OTAY MESA DETENTION CENTER

Inhumane Conditions and the Harsh Realities of ICE's Civil Detention System

Disability Rights California protects and advocates for the rights of all people with disabilities in the State of California, regardless of their ethnicity, cultural background, language, or immigration status.

Immigration detention facilities are generally ill-equipped, and are not the least restrictive setting to meet the medical, mental health, and other needs of adults and children with disabilities.

Disability Rights California has long fought for the de-institutionalization of people with disabilities and for their right to live and receive services in the community. Immigrants with disabilities deserve this same treatment.

Monitoring and Report by:

Disability Rights California Immigration Justice Project

Investigations Unit

Richard Diaz, Staff

Attorney II Liz Logsdon,

Managing Attorney

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Introduction and Summary of Findings

Now more than ever, as society attempts to combat ableism, racism,xenophobia, and white supremacy, it is critical to look at the practice of imprisoning civil immigration detainees.[1] To this end, in March 2019, Disability Rights California (DRC) released a report detailing our investigation into the treatment of people with disabilities in an immigration detention center in Adelanto, California.

Our report, entitled "There Is No Safety Here: The Dangers for People with Mental Illness and Other Disabilities in Immigration Detention at GEO Group's Adelanto ICE Processing Center"[2] documented inadequate mental health treatment, harsh conditions of confinement, and denial of accommodations for people with disabilities at that facility, which is operated by a private, for-profit correctional group.

This new report documents the findings of DRC's year-long investigation into conditions in another immigration facility: the Otay Mesa Detention Center ("Otay Mesa"), located in San Diego, California.

Otay Mesa is owned and operated by another private, for-profit correctional services corporation, CoreCivic.[3] CoreCivic contracts with U.S. Immigration and Customs Enforcement (ICE) to house and care for people at Otay Mesa. DRC initiated this investigation in response to complaints from people in ICE custody housed there as well as scathing media reports[4] Most recently, following a death at the facility due to lack of COVID-19 precautions and medical neglect, ICE's own Inspector General, two Congressional committees and a Senator from California have called for more oversight.[5] Even the facility guards have sued over poor conditions at Otay Mesa.[6]

DRC's investigation confirms that conditions in Otay Mesa violate ICE's own standards as well as those required by the U.S. Constitution and federal statutes prohibiting disability discrimination. People with disabilities detained there, as well as other people in detention, experience serious psychological and physical harm due to the following problems:

A. Inadequate mental health treatment, which is especially troubling since ICE uses Otay Mesa as a specialized center for housing people with mental illness;
B. An unreliable and ad hoc system for providing accommodations to people with disabilities;
C. Excessive and harsh use of isolation and solitary confinement, including unjustified isolation of people based on their medical conditions;
D. Punitive treatment that should not be imposed on civil detainees such as those housed at Otay Mesa;
E. Inadequate medical care and the denial of needed dental care;
F. Discriminatory treatment of people who identify as LGBTQIA2S+; and
G. A wholly inadequate response to the COVID-19 pandemic.

As noted above, DRC's new report is not the first to find unacceptable conditions at Otay Mesa:

- In 2007, the ACLU filed a lawsuit alleging that people housed at Otay Mesa were subjected to long delays before mental health treatment. The case settled in 2010 and terms of the settlement agreement included hiring an additional full-time psychiatrist and four full-time psychiatric nurses.[7]
- A 2018 report on Otay Mesa from experts with the Department of Homeland Security's Office for Civil Rights and Civil Liberties found inadequate medical and mental health care and made numerous recommendations for improvement, although DRC's investigation found similar conditions exist today.[8]

