomach pain and again refused a rectal examination; and, on April 17, 2019, he had a follow-up appointment but indicated that he had no complaints at that time.

Detainee Handbook: Thirty-two Indian detainees interviewed in housing unit E-1 all claimed their proficient language to be Punjabi. Each also stated they received both the ICE National Handbook and the local supplement handbook only in English. Because they could not read or understand the content of the handbooks, the detainees were unaware of how to report instances of sexual abuse and how to access services like the law library, the grievance process, etc.

- Action Taken: ODO informed facility staff and ERO's Officer in Charge (OIC) of the detainees' concerns. The OIC stated she is aware of those detainees in the facility who are not proficient in English. The OIC also stated she is in frequent

communication with GEO staff, informing them of the ICE website where handbooks and other information are available in other languages.

COMPLIANCE INSPECTION FINDINGS

SAFETY

ENVIRONMENTAL HEALTH AND SAFETY (EH&S)

ODO found hazardous substances stored in the facility's warehouse were not accurately inventoried **(Deficiency EH&S-1[7])**. Specifically, ODO observed [redacted] that were not on the inventory list.

SECURITY

ADMISSION AND RELEASE (A&R)

ODO's review of 30 detention files found three Orders to Release or Detain (Form I-203) that were not signed by the appropriate ICE ERO authorizing official and two files that were missing the Form I-203 **(Deficiency A&R-1[8])**.

During interviews with housing unit officers, ODO learned that when a detainee is released, the housing unit officer does not set aside the detainee's mattress for rinse and wipe-down with a disinfectant or other solution prescribed by the medical department **(Deficiency A&R-2[9])**.

ODO found DCDF is not within walking distance of public transportation and that when detainees are released, they are not provided with transportation to local bus, train, or subway stations. ODO also learned that DCDF does not provide detainees with a list of legal, medical, and social services available in the release community or a list of shelter services available in the immediate area, along with directions to each shelter, when they are released **(Deficiency A&R-3[10])**.

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[7] "Inventory records for a hazardous substance must be kept current before, during and after each use." *See* ICE PBNDS 2011, Standard, Environmental Health and Safety, Section (V)(B)(6)(d).

[8] "An Order to Detain or an Order to Release the detainee (Form I-203 or I-203a), bearing the appropriate ICE/ERO Authorizing Official signature, must accompany each newly arriving detainee." *See* ICE PBNDS 2011, Standard, Admission and Release, Section (V)(E).

[9] "The staff shall: …

d. set aside the plastic-covered or -sheathed mattress for rinse and wipe-down with disinfectant or other solution prescribed by the medical department."

See ICE PBNDS 2011, Standard, Admission and Release, Section (V)(H)(10)(d).

[10] "Facilities that are not within a reasonable walking distance of, or that are more than one mile from, public transportation shall transport detainees to local bus/train/subway stations prior to the time the last bus/train leaves such stations for the day. If public transportation is within walking distance of the detention facility, detainees shall be provided with an information sheet that gives directions to and describes the types of transportation services available. However, facilities must provide transportation for any detainee who is not reasonably able to walk to public transportation due to age, disability, illness, mental health or other vulnerability, or as a result of weather or other environmental conditions at the time of release that may endanger the health or safety of the detainee. Detainees will be provided with a list of legal, medical, and social services that are available in the release community, and a list of shelter services available in the immediate area along with directions to each shelter." *See* ICE PBNDS 2011, Standard, Admission and Release, Section (V)(I).

CUSTODY CLASSIFICATION SYSTEM (CCS)

During a tour of female housing [redacted], ODO observed [redacted] custody detainees with a history of assaultive or combative behavior housed in a [redacted] detainee housing unit **(Deficiency CCS-1[11])**. ODO reviewed the files of the [redacted] detainees and confirmed they had assaultive or combative behavior in their criminal history.

FACILITY SECURITY AND CONTROL (FS&C)[12]

While inspecting the Special Management Units (SMU) standard, ODO found that general population (GP) detainees were housed in Restricted Housing Unit ([redacted] with detainees on administrative segregation (AS) and disciplinary segregation (DS) status. According to staff, this was done due to the lack of GP bed space. During the construction of [redacted] was installed to restrict the entrance and exit of the unit, in accordance with the standard. Housing GP detainees in the unit circumvents [redacted] and the intent of the standard to separate detainees on AS and DS from GP detainees **(Deficiency FS&C-1[13])**.

