



**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

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Office of Detention Oversight  
Compliance Inspection

Enforcement and Removal Operations  
ERO Newark Field Office

Essex County Correctional Facility  
Newark, New Jersey

March 29-April 2, 2021

**COMPLIANCE INSPECTION**  
**of the**  
**ESSEX COUNTY CORRECTIONAL FACILITY**  
Newark, New Jersey

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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 Essex County Correctional Facility (ECCF) in Newark, New Jersey, from March 29 to April 2, 2021.<sup>1</sup> The facility opened in 2004 and is owned and operated by Essex County. The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at ECCF in 2008 under the oversight of ERO’s Field Office Director (FOD) in Newark (ERO Newark). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2011 (Revised 2016).

ERO has assigned deportation officers and a detention services manager to the facility. An ECCF warden handles daily facility operations and manages █████ support personnel. GD Correctional Services, LLC provides food services, CFG Health Systems, LLC provides medical care, and Keefe provides commissary services at the facility. The facility was accredited by the American Correctional Association in August 2019 and the National Commission on Correctional Health Care in July 2017.

Capacity and Population Statistics	Quantity
ICE Detainee Bed Capacity <sup>2</sup>	800
Average ICE Detainee Population <sup>3</sup>	████
Male Detainee Population (as of 3/29/2021)	████
Female Detainee Population (as of 3/29/2021)	N/A

During its last inspection, in Fiscal Year (FY) 2020, ODO found 17 deficiencies in the following areas: Custody Classification System (4); Staff-Detainee Communication (1); Use of Force and Restraints (3); Significant Self-harm and Suicide Prevention and Intervention (1); Religious Practices (1); Telephone Access (1); Visitation (1); and Grievance System (5).

<sup>1</sup> This facility holds male detainees with low, medium-low, medium-high, and high-security classification levels for periods longer than 72-hours.

<sup>2</sup> Data Source: ERO Facility List Report as of March 29, 2021.

<sup>3</sup> *Ibid.*

## 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 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.<sup>4</sup>

ODO identifies violations of ICE detention standards, ICE policies, or operational procedures as “deficiencies.” ODO also highlights instances in which 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 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. ODO’s findings inform ICE executive management in their decision-making to better allocate resources across the agency’s entire detention inventory.

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.

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<sup>4</sup> ODO reviews the facility’s compliance with selected standards in their entirety.

**FINDINGS BY PERFORMANCE-BASED NATIONAL  
DETENTION STANDARDS 2011 (REVISED 2016)  
MAJOR CATEGORIES**

<b>PBNDS 2011 (Revised 2016) Standards Inspected<sup>5</sup></b>	<b>Deficiencies</b>
<b>Part 1 – Safety</b>	
Emergency Plans	0
Environmental Health and Safety	0
<b>Sub-Total</b>	<b>0</b>
<b>Part 2 – Security</b>	
Admission and Release	0
Custody Classification System	0
Facility Security and Control	0
Funds and Personal Property	0
Population Counts	0
Sexual Abuse and Assault Prevention and Intervention	0
Special Management Units	0
Staff-Detainee Communication	2
Use of Force and Restraints	0
<b>Sub-Total</b>	<b>2</b>
<b>Part 4 – Care</b>	
Food Service	0
Hunger Strikes	0
Medical Care	0
Significant Self-harm and Suicide Prevention and Intervention	0
Disability Identification, Assessment, and Accommodation	0
<b>Sub-Total</b>	<b>0</b>
<b>Part 5 – Activities</b>	
Religious Practices	0
Telephone Access	0
<b>Sub-Total</b>	<b>0</b>
<b>Part 6 – Justice</b>	
Grievance System	4
Law Libraries and Legal Material	1
<b>Sub-Total</b>	<b>5</b>
<b>Total Deficiencies</b>	<b>7</b>

<sup>5</sup> For greater detail on ODO’s findings, see the *Compliance Inspection Findings* section of this report.

## DETAINEE RELATIONS

ODO interviewed 13 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, the ERO field office and facility were not able to accommodate this request due to technology issues. As such, ODO conducted the detainee interviews via telephone.

*Medical Care:* One detainee stated he had dental pain and a cavity, and the facility did not fill the cavity. The detainee stated the facility only provided medicine for the pain.

- Action Taken: ODO discussed the detainee's complaints with the health services administrator (HSA), reviewed the detainee's medical record, and found the dentist saw the detainee on March 16, 2021, for his annual dental visit. During the visit, the dentist prescribed the detainee ibuprofen for his tooth pain, scheduled an appointment for April 06, 2021, to place a temporary filling on the detainee's tooth, provided the detainee oral hygiene instructions, and educated the detainee regarding his diagnosis and the plan to place a filling on his tooth. The detainee stated he understood his current health status, had no other concerns, and provided verbal consent of the plan to the dentist.