- A lawsuit filed in 2018 alleged understaffing at Otay Mesa, and DRC determined that this problem persists, especially as to mental health care.[9]
- In January 2019, a non-profit monitoring group released a report documenting detainee complaints about denial of medical care, denial of accommodations, prolonged isolation and denial of civil liberties.[10]
- In February 2019, the California Attorney General released a report documenting problems in private, for-profit immigration detention facilities including Otay Mesa. This report found "issues with medical and mental health care; the detainee death review process; and allegations of sexual assault, neglect, and harassment" at Otay Mesa.[11]
- A 2019 report from the Office of the Inspector General for the Department of Homeland Security found that ICE failed to hold its contractors responsible for compliance with minimum standards, mentioning Otay Mesa by name.[12]

The persistence of these deficiencies in spite of numerous reports detailing inhumane conditions and recommendations to improve those conditions indicates that CoreCivic and ICE are not committed to providing humane care for people they are charged to protect.

Consequently, rather than propose another set of corrective actions to address the unacceptable conditions at Otay Mesa, our sole recommendation is that people with disabilities should no longer be housed there and that ICE should no longer use the facility as a hub for mental health treatment.

More broadly, the conditions are such that no people–people with disabilities or people without disabilities–should be housed there in the future.

Scope of Investigation

Disability Rights California is the state's designated protection and advocacy system, charged with protecting the rights of people with disabilities.[13] DRC has the legal authority to inspect and monitor conditions in facilities that provide care and treatment to people with mental illness and other disabilities.[14] Pursuant to this authority, DRC initiated an investigation into conditions at the Otay Mesa Detention Center based on troubling accounts from advocacy and community groups, information received from people with disabilities detained at Otay Mesa, media reports and public reports regarding facility conditions. Otay Mesa has the capacity to hold 1,482 people, 18 years old and older, in their custody.[15] ICE has been forced to release many detainees as a result of litigation over the spread of COVID-19, so as of October 2020 the census is now approximately 330 people.[16]

As the contracting entity, ICE is responsible for overseeing the conditions in the detention center.[17] Otay Mesa is one of two facilities in the ICE system that is supposedly tasked with serving people in immigration detention with acute mental health needs.[18]

DRC's yearlong monitoring of the facility began with an on-site tour of the Otay Mesa Detention Center on October 29 and 30, 2019. DRC attorneys and advocates inspected areas accessible to people in detention, including intake areas, health care treatment areas, recreation areas, visitation areas, and housing units. During the visit, facility staff provided information and answered questions about the programs and services available at Otay Mesa.

DRC also interviewed dozens of people detained at the facility in housing unit common areas or at cell-front.

DRC obtained releases, requested documents from ICE and CoreCivic, reviewed and analyzed housing and medical records, and kept in communication with people to follow up on their concerns. Statements describing the experiences from some of the people DRC interviewed are included in this report. Since October 2019, DRC has continued to conduct telephonic follow up interviews with people detained in Otay Mesa.

Image: Men's General Population Unit

Findings

A. Inadequate Mental Health Treatment

1. Failure to Provide Treatment

We found that the Otay Mesa Detention Center does not provide adequate or timely treatment to people with serious mental health needs.

There were long delays for people to meet with facility mental health staff. When encounters with mental health staff did occur the interactions were infrequent and cursory. Our file review revealed that a person waited almost four months to speak with a psychiatrist even after frequent complaints about their medication not being effective. Another file review revealed the delay of a psychiatric appointment due to a lack of escort staff.

I would wait weeks, sometimes months to see a mental health staff person.

I spent weeks asking for help with my symptoms, and staff would not help me.

In addition, we found the current system lacks structured and unstructured mental health treatment programming.

Even in jails and prisons, contemporary standards require “basic on-site outpatient [mental health] services,” including “individual counseling, group counseling and psychosocial/psychoeducational programs.”[19] Otay Mesa fails to provide such services to meet the needs of its population. People spend the majority of their time idle because of the lack of programming, which is detrimental to their overall mental health

We spoke with many people who reported that they did not regularly receive individual therapy and when they did it was very brief and lacked in-depth discussions of their issues. People also reported not having access to group therapy to help treat their conditions. Based on records review and interviews, mental health treatment at Otay Mesa is primarily limited to brief assessments and medication.