SPECIAL MANAGEMENT UNITS (SMU)

ODO's review of SMU records found that five detainees on protective custody (PC) status were housed in SMU for 274, 217, 169, 86 and 9 days, respectively. ODO found another detainee was housed in SMU on medical observation for 68 days. ODO found the files of the five detainees on PC status contained no information supporting their placement in SMU **(Deficiency SMU-1[14])**. Additionally, none of the files for the five PC cases, or the one medical observation case,

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[11] "Ordinarily, detainees in different custody classification levels are housed separately. When it becomes necessary to house detainees of different classification levels in the same housing unit, the following guidelines shall apply:…

5. Under no circumstance may a medium custody detainee with a history of assaultive or combative behavior be placed in a low custody housing unit."

See ICE PBNDS 2011, Standard, Custody Classification System, Section (V)(G)(5). **This is a Priority Component**.

[12] ODO did not review this standard in its entirety but notes non-compliant areas as they were observed during the course of the inspection.

[13] "In facilities with the ability to do so, the SMU entrance in regular use shall have [redacted], which shall be [redacted] Officers on the inside and outside shall independently check the identification of every person going in or out, and each officer must positively confirm a person's identity before allowing him/her through the door. Also, in accordance with written procedures established by the facility administrator, these officers shall take precautions to ensure that the person requesting entry or exit is not doing so under duress." *See* ICE PBNDS 2011, Standard, Facility Security and Control, Section (V)(E)(2).

[14] "Each facility shall develop and follow written procedures, consistent with this standard, governing the management of its administrative segregation unit. These procedures should be developed in consultation with the Field Office Director having jurisdiction for the facility. These procedures must document detailed reasons for placement of an individual in administrative segregation." *See* ICE PBNDS 2011, Standard, Special Management Units, Section (V)(A).

contained documentation that alternative placement was considered **(Deficiency SMU-2[15])** or the reason for continued placement in SMU **(Deficiency SMU-3[16]).**

USE OF FORCE AND RESTRAINTS (UOF&R)

DCDF has two hand-held digital video cameras. [redacted] ODO notes that although both cameras were operable, records show they are checked daily for functionality, and DCDF's post orders for central control require daily checks of the camera located in [redacted], ODO found that the post orders for the shift supervisor do not cover testing and maintenance of audio-visual equipment **(Deficiency UOF&R-1[17])**.

CARE

FOOD SERVICE (FS)

ODO's inspection of the cooler on the first day of the inspection found there were approximately five boxes of food that were stored against the wall in the walk-in cooler **(Deficiency FS-1[18]).**

- *Corrective Action:* Prior to the completion of the inspection, the facility initiated corrective action by moving the boxes away from the wall **(C-1)**.

ODO's inspection of the housing units found that the countertops in all 12 housing units, which are the designated areas for detainees to microwave and prepare food items, were painted **(Deficiency FS-2[19])**. ODO observed much of the paint was peeling or partially scrubbed off.

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[15] "Some examples of incidents warranting a detainee's assignment to administrative segregation include, but are not limited to, the following: …b) A detainee is a threat to the security of the facility. The facility administrator may determine that a detainee's criminal record, past behavior at other institutions, behavior while in ICE/ERO detention, or other evidence is sufficient to warrant placement of the detainee in administrative segregation." In this case, "2) Continued placement in segregation based on prior behavior should be reviewed at the required intervals, taking into account the detainee's behavior while in segregation. The facility shall continue to consider, in coordination with the Field Office Director where necessary, whether there are more appropriate alternatives to segregation, such as medium- to maximum-security general population housing units either within the facility or elsewhere," and "3) Copies of records supporting this action shall be attached to the administrative segregation order." *See* ICE PBNDS 2011, Standard, Special Management Units, Section (V)(A)(1)(b)(2) and (3).

[16] "All facilities shall implement written procedures for the regular review of all detainees held in administrative segregation, consistent with the procedures specified below. …2) A written record shall be made of the decision and the justification. The administrative segregation review (Form I-885) shall be used for the review." *See* ICE PBNDS 2011, Standard, Special Management Units, Section (V)(A)(3)(a)(2).

[17] "Since audiovisual recording equipment must often be readily available, each facility administrator shall designate and incorporate in one or more post orders responsibility for: 1. Maintaining cameras and other audiovisual equipment; 2. regularly scheduled and documented testing to ensure all parts, including batteries, are in working order; and 3. keeping back-up supplies on hand (batteries, tapes or other recording media, lens cleaners)." *See* ICE PBNDS 2011, Standard, Use of Force and Restraints, Section (V)(K).

