OFFICE OF INSPECTOR GENERAL

Management Alert – Immediate Removal of All Detainees from the Torrance County Detention Facility

Homeland Security

March 16, 2021

OIG-22-31

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

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

March 16, 2022

MEMORANDUM FOR: Tae D. Johnson
Acting Director
U.S. Immigration and Customs Enforcement

FROM: Joseph V. Cuffari, Ph.D.
Inspector General

JOSEPH V CUFFARI Digitally signed by JOSEPH V CUFFARI Date: 2022.03.16 19:32:37 -04'00'

SUBJECT: *Management Alert – Immediate Removal of All Detainees from the Torrance County Detention Facility*

Attached is our management alert, *Management Alert – Immediate Removal of All Detainees from the Torrance County Detention Facility*, notifying you of urgent issues that require immediate attention and action. Specifically, we have determined that U.S. Immigration and Customs Enforcement must take immediate steps to address the critical staffing shortages that have led to safety risks and unsanitary living conditions at the Torrance County Detention Facility in Estancia, New Mexico. We are conducting this work pursuant to the *Inspector General Act of 1978*, as amended, and in connection with an ongoing inspection according to the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

The formal comments your office provided in response to this alert are included in Appendix B. We have also provided our response to your comments.

Consistent with our responsibility under the *Inspector General Act of 1978*, as amended, we will provide copies of our alert to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will also post this alert on our website.

Please call me with any questions, or your staff may contact Thomas Kait, Deputy Inspector General for Inspections and Evaluations, at (202) 981-6000.

Attachment

Summary of Issues

The Torrance County Detention Facility (Torrance) in Estancia, New Mexico, houses U.S. Immigration and Customs Enforcement (ICE) detainees while their immigration cases are reviewed. Torrance is critically understaffed, which has prevented the facility from meeting contractual requirements that ensure detainees reside in a safe, secure, and humane environment. We recommend the immediate relocation of all detainees from the facility unless and until the facility ensures adequate staffing and appropriate living conditions.

Background

ICE houses detainees at roughly 130 facilities nationwide, and the conditions and practices at those facilities can vary greatly. ICE is required to comply with detention standards and establish an environment that protects the health, safety, and rights of detainees. As mandated by Congress,[1] we conduct unannounced inspections of ICE detention facilities to ensure compliance with detention standards.

ICE's intergovernmental service agreement with Torrance requires the facility to comply with the 2011 *Performance Based National Detention Standards* (PBNDS), as revised in December 2016.[2] According to ICE, the 2011 PBNDS establishes consistent conditions of detention, program operations, and management expectations within ICE's detention system. These standards set requirements in areas such as:

- environmental health and safety, including cleanliness, sanitation, security, detainee searches, segregation, and disciplinary systems;
- detainee care, e.g., food service, medical care, and personal hygiene;
- activities, including visitation and recreation; and
- grievance systems.

From February 1, 2022, to February 3, 2022, we conducted an unannounced, in-person inspection of Torrance to determine whether it complied with the 2011 PBNDS. At the start of our inspection, Torrance housed a total of 176 male ICE detainees.[3]

[1] *Consolidated Appropriations Act, 2021,* Pub. L. No. 116-260, Division F; *Department of Homeland Security Appropriations Act, 2021,* H.R. Rep. No. 116-458 (2021).
[2] Torrance is owned and operated by CoreCivic.
[3] In addition to housing ICE detainees, the Torrance facility also holds county inmates and U.S. Marshals Service inmates.

Based on the contractual requirement from ICE, Torrance receives approximately $2 million a month to house ICE detainees.
During our inspection, we found such egregious conditions in the facility that we are issuing this management alert to notify ICE.[4] We have determined that ICE must take immediate steps to address the critical facility staffing shortages and unsanitary living conditions that have led to health and safety risks for detainees at Torrance.