I was told they can't provide the type of mental health treatment that I need here. I feel like they are treating me like a mummy from one medication to another and they are not working.

Medical and mental health staff at Otay Mesa attributed the inadequate treatment to lack of staffing. In interviews, staff stated that many medical staff positions were unfilled at the time of our inspection. In one medical record, medical staff referred directly to the "challenges of being short-staff which have contributed to the longer wait than normal." Additionally, even before COVID-19, psychiatrists were only available remotely through video-conferencing.

2. Harms Stemming from Unmet Mental Health Treatment Needs

We interviewed many people with serious mental health treatment needs who were not receiving adequate treatment. People reported issues with receiving prescribed psychiatric medications, in some cases not receiving medications for weeks. As described above, talk therapy was cursory and brief, with clinicians briefly checking in with people who would have likely benefitted from more intensive, individualized therapy. We interviewed several people with severe symptoms of mental illness (e.g.,
hearing voices, responding to internal stimuli) who reported self-harming or attempting suicide. Additionally, our file review revealed a case where a person consistently engaged in self-harm behaviors such as puncturing and cutting their skin. This person's condition continued to deteriorate over time, and at no point during the period we reviewed did Otay Mesa provide this person with robust, thorough individualized therapy, despite their significant self-harm behaviors and decompensation.

At Otay Mesa I never got my psychiatric medication that I had been taking at a previous facility and prior to being in detention. They kept telling me I didn't qualify and it led to me not feeling well and eventually banging my body and head against the cell doors. The guards would only laugh at me and not do anythin

B. Absence of a System to Request Accommodations for People with Disabilities

Under Section 504 of the Rehabilitation Act of 1973, ICE is prohibited from discriminating against people with disabilities.

In addition, the Department of Homeland Security has adopted a regulation guaranteeing that "[n]o qualified individual with a disability in the United States, shall, by reason of his or her disability, be excluded from the participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity conducted by the Department [of Homeland Security]."[20] Section 504 and the Americans with Disabilities Act (ADA) also require detention facilities to provide a system by which people with disabilities may request accommodations for their disability-related needs.[21]

Otay Mesa's system for requesting and providing disability-related accommodations is unreliable, ad hoc and ineffective. At the time of our monitoring visit, Otay Mesa did not have a specific process or form for people to request disability related accommodations. Without a clear process for requesting accommodations, Otay Mesa is denying many people with disabilities their rights to these accommodations. People with disabilities are required to use the general facility grievance or medical request form to request accommodations, which for many is unclear and ends up delaying a response from staff.

The medical staff told me "I think you are lying," I told them that I don't need to lie. I'm coming here to tell them because I'm in pain. They finally gave me some treatment after about a month of complaints.

Otay Mesa also arbitrarily denies accommodations to detainees who had a history
of past accommodations in place prior to entering the facility. For example, our file review revealed that Otay Mesa repeatedly denied a back brace and extra mattress to one person, although their file documented that they needed and had received these accommodations at another CoreCivic immigration detention facility.

We also found physical barriers in one housing unit that included people who use wheelchairs and was supposedly accessible. However, the internal doors in the unit were too heavy for a wheelchair user to operate, in violation of standards in the ADA and Section 504.[22] Further, people reported that staff refused to assist them with opening doors upon request. Physical barriers as well as the refusal of staff to
provide the reasonable accommodation of assistance with heavy doors discriminates against people with disabilities, who cannot move about their housing unit freely like their non-disabled peers.

C. Harmful Solitary Confinement and Punitive Conditions

1. Extreme Isolation Conditions

DRC uncovered extreme levels of isolation and deprivation in solitary confinement units. For example, in disciplinary isolation units, people are confined to their cells 22 to 23 hours per day. People in these highly restrictive units have limited human contact and programming.

It really difficult having to be locked up 23 hours a day, except for two hours in a cage for recreation. COVID has made us have to stay in even longer.