[18] "Store all food item products at least six inches from the floor and sufficiently far from walls to facilitate pest-control measures. A painted line may guide pallet placement. Wooden pallets may be used to store canned goods and other nonabsorbent containers, but not to store dairy products or fresh produce." *See* ICE PBNDS 2011, Standard, Food Service, Section (V)(K)(3)(d).

[19] "Paint is prohibited on any surface that may come into contact with food." *See* ICE PBNDS 2011, Standard, Food Service, Section (V)(J)(7)(b)(2).

ODO observed the dish washing process and temperature logs and found the facility's dishwasher does not maintain proper temperatures for the final rinse phase of the washing process **(Deficiency FS-3[20])**. ODO observed the temperature fell below 180 degrees and was not hot enough to sanitize the dishes. ODO notes the food service area has a hot water booster, which maintained proper dish water temperature at the beginning of the meal but was unable to maintain proper temperature during food service.

MEDICAL CARE (MC)

ODO's review of 30 medical records confirmed initial physical assessments were completed within 14 days by a provider or a trained Registered Nurse (RN), with review by the Clinical Director (CD). ODO found eight of 16 detainees who had significant clinical problems identified at the time of intake did not receive an initial physical assessment within two working days **(Deficiency MC-1[21]).**

ODO observed DCDF houses a significant number of detainees with complex medical problems. A record review of 16 detainees in chronic care found four were not provided an assessment every 90 days to determine treatment compliance and effectiveness **(Deficiency MC-2[22])**. One such case was for an HIV positive detainee.

ODO's review of medical records found a female detainee who complained of post-traumatic stress disorder (PTSD) as a result of physical abuse was not referred to mental health **(Deficiency MC-W-1),** and the medical staff who learned this information did not notify the HSA of the detainee's complaint **(Deficiency MC-3[23]).**

MEDICAL CARE (WOMEN) (MCW)

ODO found that complaints of domestic or sexual abuse were generally addressed with referrals to mental health; however, in one case, a female detainee who complained of physical abuse, PTSD, and other mental health problems was not referred at the time of the intake screening, when the issues were reported **(Deficiency MC-W-1[24]).**

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[20] "The following temperatures must be maintained for hot-water sanitizing: …c) Multi tank, conveyor machine: wash temperature of 150 F degrees; pumped rinse, 160 F degrees; final rinse, 180 F degrees." *See* ICE PBNDS 2011, Standard, Food Service, Section (V)(J)(7)(g)(3)(c).

[21] "Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(J). **This is a Priority Component and Repeat Deficiency**.

[22] "When a detainee requires close medical supervision, including chronic and convalescent care, a written treatment plan, including access to health care and other care and supervision personnel, shall be developed and approved by the appropriate qualified licensed health care provider, in consultation with the patient, with periodic review." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(W).

[23] "If, at any time during the screening process, there is an indication of need of, or a request for, mental health services, the HSA must be notified within 24 hours. The CMA, HSA, or other qualified licensed health care provider shall ensure a full mental health evaluation, if indicated." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(J). **This is a Priority Component and Repeat Deficiency**.

[24] "If the initial medical intake screening indicates any history of domestic abuse or violence, the detainee shall be referred for and receive a mental health evaluation by a qualified mental health provider within 72 hours, or sooner if appropriate, consistent with Standard '4.3 Medical Care.'" *See* ICE PBNDS 2011, Standard, Medical Care (Women), Section (V)(B)(2). **This is a Priority Component**.

ODO confirmed initial physical examinations were completed timely with the exception of one female detainee identified with hypertension who, at intake, was not evaluated within two working days (**Deficiency MC-2**). ODO notes the detainee was evaluated by a provider on working day three. Reviews of the initial physical examinations showed breast examinations were conducted; however, PAP smears were not offered or provided **(Deficiency MC-W-2[25])**.

SIGNIFICANT SELF-HARM AND SUICIDE PREVENTION AND INTERVENTION (SS-H&SPI)

DCDF has [redacted] suicide watch cells located in the medical unit. [redacted] One of the cells is free of structures that could assist in a suicide attempt; however, [redacted] suicide watch cell, [redacted] which could facilitate self-harm or a suicide attempt **(Deficiency SSH&SP&I-1[26])**.