Critical Staffing Shortages

According to the 2011 PBNDS,[5] each detention facility housing detainees must provide sufficient supervision of detainees. Based on our observations and review of staffing plans for Torrance, the facility has not maintained appropriate staffing levels required by its contract with ICE.

The ICE contract for Torrance requires specific staffing levels for the safety and security of detainees. At designated staffing levels the facility should have 245 full-time staff. At the time of our inspection, Torrance was at 54 percent of required staffing, with 133 full-time employees. Torrance has 112 staffing vacancies, with the majority (94 positions) in the area of security.

ICE issued a Contract Discrepancy Report[6] in December 2020 related to medical staffing shortages, but the report also indicated that staffing issues extended beyond medical vacancies. ICE warned the facility that the Contract Discrepancy Report "may be expanded to include other staffing areas that are currently showing critical shortages. [Torrance] is not at 95% staffing levels across the board and a comprehensive plan needs to be developed to meet these shortages." Nevertheless, Torrance continues to remain severely understaffed over 1 year later, requiring current staff to work a minimum of six overtime shifts per month to help bridge the gap.

Torrance staff acknowledged the understaffing problem, and one staff member indicated that a reason for understaffing could be the facility's remote location, which is approximately a 1-hour drive from Albuquerque, New Mexico. CoreCivic has explored using hiring incentives, such as subsidized housing for facility staff, but the facility remains critically understaffed. Therefore, Torrance cannot keep up with the contractual requirements needed to safely and properly maintain the facility.

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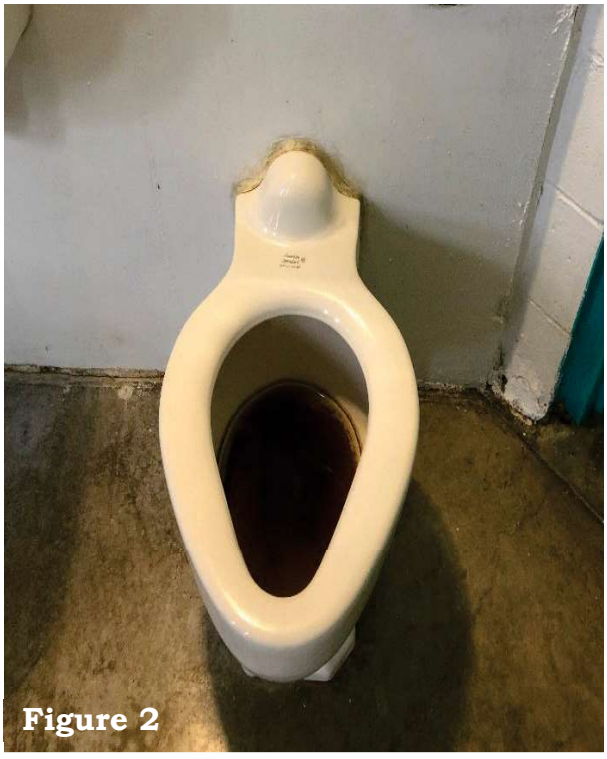
[4] OIG also plans a forthcoming report on Torrance County Detention Facility with additional findings, including deficiencies in staff-detainee communications, detainee classification, COVID-19 mitigation, special management units, medical care, access to legal services, and detainee population not meeting the contract's guaranteed minimum number of detainees.
[5] 2011 PBNDS, Section 2.4 V., *Expected Practices* (Revised Dec. 2016).
[6] A Contract Discrepancy Report is notification to the contractor that they are not complying with all terms of the contract.

Unsanitary Conditions in Detainee Housing Units

The 2011 PBNDS requires detention facilities to meet high standards of cleanliness and sanitation and facility staff to complete preventive maintenance and regular inspections.[7] We found, however, that Torrance exposed staff and detainees to excessive and avoidable unsanitary conditions. Torrance houses ICE detainees in 8 of their 11 housing units. We reviewed all 157 cells in the 8 housing units holding detainees and found 83 detainee cells (roughly 53 percent) with plumbing issues, including toilets and sinks that were inoperable, clogged, or continuously cycling water (see Figures 1 and 2 for illustrative examples).