*Medical Care:* One detainee stated he had back pain caused by the mattress provided. The detainee stated facility staff confiscated his egg crate (foam mat), which helped his back pain after he was sent to disciplinary segregation.

- Action Taken: ODO discussed the detainee's complaints with the HSA and reviewed his medical record. ODO found the detainee submitted a sick call request on August 27, 2020, for back and extreme pain upon waking, and the nurse practitioner (NP) evaluated him and issued him an egg crate. The detainee's remaining medical record entries until February 2021 were for multiple mental health follow-up visits and medication refusals. There was no complaint about a missing egg crate or mattress, nor improper treatment from medical staff. On March 24, 2021, the medical staff conducted an annual history and physical on the detainee and denied his request for an egg crate at that time. However, the medical director recommended an orthopedic specialist evaluate the detainee, the facility's medical staff scheduled the appointment with the orthopedic specialist for April 8, 2021, and advised the detainee of the pending appointment.

*Medical Care:* One detainee stated he had an infected molar and medical staff only monitored him for pain and provided medication without treating the tooth. The detainee also requested a medical diet for high blood pressure.

- Action Taken: ODO discussed the detainee's complaints with the HSA, reviewed his medical record, and found the dentist examined the detainee on March 30, 2021. During this appointment, the detainee reported his pain was an 8 out of 10, and the dentist noted the detainee had decay with gingivitis on molar #14 that would require extraction. The dentist explained the procedure and rationale for the extraction to the

detainee, who agreed to have the extraction. The dentist referred the detainee to an oral surgeon for the extraction, prescribed the detainee antibiotics and pain medication, and advised the detainee of the upcoming appointment with the oral surgeon. Regarding the detainee's complaint of not receiving a medical diet, ODO found the NP saw the detainee on October 26, 2020, for a chronic care follow-up for hypertension and dyslipidemia, and recommended the detainee begin a low-sodium and low-fat diet. The detainee had not made any complaints or sick call requests since October 26, 2020, and ODO did not find any documentation in which the doctor or any medical staff denied the detainee a low-sodium and low-fat diet. On April 1, 2021, the HSA followed up with the food service department to ensure the detainee would be placed on the low-sodium and low-fat diet immediately, and the assistant HSA notified the detainee his low-sodium and low-fat diet would be effective April 1, 2021.

*Medical Care:* One detainee stated he hurt his knee during recreation and still has internal pain. The detainee stated he had not seen the doctor, and medical staff only monitored the pain and provided pills.

- Action Taken: ODO discussed the detainee's complaints with the HSA, reviewed his medical record, and found the nurse's evaluations of the detainee on March 2, 2021, and March 7, 2021, for right knee pain caused by a fall while playing soccer. The nurse provided the detainee ibuprofen and educated him on how to care for his knee. On March 10, 2021, the nurse saw the detainee for knee pain and offered the detainee ibuprofen, but he refused the medication. On March 4, 2021, and March 15, 2021, the NP examined the detainee regarding knee pain, noted both times the detainee was sweating from playing soccer in the gym, and prescribed muscle rub. Additionally, on March 15, 2021, the NP submitted an orthopedic referral. On March 22, 2021, an orthopedic specialist examined the detainee, prescribed physical therapy, and ordered an x-ray. Medical staff scheduled the x-ray of the detainee for the evening of March 31, 2021, and physical therapy for April 7, 2021.

*Significant Self-harm and Suicide Prevention and Intervention:* One detainee stated medical staff stopped his medication for depression and anxiety.

- Action Taken: ODO discussed the detainee's complaints with the HSA, reviewed his medical record, and found the detainee returned to the facility from an outside hospital on March 1, 2021. The medical provider, who admitted the detainee to the facility's infirmary, noticed the detainee's medications were discontinued when the detainee went to an outside hospital, and wrote a new prescription, expiring on March 15, 2021. The detainee was originally scheduled to meet with a mental health professional on April 1, 2021, to review his medications. However, the mental health professional was not aware the detainee's medications were discontinued nor that his temporary prescription expired on March 15, 2021. Once mental health staff realized the detainee's medication prescription had expired, a mid-level provider met with the detainee on March 28, 2021, renewed his medications, and scheduled a consultation with the psychiatrist. On March 30, 2021, the psychiatrist met with the detainee, noted the detainee's medication concerns, and found no evidence of formal thought disorder nor suicidal ideation. The psychiatrist prescribed the detainee two new medications at low-dose levels, continued the original medication at a lower dose, and discussed the



medications with the detainee. Mental health staff stated they would continue to monitor the detainee. Additionally, the HSA stated he was aware of the error in the facility's computer system, which caused the detainee's medication to be discontinued when he left the facility for his outside hospital appointment, and would ensure the error would not occur again.