DISABILITY IDENTIFICATION, ASSESSMENT, AND ACCOMMODATION (DIA&A)

ODO reviewed the facility's disability identification, assessment and accommodation policy, as well as the ICE National Detainee Handbook, the facility detainee handbook, and the facility orientation video. In addition, ODO toured the detainee housing units and facility detainee common areas on multiple occasions throughout the inspection. ODO determined the facility did not post information on how a detainee may request reasonable accommodation, nor is the information in the facility detainee handbook, facility orientation video, or ICE National Detainee Handbook **(Deficiency DIA&A-1[27])**.

ODO cites as an **Area of Concern** that facility and ERO staff were not aware of all detainees using assistive devices in the facility. ODO identified that two detainees in a high security housing unit used an assistive cane; however, during an interview with the facility captain, the captain stated he was only aware that one detainee in the unit used a cane. When ODO requested to review a consolidated list of detainees using assistive devices (e.g., canes, crutches and walkers) in the facility, the acting HSA produced multiple lists, one of which contained information on detainees no longer in the facility, and none of which contained information on the two detainees currently using assistive devices in the detainee housing unit.

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[25] "Preventative services specific to women shall be offered for routine age appropriate screenings, to include breast examinations, pap smear, STD testing and mammograms." *See* ICE PBNDS 2011, Standard, Medical Care (Women), Section (V)(D). **This is a Priority Component**.

[26] "A suicidal detainee requires close supervised in a setting that minimizes opportunities for self-harm.…The isolation room must be suicide resistant, which requires that it be free of objects and structural elements that could facilitate a suicide attempt. Security staff shall ensure that the room is inspected prior to the detainee's placement so that there are no objects that pose a threat to the detainee's safety.…The detainee may, as a last resort, be temporarily placed in an administrative segregation cell in a Special Management Unit, provided space has been approved for this purpose by the medical staff and such space allows for constant and unobstructed observation." *See* ICE 2011, PBNDS, Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(F). **This is a Priority Component**.

[27] "The facility orientation program…and the detainee handbook…shall notify and inform detainees about the facility's disability accommodations policy, including their right to request reasonable accommodations and how to make such a request. The facility will post other documents for detainee awareness in detainee living areas and in the medical unit, as requested by the local ICE/ERO Field Office." *See* ICE PBNDS 2011, Disability Identification, Assessment, and Accommodation, Section (V)(J).

ACTIVITIES

TELEPHONE ACCESS (TA)

ODO tested detainee telephones throughout the facility and found two telephones in the telephone bank in housing unit C-3 did not work. Additionally, ODO found no evidence in telephone logs that facility second shift housing officers were testing telephones as required by the post orders **(Deficiency TA-1[28])**. Senior facility staff interviewed by ODO stated the second shift officers likely needed additional training on how to check detainee telephones, record the results in the unit housing logs, and report any deficiencies found with the telephones.

CONCLUSION

During this inspection, ODO reviewed the facility's compliance with 20 standards under the ICE PBNDS 2011. ODO found the facility compliant with nine standards and identified 21 deficiencies in the remaining 11 standards.

ODO observed several staff assigned to intake speak both English and Spanish, a telephonic language translation service was available to assist officers in processing non-English/Spanish-speaking detainees, and a telecommunications device for the deaf (TDD) was available to assist in processing deaf detainees. However, during detainee interviews, several detainees complained they did not understand the information provided during intake because it was presented in a language in which they were not proficient, and translated material was not provided. ODO recommends DCDF utilize telephonic interpretation services, as well as the many translations of the ICE National Detainee Handbook available from ERO, to help ensure all detainees receive equitable education on the services available to them.

Finally, during the inspection, ODO found that GP detainees were housed in SMU/RHU E-1 with detainees on both AS and DS status. According to staff, this housing arrangement resulted from lack of GP bed space.

ODO recommends ERO work with the facility to remedy any deficiencies that remain outstanding, as applicable and in accordance with contractual obligations.

Compliance Inspection Results Compared	FY 2019 (PNDS 2011)
Standards Reviewed	20
Deficient Standards	11
Overall Number of Deficiencies	21
Deficient Priority Components	6

[28] "Each facility shall maintain detainee telephones in proper working order. Designated facility staff shall inspect the telephones daily, promptly report out-of-order telephones to the repair service so that required repairs are completed quickly. This information shall be logged and maintained by each Field Office." *See* ICE PBNDS 2011, Standard, Telephone Access, Section (V)(A)(3).

Repeat Deficiencies	2
Corrective Action	1