Figures 1 and 2. A Non-Functioning, Moldy Sink (left) and a Clogged Toilet Full of Human Waste (right) Observed in Vacant Cells in an Occupied Housing Unit

Source: DHS OIG photos

Our inspection team identified faucets with missing cold and hot water buttons, and in some instances the faucets did not produce hot water. Broken sinks in facility housing units (see Figure 3), as well as water fountains, restricted from use due to COVID-19, resulted in detainees obtaining their

[7] 2011 PBNDS, Section 1.2, *Environmental Health and Safety* (Revised Dec. 2016).

drinking water from a communal area faucet intended for filling mop buckets (see Figure 4).

Figures 3 and 4. Detainee Cell Sink with Missing Hot Water Button (left) and a Detainee Demonstrating Filling a Drinking Cup from a Housing Unit Floor Mop Sink (right)

Source: DHS OIG photos

In addition, we encountered mold and water leaks throughout the facility (see Figures 5 and 6 for illustrative examples). These issues exacerbate unsanitary conditions and can lead to slips and falls by detainees or facility staff. Further, it could also lead to health issues for both detainees and staff breathing in the mold. Work orders showed that most problems we observed during our inspection went unresolved for 12 or more days.

Figures 5 and 6. Leaking Detainee Cell Sink and Toilet, with Floor Mold in a Vacant Cell Located in an Occupied Housing Unit (left) and Housing Unit Ceiling Mold from Leaks (right)

Source: DHS OIG photos

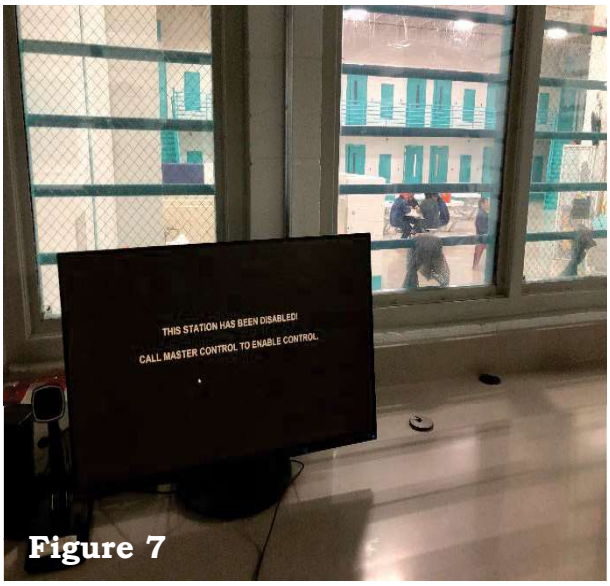
Security Lapses throughout the Facility

The 2011 PBNDS provides standards for observation, supervision, and personal contact between staff and detainees to ensure facility safety, security, and good order.[8] Specifically, security officer posts must be located in or immediately next to detainee housing units, because officers are required to personally interact with detainees and quickly respond to detainee emergencies. Further, the facility must also staff a secure control center at all times to monitor and coordinate facility security, safety, and communication systems.[9] Based on our observations, the requirements for effective security are not being met at Torrance.

Specifically, we identified that Torrance officers did not properly supervise and monitor detainees in the housing units. Primary control rooms are physically separated from detainees by interior walls and windows, providing poor sight lines, and are understaffed, having only one posted officer to supervise and interact with the detainees in four housing units. Blind spots under stairwells and behind barrier walls for showers and telephones further increase the difficulty of viewing detainees in the housing units. Consequently, these control rooms limit staff observation and personal contact between staff and

[8] 2011 PBNDS, Section 2.4, *Facility Security and Control*, section D. *2. Supervision and Communication*, (Revised Dec. 2016).
[9] 2011 PBNDS, Section 2.4 V, *Expected Practices*, section B. *Control Centers.*

detainees. To compound this issue, we observed control rooms that were dark and empty without posted officers (see Figure 7). Further, these control rooms had poor visibility of detainees, through multiple sets of barred and dirty windows (see Figure 8).



