U.S. Department of Homeland Security
U.S. Immigration and Customs Enforcement
Office of Professional Responsibility
Inspections and Detention Oversight Division
Washington, DC 20536-5501

Office of Detention Oversight
Follow-Up Compliance Inspection

Enforcement and Removal Operations
ERO Chicago Field Office

Dodge County Jail
Juneau, Wisconsin

August 16-19, 2021

FOLLOW-UP COMPLIANCE INSPECTION
of the
DODGE COUNTY JAIL
Juneau, Wisconsin

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FOLLOW-UP COMPLIANCE INSPECTION TEAM MEMBERS

[redacted]	Acting Team Lead	ODO
	Contractor	Creative Corrections
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	Contractor	Creative Corrections

FACILITY OVERVIEW

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR) Office of Detention Oversight (ODO) conducted a follow-up compliance inspection of the Dodge County Jail (DCJ) in Juneau, Wisconsin, from August 16 to 19, 2021.[1] The inspection focused on the standards found deficient during ODO's last inspection of DCJ from April 5 to 8, 2021. The facility opened in 2001, is owned by Dodge County, and is operated by the Dodge County Sheriff's Office. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at DCJ in 2002 under the oversight of ERO's Field Office Director in Chicago (ERO Chicago). The facility operates under the National Detention Standards (NDS) 2000.

ERO has assigned a detention services manager to the facility. A DCJ captain handles daily facility operations and manages [redacted] support personnel. Aramark Corporation provides food services and commissary services at the facility, and Wellpath provides medical care. The facility does not hold any accreditations from any outside entities.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity[2]	[redacted]
Average ICE Detainee Population[3]	[redacted]
Male Detainee Population (as of August 16, 2021)	[redacted]
Female Detainee Population (as of August 16, 2021)	[redacted]

During its last inspection, in Fiscal Year (FY) 2021, ODO found 14 deficiencies in the following areas: Admission and Release (4); Detainee Classification System (1); Food Service (1); Population Counts (1); Staff-Detainee Communication (1); and Use of Force (6).

[1] This facility holds male detainees with low, medium-low, medium-high, and high security classification levels for periods longer than 72 hours.
[2] Data Source: ERO Facility List Report as of August 16, 2021.
[3] *Ibid.*

FOLLOW-UP COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population of 10 or more detainees, and where detainees are housed for longer than 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. In FY 2021, to meet congressional requirements, ODO began conducting follow-up inspections at all ICE ERO detention facilities, which ODO inspected earlier in the FY.

While follow-up inspections are intended to focus on previously identified deficiencies, ODO will conduct a complete review of several core standards, which include but are not limited to Medical Care, Hunger Strikes, Suicide Prevention, Food Service, Environmental Health and Safety, Emergency Plans, Use of Force and Restraints/Use of Physical Control Measures and Restraints, Admission and Release, Classification, and Funds and Personal Property. ODO may decide to conduct a second full inspection of a facility in the same FY based on additional information obtained prior to ODO's arrival on-site. Factors ODO will consider when deciding to conduct a second full inspection will include the total number of deficiencies cited during the first inspection, the number of deficient standards found during the first inspection, the completion status of the first inspection's Uniform Corrective Action Plan, and other information ODO obtains from internal and external sources ahead of the follow-up compliance inspection. Conditions found during the inspection may also lead ODO to assess new areas and identify new deficiencies or areas of concern should facility practices run contrary to ICE standards. Any areas found non-compliant during both inspections are annotated as "Repeat Deficiencies" in this report.

ODO was unable to conduct an on-site inspection of this facility, as a result of the COVID-19 pandemic, and instead, conducted a remote inspection of the facility. During this remote inspection, ODO interviewed facility staff, ERO field office staff, and detainees, reviewed files and detention records, and was able to assess compliance for at least 90 percent or more of the ICE national detention standards reviewed during the inspection.

FINDINGS BY NATIONAL DETENTION STANDARDS 2000 MAJOR CATEGORIES

NDS 2000 Standards Inspected[4]	Deficiencies
Part 1 – Detainee Services	
Admission and Release	0
Detainee Classification System	1
Food Service	0
Funds and Personal Property	0
Staff-Detainee Communication	1
Sub-Total	**2**
Part 2 – Security and Control	
Emergency Plans	0
Environmental Health and Safety	0
Population Counts	1
Special Management Unit (Administrative Segregation)	0
Special Management Unit (Disciplinary Segregation)	0
Use of Force	1
Sub-Total	**2**
Part 3 – Health Services	
Hunger Strike	0
Medical Care	2
Suicide Prevention and Intervention	0
Sub-Total	**2**
Other Standards Inspected	
NDS 2019 Personal Hygiene	0
Sub-Total	**0**
Total Deficiencies	**6**

[4] For greater detail on ODO's findings, see the *Compliance Inspection Findings* section of this report.

