Office of Professional Responsibility

Denver Contract Detention Facility Inspection 2024-002-330

August 13–15, 2024

U.S. Immigration and Customs Enforcement

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Office of Detention Oversight
Follow-Up Compliance Inspection
2024-002-330

Enforcement and Removal Operations
ERO Denver Field Office

Denver Contract Detention Facility
Aurora, Colorado

August 13-15, 2024

FOLLOW-UP COMPLIANCE INSPECTION
of the
DENVER CONTRACT DETENTION FACILITY
Aurora, Colorado

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FOLLOW-UP COMPLIANCE INSPECTION TEAM MEMBERS

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	Senior Inspections and Compliance Specialist	ODO
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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 follow-up compliance inspection of the Denver Contract Detention Facility (DCDF) in Aurora, Colorado, from August 13 to 15, 2024..[1] This inspection focused on the standards found deficient during ODO's last inspection of DCDF from February 13 to 15, 2024. The facility opened in 1987 and is owned and operated by The GEO Group, Inc. (GEO). The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at DCDF in 1987 under the oversight of ERO's Field Office Director in Denver (ERO Denver). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2011 (Revised 2016).

[redacted] A facility administrator handles daily operations and manages [redacted] support personnel. GEO provides food services and medical care, and Keefe Commissary provides commissary services at the facility. The facility was accredited by the National Commission on Correctional Health Care in October 2019 and the American Correctional Association (ACA) in January 2021. In August 2021, DCDF was audited for the Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) and was DHS PREA certified.

Capacity and Population Statistics	Quantity
ICE Bed Capacity.[2]	[redacted]
Average ICE Population.[3]	[redacted]
Adult Male Population (as of August 13, 2024)	[redacted]
Adult Female Population (as of August 13, 2024)	[redacted]
Adult Transgender Population (as of August 13, 2024)	[redacted]

During its last rated inspection, in Fiscal Year (FY) 2024, ODO found 13 deficiencies in the following areas: Detainee Transfers (1); Environmental Health and Safety (1); Grievance System (1); Medical Care (8); Religious Practices (1); and Significant Self-harm and Suicide Prevention and Intervention (1).

[1] This facility holds male and female detainees with low, medium-low, medium-high, and high security classification levels for periods greater than 72 hours.
[2] Data Source: ERO Custody Management Division Authorized Facility List as of August 13, 2024.
[3] *Ibid.*

FOLLOW-UP COMPLIANCE INSPECTION PROCESS

ODO conducts biannual oversight inspections of ICE detention facilities with an average daily population (ADP) of 10 or more detainees, and where detainees are housed for longer than 72 hours, to assess compliance with ICE National Detention Standards. In FY 2021, to meet congressional requirements, ODO began conducting follow-up inspections at all over-72-hour ICE detention facilities with an ADP of 10 or more detainees that ODO conducted a full inspection of earlier in the FY. Follow-up inspections focus on facility compliance with detention standards that directly affect detainee life, health, safety, and/or well-being, and other standards ODO found deficient during the previous rated inspection to assess the facility's corrective actions taken to address those previously cited deficiencies. [4]

ODO identifies violations of ICE detention standards, ICE policies, or operational procedures, as "deficiencies." ODO 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.

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 (UCAP), 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 the full and follow-up inspection are annotated as "Repeat Deficiencies" in this report.

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

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

PBNDS 2011 (Revised 2016) Standards Inspected[5,6]	Deficiencies
Part 1 - Safety	
Emergency Plans	0
Environmental Health and Safety	1
Sub-Total	**1**
Part 2 - Security	
Admission and Release	0
Custody Classification System	0
Facility Security and Control	2
Funds and Personal Property	0
Special Management Units	0
Staff Detainee Communication	2
Use of Force and Restraints	0
Sub-Total	**4**
Part 4 - Care	
Food Service	0
Hunger Strikes	0
Medical Care	0
Medical Care (Women)	0
Significant Self-harm and Suicide Prevention and Intervention	1
Sub-Total	**1**
Part 5 - Activities	
Religious Practices	0
Telephone Access	0
Sub-Total	**0**
Part 6 - Justice	
Grievance System	0
Sub-Total	**0**
Part 7 - Administration and Management	
Detainee Transfers	0
Sub-Total	**0**
Total Deficiencies	**6**

[5] For greater detail on ODO's findings, see the *Follow-up Compliance Inspection Findings* section of this report.
[6] Beginning in FY 2024, ODO instituted a process of rotating all standards every other year. As a result, some standards may not be present in all inspections.

DETAINEE RELATIONS

ODO interviewed 24 detainees who each voluntarily agreed to participate. None of the detainees made allegations of discrimination, or mistreatment; however, one detainee alleged sexual abuse by another detainee. ODO followed up with ERO Denver staff to ensure proper reporting and resolution of the allegation. Most detainees reported satisfaction with facility services except for the concerns listed below.