Figures 7 and 8. Detainee Housing Unit Control Room without Posted Officers (left) and with Poor Sight Lines through Barred and Dirty Windows (right)
Source: DHS OIG photos

When questioned about these security lapses and the absence of officers at posts in the housing units or in the housing unit control rooms (see Figure 9), Torrance management explained officers in the master control room monitor housing units through cameras and electronic door systems when no officers are posted in the primary control rooms. This backup system of monitoring proved to be ineffective when we observed the entry door to a housing unit was left ajar (see Figure 10). An interviewed detainee corroborated this unsafe and unsecure environment, telling us that he felt he would be unable to get the attention of staff in the event of an emergency. We also observed unsupervised detainees in the housing units dumping buckets of water from the second story railing in what appeared to be an attempt to quickly clean the housing area.


Figure 9

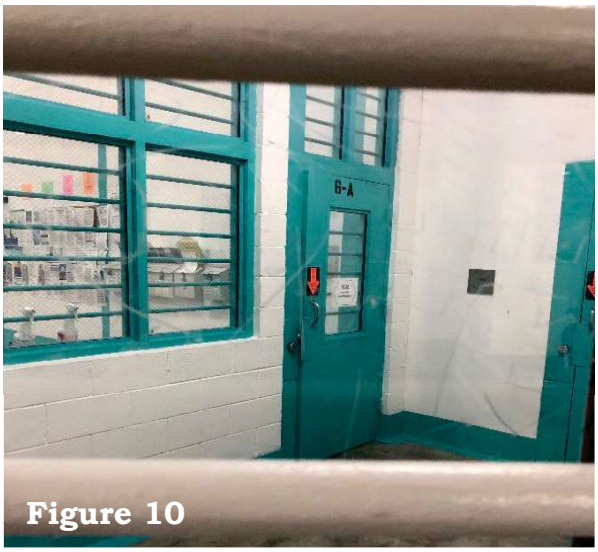


Figure 10

Figures 9 and 10. Detainee Housing Unit without an Officer Posted Inside (left) and Door to Detainee Housing Unit Left Ajar (right)

Source: DHS OIG photos

Recommendation

We recommend that the Acting Director of ICE immediately relocate all detainees from Torrance County Detention Facility and place no detainees there unless and until the facility ensures adequate staffing and appropriate living conditions.

Management Comments and OIG Analysis

ICE did not concur with OIG's recommendation. Appendix B contains ICE management comments in their entirety. We also received technical comments on the draft report and made revisions as appropriate. We consider the recommendation unresolved and open.

ICE also disputed the management alert overall, stating that OIG "ignored facts presented to it in order to achieve preconceived conclusions." We take these concerns seriously but fully disagree. Our inspection team provided professional, independent oversight and has documented support for all reported findings. Our employees' impartiality, independence, and integrity are essential to our oversight work and will remain so moving forward. ICE's concerns, as well as our response, are described below.

ICE disagreed with OIG's characterization of Torrance as "critically understaffed." At the time of our inspection, the facility was at 54 percent of required staffing, with the majority of staffing vacancies in the area of security.

ICE's disagreement with this finding is in direct conflict with its own documentation indicating that Torrance was critically understaffed. On March 1, 2022, ICE issued Torrance a contract discrepancy report that stated:

> The Torrance County Detention Facility (TCDF) located in Estancia, NM has been repeatedly in violation of the 2011 Performance Based National Detention Standards (PBNDS) and the signed ICE/ERO IGSA contractual agreement …. The critically short staffing plans are directly responsible for the breakdown in the overall operational capabilities of the TCDF. CoreCivic has not been able to demonstrate the ability to provide a safe environment for staff and noncitizens, provide the necessary security for proper facility security and control measures, and care necessary to ensure proper facility maintenance, overall cleanliness, and personal hygiene needs described in the PBNDS standards. The Performance Requirements Summary areas of work force integrity, safety, security, and care are all at risk, have been on-going violations, and do not meet contractual requirements. These continued violations seriously impact the El Paso Field Office's ability to support the southwest border security mission.