DETAINEE RELATIONS

ODO interviewed 12 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. ODO attempted to conduct detainee interviews via video teleconference; however, ERO Chicago and the facility were not able to accommodate this request due to technology issues. As such, ODO conducted the detainee interviews via telephone.

Personal Hygiene: Six male detainees stated female facility staff members do not announce their presence when entering the housing unit.

- Action Taken: ODO reviewed the facility's policy, interviewed the deputy jail administrator, and found the facility staff members of the opposite gender are required to announce their presence when entering a housing unit. On August 18, 2021, the deputy jail administrator sent a reminder to all facility staff members to announce their presence when entering a housing unit of the opposite gender. ODO noted this as an Area of Concern in the *Personal Hygiene* section of the report.

Staff-Detainee Communication: One detainee stated he submitted an ICE request about his case and received a response written in English, not in his native language of Spanish. The detainee stated he had a copy of the response.

- Action Taken: ODO interviewed the deputy jail administrator and requested the facility provide a Spanish translation of the response to the detainee. On August 18, 2021, the facility delivered a translated copy of the response to the detainee.

Staff-Detainee Communication: Multiple detainees stated ICE staff entered the housing unit weekly; however, they reported a language barrier between the ICE staff and detainees.

- Action Taken: On August 18, 2021, ODO interviewed ERO Chicago about the detainees' concerns. ERO Chicago stated ICE staff have available language line services and personnel fluent in Spanish. On the same day, ERO Chicago sent a reminder to all ICE staff about effective officer-detainee communication. ERO Chicago also reminded staff to use the language line to speak with detainees who wanted to speak with them and to use the ERO language line flier. In addition, ERO Chicago informed staff to use another detainee to interpret as a last resort and to document when ICE staff cannot find an interpreter. ODO noted this as an Area of Concern in the *Staff-Detainee Communication* section of the report.

Medical Care: One detainee stated he was exposed to COVID-19 while working in the kitchen. On approximately August 10, 2021, the facility placed him in a quarantined housing unit. The detainee reported he did not display any symptoms and wanted to return to his previous housing unit.

- Action Taken: ODO interviewed the deputy jail administrator and found a contracted kitchen employee tested positive for COVID-19 the day after working in the kitchen. The deputy jail administrator stated the facility followed the guidelines of the Dodge

County Public Health that recommended a 14-day quarantine. On August 19, 2021, the facility's corporal explained the quarantine process to the detainee. On August 21, 2021, the detainee returned to his general population housing unit and resumed working in the kitchen on August 26, 2021.

Medical Care: One detainee stated he lost eight pounds since he arrived at the facility. On approximately August 5, 2021, the detainee stated he submitted a medical request for vitamins, anxiety, vision, and the inability to sleep. The detainee said he received a vision test while at the facility's medical department, but still cannot see and remains concerned about his vision.

- Action Taken: ODO reviewed the detainee's medical record and interviewed the facility's health service administrator (HSA). On August 5, 2021, the detainee submitted a medical request, and the facility's medical staff scheduled the detainee for an appointment for August 10, 2021. During the appointment, the detainee completed a medical history and physical exam that included a vision screening. The staff determined his vision to be 20/30 in both eyes. The HSA stated that the detainee did not qualify for a referral to an eye doctor because ICE regulations require a chronic condition in which vision exceeds 20/50. In addition, the HSA stated the detainee received Tylenol and hydroxyzine for his anxiety and lack of sleep. ODO interviewed the facility medical staff and determined the detainee did not need vitamins since his daily meals provide him with sufficient nutrients.

Medical Care: One detainee stated he had extreme mouth and gum pain because of his brackets. During a dental exam, the dentist informed the detainee he needed oral surgery. On approximately August 14, 2021, the detainee stated the facility nurse photographed his mouth and gums.

- Action Taken: ODO spoke with the facility's HSA and found the detainee met with the facility medical staff multiple times between July 20, 2021, and August 17, 2021. Prior to his dental appointment on July 29, 2021, the facility medical staff prescribed the detainee Tylenol and Naproxen for the pain, as needed. However, the HSA stated the detainee refused his medication during pill pass. On July 29, 2021, at the detainee's dental appointment, the dentist prescribed the detainee with an antibiotic and ibuprofen and referred him to an external oral surgeon. With the detainee's consent, the facility medical staff provided photographs to the oral surgeon, who stated the detainee needed to go back to the original location where he received his brackets. The facility's medical staff spoke with the field medical coordinator (FMC) about the detainee's surgery, and the facility's HSA confirmed the detainee's case is under the FMC's review.