Additionally, the women's disciplinary isolation unit does not have a designated day room area and instead uses an empty cell as a day room. When the converted day room cell is needed, the whole unit operates without a dayroom. This leads to further restriction and isolation for people in the women's disciplinary isolation unit.

We also found that people with significant medical treatment needs are housed in the medical unit where they are confined to their cells nearly 24 hours per day. We interviewed several people who had significant treatment needs but whose treatment could have been accommodated in a less restrictive unit. These detainees were being placed in punitive solitary confinement conditions solely based on their medical conditions. A media report in 2019 describing inadequate medical care also confirmed that patients are held in "medical segregation," described as "solitary confinement."[23] Even jails in California now provide people with more out of cell time.[24] These isolation conditions are therefore worse than in jails even though people in Otay Mesa are not being held for committing a crime.

Solitary confinement conditions can adversely affect all individuals, and in particular people with mental illness and other disabilities. Even a short stay in conditions of extreme isolation can lead to deterioration of a person's mental health, causing them to experience serious, often debilitating and irreparable, psychological and physical harms, including an increased risk of suicide.[25]

Punitive Conditions

People detained at Otay Mesa are being held under civil detention standards. They are not being held due to pending criminal charges or to serve a criminal sentence. Courts have recognized that people held in civil detention should not be subjected to conditions that amount to punishment when less harsh alternatives exist, particularly when it comes to access to medical care, mental health care, and other services.

Courts have found that detention conditions "are presumptively punitive if they are identical to, similar to, or more restrictive than, those in which [a civil detainee's] criminal counterparts are held."[26] At Otay Mesa, conditions are identical and sometimes more restrictive than jail or prison facilities. CoreCivic is intimately aware of this fact since they own and operate jails and prisons across the country.

Image: Holding Cell

The treatment at Otay Mesa is horrible, they treat you like just another immigrant, waiting to be deported. Not like a human being.

Through DRC's numerous investigations into detention facilities, we have found that people in detention, particularly those with disabilities, are among the most vulnerable to harms resulting from harsh or punitive conditions, and that the harms they face are severe and irreparable.[27] Otay Mesa was no exception, where we found punitive conditions that severely impacted people with disabilities.

The guards would be disrespectful, the way they would speak to you, they would call you names and tell you that you don't belong in this country.

Many people reported the harsh treatment and disrespect they experienced from Otay Mesa staff. Our file review revealed an incident where a person was forced to urinate on themselves because facility staff would not let them out of their recreation cage in order to use the restroom. This same person reported that facility staff later threw their food on the ground in retaliation for making complaints about their treatment. The House Congressional Committee on Homeland Security similarly found that people in detention at Otay Mesa "who did not speak English or Spanish faced additional derision and abuse by guards."[28]

D. Inadequate Medical and Dental Treatment

We found long delays in accessing medical care. This includes several people who had significant delays in obtaining appointments with outside specialists even though their health conditions were deteriorating. Our file review revealed Otay Mesa's failure to make a specialist appointment for a person even after medical staff identified the need for the referral. The recent Homeland Security Committee report on ICE detention corroborates our findings, stating people "… at Otay Mesa ... recalled being told to prioritize 'one problem at a time' and not raise multiple concerns when visiting health professional. And they had to wait days for a trip to the hospital for treatment or examination."[29] Another recent report on immigration detention by the House Oversight Committee found that a person in Otay Mesa "had exhibited symptoms of a stroke, but facility staff failed to take the issue seriously or call 911 in a timely manner. According to these accounts, the woman survived, but was partially paralyzed."[30]

[Treatment here is bad, when you need something they will not help you. I would try and get help from staff and they would not help me. Even after the psychologist sent a note to have medical staff help me they still did not provide me with any treatment.