ICE issued its first contract discrepancy report in December 2020, and Torrance has yet to comply, despite multiple corrective action plans aimed at improving facility staffing. As a result, ICE imposed a 10 percent monthly reduction in billing against the facility for staffing shortages. Because Torrance could not achieve proper staffing, ICE issued a contract modification on March 1, 2022, reducing the facility capacity from 714 detainees to 505 detainees. ICE increased the monthly penalty to a 25 percent reduction in monthly billing. In addition, OIG inspectors witnessed the insufficient staffing during the inspection.

In addition, ICE's response stated that an OIG inspector acted unprofessionally during the inspection. Specifically, ICE accused an OIG inspector of stating, "There's no way detainees should be housed here." We disagree with ICE's assessment. Following our standard operating procedure, and consistent with professional standards, OIG inspectors conducted a thorough walkthrough of the detainee housing units at Torrance. During that walkthrough, OIG inspectors identified facility conditions that necessitated prompt facility action and provided, in real time, the information to the Torrance management staff who were accompanying the inspectors. These problems were also documented in our interviews with detainees and the extensive list of backlogged work orders for facility repairs. Further, we conducted an exit briefing, while on site, with Torrance and ICE personnel at which the inspection team's observations were summarized and referenced to detention standards. At no time during

the walkthrough or exit briefing did Torrance or ICE personnel express any misgivings about the professional behavior of OIG staff.

ICE also disputed our reporting that the faucets in detainee housing units did not produce hot water. ICE's response stated that ICE informed OIG inspectors that "like many faucets, the hot water takes some time to arrive in a faucet that starts cold," but the OIG inspectors still declined to run the tap. We disagree with this assessment. Facility staff were present while OIG inspectors let hot water faucets run, sometimes for many minutes, before determining that the water did not get hot. In interviews, detainees also confirmed that the hot water did not work and had not worked for quite some time. Finally, facility work orders also documented these hot water issues and confirmed that they were prevalent throughout the facility.

Finally, ICE disputed the characterization of the photograph of a detainee holding a cup under running water (Figure 4), stating that the photo was staged. We disagree with this assessment. During the normal walkthrough of the detention center, accompanied by CoreCivic and ICE staff members, OIG inspectors observed the pictured detainee filling a cup with water from a communal area faucet intended for filling mop buckets, but were unable to photograph the detainee in time as he did so. Therefore, OIG inspectors asked him to demonstrate how he filled the cup to allow for a photo to document the issue. The photo was not staged, but rather a recreation of what the team had observed just moments prior. We revised the caption for the photo to clarify that the picture shows the detainee demonstrating how he filled his cup with water from the mop sink.

A summary of ICE's response to our recommendation and our analysis follows.

Recommendation 1: We recommend the Acting Director of ICE immediately relocate all detainees from Torrance County Detention Facility and place no detainees there unless and until the facility ensures adequate staffing and appropriate living conditions.

ICE Response to Recommendation 1: Non-concur. ICE leadership believes Torrance is in compliance with relevant detention standards for staffing and sanitary conditions and that OIG's recommendation is unwarranted. Torrance has only housed a number of detainees that is commensurate with current staffing levels at any given time. Since the OIG inspection, Torrance has detailed additional staff to the facility, increasing the number of staff by 29 percent to a current staffing level of 83 percent. Torrance is also using overtime to ensure coverage of shifts, as appropriate. Additionally, Torrance substantially completed repairs addressing all of the conditions identified in OIG's report prior to the conclusion of the inspection. On February 28, 2022, ICE leadership toured the facility with Torrance management and verified that

these items were either already corrected or were scheduled to be corrected by March 31, 2022 (pending the receipt of needed plumbing parts, etc.). Torrance management is in the process of documenting how it plans to move forward with the staffing level requirements outlined in its contract.