FOLLOW-UP COMPLIANCE INSPECTION FINDINGS

DETAINEE SERVICES

DETAINEE CLASSIFICATION SYSTEM (DCS)

ODO reviewed the facility's detainee handbook and found it did not include an explanation of the

classification levels, with the conditions and restrictions applicable to each **(Deficiency DCS-50[5])**. **This is a repeat deficiency**.

STAFF-DETAINEE COMMUNICATION (SDC)

ODO reviewed the ICE Request Tracking Log from April 1, 2021 through August 14, 2021, and found ERO Chicago did not respond to [redacted] out of [redacted] detainee requests within 72 hours from receiving the request **(Deficiency SDC-29[6])**. **This is a repeat deficiency**.

During the detainee interviews, several detainees informed ODO that ICE staff entered the housing unit weekly; however, they reported a language barrier between ICE staff and detainees. ERO Chicago leadership reminded ICE staff about effective officer-detainee communication by using the language line and the ERO language line flier. Additionally, ERO Chicago informed staff to use another detainee as an interpreter as a last resort and to document when ICE staff could not find an interpreter. ODO noted this as an **Area of Concern**.

SECURITY AND CONTROL

POPULATION COUNTS (PC)

ODO reviewed the facility's PC procedures, interviewed the deputy jail administrator, and found the facility does not conduct a formal count at least once per shift **(Deficiency PC-2[7])**. **This is a repeat deficiency**.

USE OF FORCE (UOF)

ODO reviewed the facility's UOF policy and one immediate UOF file and found the after-action review team consisted of only three members. Specifically, the team did not include the officer in charge **(Deficiency UOF-104[8])**. **This is a repeat deficiency**.

HEALTH SERVICES

MEDICAL CARE (MC)

ODO reviewed [redacted] detainee medical records and found [redacted] out of [redacted] detainees did not receive a comprehensive health assessment, including a physical examination and mental health screening within 14 days of arrival at the facility. Specifically, the facility completed the 14-day health

[5] "The detainee handbook's section on classification will include the following:
1. An explanation of the classification levels, with the conditions and restrictions applicable to each." *See* ICE NDS 2000, Standard, Detainee Classification System, Section (III)(I)(1).

[6] "In IGSA facilities without ICE on-site presence, the detainee requests shall be forwarded to the ICE office of jurisdiction within 72 hours and answered as soon as possible and practicable, but not later than within 72 hours from receiving the request." *See* ICE NDS 2000, Standard, Staff-Detainee Communication, Section (III)(B)(1)(b).

[7] "A formal count should be conducted at least once per shift, with a shift supervisor verifying its accuracy." *See* ICE NDS 2000, Standard, Population Counts, Section (III)(A).

[8] "*The OIC, the Assistant OIC, the CDEO, and the Health Services Administrator shall conduct the after-action review*." *See* ICE NDS 2000, Standard, Use of Force, Section (III)(K).

assessments between [redacted] days after the detainees arrived at the facility **(Deficiency MC-23[9])**.

ODO reviewed the facility's policy, interviewed the HSA, who stated the facility does not notify ERO Chicago each time they released a detainee's medical record **(Deficiency MC-114[10])**.

OTHER STANDARDS INSPECTED

NDS 2019 PERSONAL HYGIENE

During the detainee interviews, [redacted] male detainees informed ODO that female officers do not announce their presence when entering the housing unit. The facility deputy jail administrator followed up by reminding all DCJ staff members to announce their presence when entering a housing unit of the opposite gender. ODO noted this as an **Area of Concern**.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 14 standards under NDS 2000 and 1 standard under NDS 2019 and found the facility in compliance with 10 of those standards. ODO found six deficiencies in the remaining five standards. ODO commends the facility staff members for their responsiveness during this inspection. ODO recommends ERO Chicago work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. ODO has not received the uniform corrective action plan for ODO's last inspection of DCJ in April 2021.

Compliance Inspection Results Compared	First FY 2021 (NDS 2000)/ (NDS 2019)	Second FY 2021 (NDS 2000)/ (NDS 2019)
Standards Reviewed	18/2	14/1
Deficient Standards	6	5
Overall Number of Deficiencies	14	6
Repeat Deficiencies	N/A	4
Areas of Concern	8	1/1
Corrective Actions	3	0

[9] "The health care provider of each facility will conduct a health appraisal and physical examination on each detainee within 14 days of arrival at the facility." *See* ICE NDS 2000, Standard, Medical Care, Section (III)(D).
[10] "IGSA facilities shall notify INS each time a detainee medical records are released." *See* ICE NDS 2000, Standard, Medical Care, Section (III)(M).