We also received complaints from people regarding the denial of necessary dental treatment. Otay Mesa told multiple detainees that tooth extractions were the only available treatment unless they resided in the facility for more than a year. Otay Mesa's restriction on providing basic dental treatment is dangerous and can lead to severe health consequences. The Homeland Security Committee report confirmed that people "at ... Otay Mesa complained that they had to be detained at the facility for more than a year to receive any routine dental care, which ultimately makes the need for emergency dental care more likely."[31] Even in correctional settings, facilities must have specific procedures in order to provide constitutionally adequate dental care, procedures that are absent here.[32]

Image: Medical Observation Unit

E. LGBTQIA2S+ Discrimination

We received complaints regarding the treatment of people who identify as lesbian, gay, bisexual, transgender, and other sexual orientations and gender expressions at Otay Mesa. In California, discrimination based on sexual orientation is illegal.

People in Otay Mesa reported that the facility discriminates against LGBTQIA2S+ people based on their gender identities and sexual orientations.

They claimed that staff heavily restricted the interactions of LGBTQIA2S+ people because of assumptions that they were in relationships, and refused to acknowledge or use appropriate gender pronouns and names. Additionally, people reported that Otay Mesa placed them in housing units that did not correspond to their gender identity. For example, we interviewed a transgender woman who Otay Mesa housed in a men's unit.

F. COVID-19 Pandemic

Following the outbreak of COVID-19 at Otay Mesa we received numerous reports regarding the lack of personal protective equipment (PPE) and failure to translate COVID-19 related documents for people with limited English proficiency.[33] As of October 2020, Otay Mesa had confirmed a total of 169 positive cases at their facility, one of the largest counts for an ICE facility in the country.[34] In addition, one person died from the virus in May after fellow detainees reported days of neglect.[35]

As part of our investigation, DRC interviewed one person who contracted the COVID-19 virus while in Otay Mesa. They reported the facility responded slowly to the pandemic, including delays in distributing masks and staff not wearing masks, gloves, or other PPE. This person began experiencing symptoms of the virus but, following testing, remained in their general population unit for approximately nine days until
a positive result was confirmed. When the positive result was confirmed they were moved to another unit for quarantine with about 70 other people. While on this quarantine unit, they reported receiving minimal treatment from medical staff. They returned to their original housing unit after about 10 days in quarantine and continue to have trouble breathing, which they believe is a result of contracting the virus.
At the beginning of the pandemic staff were not wearing masks or gloves. After we complained they offered to give us a mask but only after we agreed to sign a document they gave us.

We raised concerns regarding PPE and language-accessible information about the virus with CoreCivic and ICE. CoreCivic denied the reports. We have continued to receive complaints regarding failures to provide PPE and improper use of chemicals to sanitize living areas.[36]

Conclusion

Conditions at the Otay Mesa Detention Center pose serious risks to people with disabilities. Access to mental health care, disability-related accommodations, and medical treatment are delayed and inadequate. Additionally, Otay Mesa maintains unnecessarily punitive conditions, placing many people, including those with disabilities, in isolation or solitary confinement. ICE and CoreCivic have failed to correct these longstanding violations of human and civil rights, despite years of
reports, complaints and calls for reform. These failures make it clear that the current system of immigration detention is dangerous and constitutionally inadequate for
all people, and especially for those with disabilities.[37] While CoreCivic operates Otay Mesa in an inhumane and deficient manner, the ultimate responsibility for the care of the people in its custody lies with ICE.

Our sole recommendation is that people with disabilities should no longer be housed at Otay Mesa and that ICE should no longer use the facility as a hub for mental health treatment.

People in civil detention should not be subjected to punitive and inhumane conditions. ICE must end its reliance on private, for-profit prisons to house immigrants and find alternatives to its current system of immigration detention.