ICE also noted that in November 2021, Torrance passed compliance inspections from the Nakamoto Technical Assistance Review and the ICE Office of Professional Responsibility, Office of Detention and Oversight, providing assurance that the facility was operating in a safe and secure manner with humane conditions. ICE requests that OIG consider this recommendation resolved and closed.

OIG Analysis: We do not consider these actions responsive to the recommendation, which is unresolved and open. ICE did not provide the supporting documentation necessary for OIG to assess completion of corrective actions taken to address the poor facility conditions, nor did it provide supporting documentation showing the staffing changes described in its response. ICE's response is in direct conflict with its recent contracting actions identifying that the Torrance facility was critically understaffed and not in compliance with standards, despite multiple corrective attempts. In addition, although ICE indicated in its response that the facility staffing level was at 83 percent, according to the latest staffing report dated March 4, 2022, Torrance is at 46 percent of the required staffing for housing the reduced population of 505 detainees. We reiterate our recommendation that detainees should be immediately removed from this facility.

Appendix A
Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General 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*.

We issued this management alert during an ongoing spot inspection of the Torrance County Detention Facility in Estancia, New Mexico. Our objective for this unannounced spot inspection is to evaluate compliance with standards in ICE's 2011 PBNDS relating to detainee classification, staff-detainee communications, grievances, supervision of detainees in special management units or segregation, and medical care. We are also conducting a limited review of facility compliance with ICE guidelines for handling the COVID-19 pandemic.

Between February 1, 2022, and February 3, 2022, we conducted an onsite spot inspection of Torrance. We toured the facility, interviewed both staff and detainees, and reviewed facility documentation related to the inspected standards.

We conducted this work pursuant to the *Inspector General Act of 1978,* as amended, and in connection with the ongoing inspection being performed according to the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. Additional information or recommendations regarding the issues addressed in this alert may be included in the final report from our ongoing inspection.

The Office of Inspections and Evaluations major contributors to this management alert are Lead Inspector Stephanie Christian; Lead Inspector Gwen Schrade; Senior Inspector Ryan Nelson; Senior Inspector Ian Stumpf; Inspector Brett Cheney; and Independent Reference Reviewer Donna Ruth.

Appendix B
ICE Comments on the Draft Management Alert

Office of the Director

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

U.S. Immigration and Customs Enforcement

March 7, 2022

MEMORANDUM FOR: Joseph V. Cuffari, Ph.D
Inspector General

FROM: Jason Houser
Chief of Staff (acting)

SUBJECT: Management Response to Draft Report: "Management Alert – Immediate Removal of all Detainees from the Torrance County Detention Facility" (Project No. 22-005-ISP-ICE (b))

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

ICE is fiercely committed to ensuring that noncitizens in its custody reside in safe, secure, and humane environments, and under appropriate conditions of confinement. ICE's detention standards, including the December 2016 revision of the Performance Based National Detention Standards 2011, ensure that the Torrance County Detention Facility (TCDF) and other facilities provide a high and efficient level of care and facilitate effective and timely oversight of conditions through regular facility inspections by the Department's various oversight bodies.

While ICE leadership continues to work on improving conditions at the TCDF in Estancia, New Mexico, we do not agree with the OIG's overall conclusion that it does not provide detainees a safe, secure, and humane environment.

In fact, we have serious concerns about the accuracy and integrity of this report and whether it meets the *Quality Standard for Inspection and Evaluation* issued by the Council of Inspectors General on Integrity and Efficiency ("Blue Book"), dated December 2020. In a number of instances, it appears OIG has falsified or mischaracterized evidence, and has ignored facts presented to it in order to achieve preconceived conclusions. The Department of Homeland Security (DHS or the Department) has previously made OIG aware of these issues.

www.ice.gov

For example, on p. 5, figure 4 of the draft report is a photograph of a detainee holding a cup under running water. OIG describes that photo as "a detainee drinking water from Housing Unit Floor Mop Sink." However, the Department has raised to OIG that video surveillance evidence indicates that, to the contrary, the photo was staged by the OIG inspector and at no time, either in the staging of the photo or during the period the inspector was observing the detainee, did the detainee drink from that water. The photo was knowingly given a false description.