Sexual Abuse and Assault Prevention and Intervention: One detainee stated she made a verbal complaint to a resident officer regarding a detainee exposing herself on May 31, 2024, and facility staff interviewed all other involved detainees except her.

- Action Taken: ODO confirmed the PREA coordinator interviewed the detainee on August 28, 2024. The detainee admitted the other detainee did not touch her inappropriately nor harass her, and she made these statements to remove the other detainee from her dorm.

  ODO found the same detainee made another PREA complaint on May 31, 2024, alleging another detainee disrobed and exposed herself to her. On June 3, 2024, the PREA Coordinator interviewed the detainee regarding the allegation. On the same day, medical staff assessed the detainee and provided Sexual Abuse and Assault Awareness pamphlets and brochures. Closed circuit television footage of the incident showed the alleged detainee wearing the standard-issue t-shirt and white boxer shorts in front of a bunk moving suggestively and exposing herself. Further, the video showed the complaining detainee sitting near the door of the pod and not in proximity to the alleged detainee. The alleged detainee told ODO she did not want to be interviewed for the investigation. The PREA Coordinator said the investigation remains ongoing.

Funds and Personal Property: One detainee stated he requested to retrieve a charger for his hearing aids from his personal property, but facility staff denied his request and would charge his hearing aids for him.

- Action Taken: ODO interviewed a DCDF nurse, reviewed the detainee's medical file, and found a certified registered nurse practitioner (CRNP) spoke with the detainee on July 24, 2024, 5 days after he arrived at the facility. The detainee reported he needed to charge his hearing aids every 4 days but did not have a charging cable for his charging hub. The detainee stated DCDF staff allowed him to keep his hearing aid charger in his room during his previous detentions at DCDF. The CRNP told the detainee that facility staff would issue him a new charging cable and he could keep the charger in his dorm if he had access to an outlet close to his bed. The detainee did not have an outlet close to his bed, so the charger would be kept in the nursing unit or social worker's office, and they would charge his hearing aids each night and return them in the morning. A facility nurse, accompanied by ODO, met with the detainee and explained to him to tell his housing unit officer anytime he needed his hearing aids charged. The detainee acknowledged understanding.

Medical Care: One detainee stated she did not understand the reason medical staff discontinued her sleep medication.

- Action Taken: ODO interviewed a mental health nurse, reviewed the detainee's medical files, and found the detainee had a psychiatric follow-up on August 9, 2024. A facility doctor noted mental health staff met with the detainee the week prior and changed the detainee's medication from Seroquel (400 mg) to Risperdal (2 mg) every night at bedtime due to GEO health care policy not allowing the use Seroquel. The detainee refused the Risperdal several times during the week and stated it did not make her tired nor help her sleep. The doctor informed the detainee the medication was not for sleep but instead for her bipolar disorder. The detainee denied any current symptoms of depression, hypomania, hallucinations, or other psychoses but did report experiencing anxiety from overthinking, especially at night. The doctor informed the detainee of the potential relapse of bipolar or psychotic symptoms and the detainee agreed to the doctor's recommendation to increase her Risperdal dosage from 2 to 3 mg, along with resuming a prescription for Vistaril (50 mg), every night at bedtime to treat her anxiety.

Medical Care: One detainee stated his current mental health medication is not working.

- Action Taken: ODO informed facility staff of the detainee's dissatisfaction with his current prescription medication. Facility staff confirmed the facility psychiatrist discontinued the detainee's prescriptions for Cymbalta (30 mg) and Hydroxyzine (25 mg) and prescribed Mirtazapine (30 mg), every night from August 14, 2024, through November 2024. On August 15, 2024, medical staff informed ODO of the detainee's improved mental state with the new prescription and scheduled the detainee to see the mental health provider on August 19, 2024. The mental health provider met with the detainee to review procedures for submitting a sick call request to mental health and how to alert security in case of a mental health emergency.

Telephone Access: One detainee stated three out of four telephones in dorm N do not work and have not been working for a while.

- Action Taken: ODO checked the four telephones in dorm N and verified by placing a call, hearing the recorded message stating "Telephone calls are being monitored," and testing that all keys worked properly. ODO watched facility staff show the detainees how to use the telephones in dorm N.

FOLLOW-UP COMPLIANCE INSPECTION FINDINGS

SAFETY

ENVIRONMENTAL HEALTH AND SAFETY (EHS)

ODO interviewed the fire safety manager and toured Denver Contract Detention Facility-North laundry and found an electrical outlet strip functioning as an extension cord for the washing

machines' automatic chemical dispensers. The National Electric Code 400.8 and National Fire Protection Association 70 do not allow for extension cords or electrical outlet strips to be used in place of permanent wiring for this specific application **(Deficiency EHS-94[7])**.