## COMPLIANCE INSPECTION FINDINGS

### SECURITY

#### STAFF-DETAINEE COMMUNICATION (SDC)

ODO reviewed the facility's detainee handbook and found the handbook did not include ERO Newark's contact information nor the scheduled days and hours staff are available for detainees to contact them (**Deficiency SDC-3<sup>6</sup>**).

ODO found the facility did not update ERO Newark's personnel contact information at least quarterly to reflect changes in ERO Newark's personnel, as required. (**Deficiency SDC-6<sup>7</sup>**).

*Corrective Action:* Prior to completion of the inspection, facility updated ERO Newark's personnel contact information and posted the information in each housing unit. The supervisory detention and deportation officer created a quarterly calendar reminder to provide the facility with an update, even if there are no changes (**C-1**).

### JUSTICE

#### GRIEVANCE SYSTEM (GS)

ODO interviewed the facility staff and found they did not document the result of an informal grievance in the detainee's detention file nor in any logs established to track such actions (**Deficiency GS-24<sup>8</sup>**). **This is a repeat deficiency.**

ODO interviewed the facility staff and found they did not document the circumstances nor resolution of informal grievances in the detainee's detention file nor the facility's grievance log (**Deficiency GS-27<sup>9</sup>**).

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<sup>6</sup> "The local supplement to the detainee handbook shall include contact information for the ICE/ERO Field Office and the scheduled hours and days that ICE/ERO staff is available to be contacted by detainees at the facility." See ICE PBNDS 2011 (Revised 2016), Standard, Staff-Detainee Communication, Section (V)(A).

<sup>7</sup> "Posted contact information shall be updated quarterly or more frequently as necessary to reflect changes in ICE/ERO personnel." See ICE PBNDS 2011 (Revised 2016), Standard, Staff-Detainee Communication, Section (V)(A).

<sup>8</sup> "If an informal grievance is resolved, the employee need not provide the detainee written confirmation of the outcome, but shall document the result for the record in the detainee's detention file and in any logs or data systems the facility has established to track such actions." See ICE PBNDS 2011 (Revised 2016), Standard, Grievance System, Section (V)(C)(1).

<sup>9</sup> "If the grievance is resolved at this informal level, the individual who resolved the issue shall document the circumstances and resolution in the detainee's detention file and in the facility's grievance log." See ICE PBNDS 2011 (Revised 2016), Standard, Grievance System, Section (V)(C)(1).

ODO reviewed the facility’s grievance log and found the facility staff did not consistently provide detainees a written nor oral response within 5 days of receipt of the grievance. ODO observed more than 10 instances where the facility exceeded 5 days in responding to grievances (**Deficiency GS-57<sup>10</sup>**). **This is a repeat deficiency.**

ODO reviewed the facility’s log for appealed grievances and found in two instances, the facility staff did not provide a decision on the grievance within 5 days of receipt of the appeal (**Deficiency GS-60<sup>11</sup>**).

### **LAW LIBRARIES AND LEGAL MATERIAL (LL&LM)**

ODO reviewed the facility’s law library schedule and sign-up sheet and found the facility did not permit the detainees to use the law library for a minimum of 5 hours per week, and instead, permitted the detainees to use the law library only 1 hour each week (**Deficiency LL&LM-7<sup>12</sup>**).

### **CONCLUSION**

During this inspection, ODO assessed the facility’s compliance with 20 standards under PBNS 2011 (Revised 2016) and found the facility in compliance with 17 of those standards. ODO found seven deficiencies in the remaining three standards. ODO commends facility staff for their responsiveness during this inspection and notes there was one instance where the facility’s staff initiated immediate corrective action during the inspection. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations.

<b>Compliance Inspection Results Compared</b>	<b>FY 2020 (PBNS 2011) (Revised 2016)</b>	<b>FY 2021 (PBNS 2011) (Revised 2016)</b>
Standards Reviewed	18	20
Deficient Standards	8	3
Overall Number of Deficiencies	17	7
Repeat Deficiencies	3	2
Areas of Concern	5	0
Corrective Actions	0	1

<sup>10</sup> “Detainee shall be provided with a written or oral response within five days of receipt of the grievance.” See ICE PBNS 2011 (Revised 2016), Standard, Grievance System, Section (V)(C)(3)(b)(1)(b).

<sup>11</sup> “The designated members of the GAB shall review and provide a decision on the grievance within five days of receipt of the appeal.” See ICE PBNS 2011 (Revised 2016), Standard, Grievance System, Section (V)(C)(3)(b)(2)(b).

<sup>12</sup> “Each detainee shall be permitted to use the law library for a minimum of five hours per week. Detainees may not be forced to forego their minimum recreation time in order to use the law library (see standard ‘5.4 Recreation’).” See ICE PBNS 2011 (Revised 2016), Standard, Law Libraries and Legal Material, Section (V)(C).