Footnotes

1. See Prisons and Punishment: Immigration Detention in California, Human Rights First, Jan. 2019, https://www.humanrightsfirst.org/sites/default/files/Prisons_and_Punishment.pdf;, et al., Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention, Human Rights Watch (June 20, 2018), https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration; American Civil Liberties Union, et al., Fatal Neglect: How ICE Ignores Deaths in Detention, Feb. 2016, https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnijc.pdf; Shadow Prisons: Immigrant Detention in the South, Southern Poverty Law Center (Nov. 2016), https://www.splcenter.org/20161121/shadow-prisons-immigrant-detention-south; Nick Schwellenbach, Locking In Profits: Top ICE Officials Leave Agency to Serve Its Top Contractor, Project on Government Oversight (Dec. 18, 2018), https://www.pogo.org/investigation/2018/12/locking-in-profits-top-ice-officials-leave-agency-to-serve-its-top-contractor/. (Return to Main Document)

2. Disability Rights California Investigation Report, There Is No Safety Here: The Dangers for People with Mental Illness and Other Disabilities in Immigration Detention at Geo Group's Adelanto ICE Processing Center, disability rights california, Mar. 2019, https://www. disabilityrightsca.org/system/files/file-attachments/DRC_REPORT_ADELANTO-IMMIG_DETENTION_MARCH2019.pdf. (Return to Main Document)

3. CoreCivic, formerly known as Corrections Corporation of America, operates 70 jail, prison and immigration detention facilities across the United States. See Find a facility, CoreCivic, https://www.corecivic.com/facilities. Private prison companies like CoreCivic dominate ICE's immigration detention system, with approximately 70% of detained people held in private facilities that operate pursuant to federal government contracts; See also, Tara Tidwell Cullen, ICE Released Its Most Comprehensive Data Yet. It's Alarming., National Immigrant Justice Center, Mar. 13, 2018; Detainee Allies, Testimony from Migrants and Refugees in the Otay Mesa Detention Center, Jan. 2019, at 5-6. https://drive.google.com/file/d/13jFd-JyPa7odT8aNYmJvG8e9pOOynk16/view. (Return to Main Document)

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https://www.nbcsandiego.com/news/local/asylum-seeker-says-she-miscarried-after-guards-ignored-pleas-for-medical- help/2244170/; Maya Srikrishnan, What We Know About the Otay Mesa Detention Center – and Its Future, Voice of San Diego (Oct. 7, 2019), https://www.voiceofsandiego.org/topics/government/what-we-know-about-the-otay-mesa-detention-center-and-its-future/; Tom Llamas, et al., Dying for salvation: A detained migrant's desperate plea for medical attention, ABC News (Dec. 13, 2018), https://abcnews. go.com/Nightline/migrant-death-shines-light-allegations-inadequate-medical-care/story?id=59790707; Kate Morrissey, Grandmother with mental health condition in ICE solitary for 3 months, The San Diego Union-Tribune (Feb. 8, 2018), https://www.sandiegouniontribune.com/ news/immigration/sd-me-ice-mentalhealth-20180124-story.html. (Return to Main Document)

5. U.S. House, ICE Detention Facilities Failing to Meet Basic Standards of Care, Committee on Homeland Security, Sept. 21, 2020 at 14, https://homeland.house.gov/imo/media/doc/Homeland%20ICE%20facility%20staff%20report.pdf; U.S. House, The Trump Administration's Mistreatment of Detained Immigrants: Deaths and Deficient Medical Care by For-Profit Detention Contractors, Committee on Oversight and Reform, Sept. 2020 at 30, https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-09-24.%20 Staff%20Report%20on%20ICE%20Contractors.pdf; Office of Inspector Gen., Report 20-42, Early Experiences with Covid-19 at ICE Detention Facilities, U.S. Dep't of Homeland Sec., June 2020, https://www.oig.dhs.gov/sites/default/files/assets/2020-06/OIG-20-42-Jun20.pdf; Harris Demands DHS OIG Investigate Treatment of Detained Individuals at Otay Mesa Detention Center, Harris.Senate.Gov, https://www.harris.senate.gov/news/press-releases/harris-demands-dhs-oig-investigate-treatment-of-detained-individuals-at-otay-mesa- detention-center; "Unmitigated Disaster": Hunger Striker at Otay Mesa Detention Center Speaks Out as COVID-19 Spreads, Democracy Now (June 30, 2020), https://www.democracynow.org/2020/6/30/an_unmitigated_disaster_hunger_striker_jailed; Kate Morrissey, First ICE detainee dies form COVID-19 after being hospitalized from Otay Mesa Detention Center, San Diego Union-Tribune (May 6, 2020, 4:29 PM), https://www.sandiegouniontribune.com/news/immigration/story/2020-05-06/first-ice-detainee-dies-from-covid-19-after-being- hospitalized-from-otay-mesa-detention-center. (Return to Main Document)