SECURITY

FACILITY SECURITY AND CONTROL (FSC)

ODO observed vehicle entrance procedures, interviewed the chief of operations and a vehicle entrance officer, and found the facility did not withhold identification of individuals entering the facility's secure perimeter **(Deficiency FSC-58[8])**.

ODO observed vehicle entrance procedures, interviewed the chief of operations and a vehicle entrance officer, and found the facility did not have drivers making deliveries go through a personal search nor question them about firearms, knives, narcotics, or other contraband **(Deficiency FSC-61[9])**.

ODO reviewed the DCDF FSC program, facility contract, staffing plan, and monthly staffing levels and found DCDF staffing levels during the inspection review period did not meet contractual requirements for custody staff and non-custody in 5 out of 6 months. ODO also found DCDF staff levels during the inspection review period did not meet contractual requirements for non-health services staff in 2 out of 6 months. During this same period, ERO Denver maintained the facility's ADP at levels sufficiently lower than the facility's maximum capacity, ensuring the facility had adequate staffing coverage for the detained population. Although ERO Denver took proactive measures regarding the facility's ADP, ODO noted the facility's staffing levels as an **Area of Concern**.

STAFF-DETAINEE COMMUNICATION (SDC)

ODO reviewed 25 detainee requests to ERO Denver and found in 8 out of 11 requests, no translated response in the original language **(Deficiency SDC-11[10])**.

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[7] "Mandatory ACA Expected Practice 4-ALDF-1C-07 requires that the facility conform to applicable federal, state and/or local fire safety codes" *See* ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(C)(1)(b).

[8] "While the driver is within the facility's secure perimeter, the officer shall hold the driver's license or identification of every person entering the facility, as specified under the "Visitor Passes" section in this standard." *See* ICE PBNDS 2011 (Revised 2016), Standard, Facility Security and Control, Section (V)(C)(2)(a).

[9] "All drivers making deliveries must submit to a personal search and questioning about firearms, munitions, knives, ropes, jacks, narcotics and other items considered contraband." *See* ICE PBNDS 2011 (Revised 2016), Standard, Facility Security and Control, Section (V)(C)(2)(c)(1).

[10] "Each facility administrator shall: …

- Ensure that the standard operating procedures include provisions to translate detainee requests and staff responses and otherwise accommodate detainees with special assistance needs based on, for example, disability, illiteracy, or limited English proficiency."

See ICE PBNDS 2011 (Revised 2016), Standard, Staff-Detainee Communication, Section (V)(B).

ODO reviewed 25 detainee requests to ERO Denver and found in 4 out of 25 requests, ERO responded within 5 to 13 business days of receipt of the request **(Deficiency SDC-16.[11])**.

CARE

SIGNIFICANT SELF-HARM AND SUICIDE PREVENTION AND INTERVENTION (SSHSPI)

ODO interviewed the health services administrator and reviewed the medical records of 10 detainees on suicide watch during the inspection period, and found in 2 out of 10 records, clinical staff made only 1 documented welfare check in 21 hours for 1 detainee, from 4:36 p.m. on April 2, 2024, to 1:30 p.m. on April 3, 2024, and after 20 hours for another detainee, from 11 p.m., April 30, 2024, to 11 a.m. on May 1, 2024 **(Deficiency SSHSPI-35.[12])**.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 18 standards under PBNDS 2011 (Revised 2016) and found the facility in compliance with 14 of those standards. ODO found six deficiencies in the remaining four standards. Since DCDF's last rated compliance inspection in February 2024, the facility has trended upward. DCDF went from 6 deficient standards and 13 deficiencies in February 2024 to 4 deficient standards and 6 deficiencies during this follow-up compliance inspection, which includes 1 area of concern for staff shortage. DCDF completed its UCAP for its last inspection in February 2024, which likely resolved the previous deficiencies ODO cited. ODO recommends ERO Denver continue to work with the facility to resolve the remaining deficiencies in accordance with contractual obligations.

Compliance Inspection Results Compared	FY 2024 Full Inspection (PBNDS 2011) (Revised 2016)	FY 2024 Follow-Up Inspection (PBNDS 2011) (Revised 2016)
Standards Reviewed	29	18
Deficient Standards	6	4
Overall Number of Deficiencies	13	6
Priority Component Deficiencies	2	0
Repeat Deficiencies	0	0
Areas Of Concern	0	1
Corrective Actions	0	0
Facility Rating	Acceptable/Adequate	N/A

[11] "The ICE/ERO staff member receiving the request shall normally respond in person or in writing as soon as possible and practicable, but no later than within three (3) business days of receipt." *See* ICE PBNDS 2011 (Revised 2016), Standard, Staff-Detainee Communication, Section (V)(B)(1)(a).

[12] "All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every 8 hours conducted by clinical staff." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(F).

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