In addition, the draft report at p. 4 states that some faucets did not produce hot water. In fact, during the inspection ICE informed an OIG inspector that, like many faucets, the hot water takes some time to arrive in a faucet that starts cold. The inspector, however, declined to run the tap to determine if that was true. The Department has raised this concern to the OIG as well and has not received a response or further engagement.

Further, ICE El Paso field office (ELP) personnel reported very disconcerting and unprofessional behavior by an OIG inspector during interactions with ELP personnel, for example, by making comments about 30-40 minutes after initiation of the 3-day inspection, such as "There's no way detainees should be housed here." CIGIE "Blue Book" Standards require that inspectors, inspection organizations, and their reports are impartial and without bias in both fact and appearance. These comments indicated to ELP personnel that TCDF would not pass the inspection and that the outcome of the inspection had been predetermined.

More broadly, the draft report further characterizes TCDF as "critically understaffed," yet that characterization ignores the fact that the facility is currently housing less than 20 percent of its maximum capacity, and that the staffing level at the time of the inspection was in fact appropriate for that lower number of detainees. Having said that, ICE acknowledges that there is a *contractual* staffing shortage in TCDF and has been working to resolve that matter with CoreCivic, the owner and operator of TCDF. CoreCivic is currently focused on hiring and training new staff, including 21 new employees who are pending clearance. These new hires along with contract staff detailed from other facilities to TCDF will ensure TCDF fully meets contractual staffing requirements and will allow ERO to increase the number of detainees housed at TCDF, as appropriate. ERO will not increase the detainee population at TCDF without appropriate facility staff being in place. ICE is concerned that these deficiencies, which ICE was addressing prior to the inspection, have been allowed to remain in the report, and believes they may call into question its conclusions.

The draft report contained one recommendation, with which ICE non-concurs. Attached please see our detailed response to the recommendation. ICE previously submitted technical comments addressing several accuracy, contextual, and other issues under a separate cover for OIG's consideration.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions.

Attachment

Attachment: Management Response to Recommendation Contained in Project No. 22-005-ISP-ICE (b))

OIG recommended that the Acting Director of ICE:

Recommendation 1: Immediately relocate all detainees from Torrance County Detention Facility and place no detainees there unless and until the facility ensures adequate staffing and appropriate living conditions.

Response: Non-concur.

ICE leadership believes the TCDF is in compliance with relevant staffing and sanitary conditions detention standards and that OIG's recommendation is unwarranted. TCDF has only housed a number of detainees that is commensurate with current staffing levels at any given time. Since the OIG inspection, TCDF has detailed addition staff to the facility, increasing the number of staff by 29 percent to a current staffing level of 83 percent. TCDF is also using overtime to ensure coverage of shifts, as appropriate.

Additionally, TCDF substantially completed repairs addressing all of the conditions identified in OIG's report prior to the conclusion of the inspection (a full list will be provided to the OIG). On February 28, 2022, ERO ELP leadership toured the facility with TCDF management and CoreCivic executive leadership and verified that these items were either already corrected or were scheduled to be corrected by March 31, 2022 (e.g., pending the receipt of needed plumbing parts, etc.). CoreCivic leadership is in the process of documenting how it plans to move forward with the staffing level requirements outlined in its contract.

Finally, it is also important to note that, in November 2021, TCDF passed independent rigorous standards and compliance inspections from the Nakamoto Technical Assistance Review and the ICE Office of Professional Responsibility, Office of Detention and Oversight, providing assurance that the facility was operating in a safe and secure manner with humane conditions.

ICE requests that the OIG consider this recommendation resolved and closed.

Appendix C
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