6. Morgan Cook & Kate Morrissey, Guards sue CoreCivic over allegedly dangerous workplace amid COVID-19, San Diego Union-Tribune (April 30, 2020 5:53 PM),

https://www.sandiegouniontribune.com/news/watchdog/story/2020-04-30/guards-sue-corecivic-over-allegedly- dangerous-workplace-amid-covid-19. (Return to Main Document)

7. See Settlement Agreement, Woods v. Myers, 3:07-cv-01078-DMS-PCL (S.D. Cal). Otay Mesa Detention Center was previously run at a different facility in San Diego prior to 2015. CoreCivic operated the previous facility and now owns and operates the current facility (Return to Main Document)

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13. Cal. Welf. & Inst. Code § 4900(h); 42 U.S.C. §§ 10802(1), (5); 42 C.F.R. § 51.2; Cal. Welf. & Inst. Code §§ 4900, 15610.07. (Return to Main Document)

14. 42 U.S.C. § 10805(a)(3); 42 C.F.R. § 51.42 (b); Cal. Welf. & Inst. Code § 4902(b)(2). (Return to Main Document)

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18. Becerra, supra note 11, at 31. (Return to Main Document)

19. National Commission on Correctional Health Care, Standards for Health Services in Jails, Standard J-G-04. (Return to Main Document)

20. 6 C.F.R. § 15.30; see also U.S. Dep't of Homeland Sec., Directive No. 065-01 (2013), https://www.dhs.gov/sites/default/files/ publications/dhs-management-directive-disability-access_0.pdf; U.S. Dep't of Homeland Sec., Instruction No: 065-01-001 (2015), https:// www.dhs.gov/sites/default/files/publications/dhs-instructionnondiscrimination - individuals-disabilities_03-07-15.pdf; U.S. Dep't of Homeland Sec., Self-Evaluation and Planning Reference Guide 065-01-001-01 at 23-24 (2016), https://www.dhs.gov/sites/default/files/ publications/disability-guide-component-self-evaluation.pdf. (Return to Main Document)

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35. "Unmitigated Disaster": Hunger Striker at Otay Mesa Detention Center Speaks Out as COVID-19 Spreads, Democracy Now (June 30, 2020). https://www.democracynow.org/2020/6/30/an_unmitigated_disaster_hunger_striker_jailed ("Last week, a woman jailed at Otay Mesa filed a petition with a San Diego court alleging the detention center, run by private prison corporation CoreCivic, has failed to protect the more than thousand people imprisoned there from the coronavirus. Instead, the virus has devastated the population inside, while prisoners report dire conditions, lack of medical care, and the repeated use of pepper spray as retaliation. In May, 57-year-old Carlos Ernesto Escobar Mejia, who came from El Salvador with his family in the '80s during the country's U.S.-backed civil war, died at Otay Mesa after contracting COVID-19. His fellow prisoners described days of horrible neglect that led to his death. When he died, Escobar Mejia had reportedly been in the hospital on a ventilator for over a week."). (Return to Main Document)

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1831 K Street, Sacramento, CA 95811-4114 • Tel: 1-916-504-5800 •
Fax: 1-916-504-5802

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