# DETENTION IN YOUR DISTRICT

STATE: New Jersey CONGRESS

CONGRESSIONAL DISTRICT: 8

FACILITIES: Hudson County Correctional Center

Elizabeth Contract Detention Facility

**COMBINED CAPACITY: 873 (approx.)** 

### Overview

This facility is owned and operated by Hudson County, New Jersey. In 1996, the United States Marshals Service, the Immigration and Naturalization Service (INS, and Hudson County signed an Intergovernmental Service Agreement (IGSA) for the purposes of detaining immigrants. In 2003, the facility was awarded \$4.6 million by the INS to expand bed capacity for immigration purposes. On October 2018, the freeholder board for Hudson County voted to extend the contract's expiration date to 2020 and increased the per diem rate for the facility to \$120. Data obtained through a Freedom of Information Act Request (FOIA) by the Immigrant Legal Resource Center (ILRC) in 2017 shows that the facility has the capacity to detain 476 men and women for ICE, yet was operating at 134% capacity -meaning that over 600 people were detained at Hudson during the fiscal year of 2017. According to a June 2019 press report, the facility is experiencing personnel shortages. According to the same press report, as of June 2019, the facility held 500 people serving criminal sentences and 530 immigrants.



Credit: U.S. Immigration & Customs Enforcement (ICE)

## **Hudson County Correctional Center**

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There have been more than 17 recorded deaths at the facility since 2013. The majority of these deaths were of people serving criminal sentences. Between June 2017 and March 2018, six people died detained at the facility, four of which were ruled as suicides. On June 2017, longtime U.S. resident and El Salvadorean national Carols Bonilla died of internal bleeding and hemorrhagic shock. According to a lawsuit filed by Mr. Bonilla's family against Hudson and ICE, "Mr. Bonilla died from complications of cirrhosis, a treatable condition (the defendants) knew about — but failed to evaluate and treat— despite their knowledge and Mr. Bonilla's repeated requests for medical attention." On April 2018, the Hudson County Freeholders board voted to replace the company that provided medical care to people in criminal and civil custody at the facility.

A December 2017 report by the Department of Homeland Security (DHS) Office of the Inspector General (OIG) documented delays in medical care, inappropriate recording of medical requests and services, lack of basic hygiene supplies, language barriers and a culture of disregard for detained people's rights by Hudson staff. The OIG cited overall "problems that undermine the protection of [detained individual's] rights, their humane treatment, and the provision of a safe and healthy environment."

In 2016, Freedom for Immigrants, in collaboration with First Friends of New Jersey and New York, filed a <u>complaint</u> on behalf of 61 people detained at the Hudson. The complaint detailed patterns of medical neglect, including delays in cancer diagnosis, lack of care for diabetic individuals and inappropriate responses to fungal infections. Data from the complaint shows that, between 2014 and 2016, the facility only took corrective action on 2% of the complaints received.

A 2018 Human Rights First (HRF) report also exposed medical neglect at the facility, including reports of detained individuals being told that the only dental care they would receive were extractions and a report of a woman using a bra strap to support a clavicle fracture. HRF cited reports from people detained at Hudson of kitchen supplies washed with dirty water and people being forced to eat off of trays that had trash residues. HRF also noted that the Hudson facility places people in isolation rooms for up to 23 hours when determined at risk of suicide. According to the report, individuals in suicide watch are "not permitted to have personal items, books, or magazines in the cell." A medical professional consulted for the report noted that Hudson's suicide watch system may lead to an increase in suicide attempts.

In October 2018, Hudson County officials passed a resolution to establish a county advisory board to monitor conditions in the facility and submit recommendations on how to improve conditions. The advisory board is composed of immigration advocates and county officials. Since its inception, the board has produced one report on conditions and recommendations to the county.



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**STATE**: New Jersey

**CONGRESSIONAL DISTRICT: 8** 

FACILITIES: Hudson County Correctional Center Elizabeth Contract Detention Facility

CAPACITY: 873 (approx.)

### Elizabeth Contract Detention Facility

The Elizabeth Contract Detention Facility (ECDF) is privately owned and operated by CoreCivic, formerly Corrections Corporations of America (CCA). According to <u>contract</u> data obtained through FOIA requests, CoreCivic entered into a direct, three-year agreement with ICE in 2005, with the option for ten, one-year renewals (resulting in an effective 13-year contract). ECDF's current contract ends in April 2021. According to additional FOIA <u>data</u>, as of September 2017, the ECDF has a capacity of 310 and detains people men and women. A <u>2011</u> ICE Office of Enforcement and Removals Operations (ERO) inspection, conducted by private company MGT of America Inc., records a per diem amount of \$120.

There have been two reported deaths of immigrants detained at ECDF between 2003-2013. In May 2007, Boubacar Bah, a Guinean national whose work permit was cancelled, died of a traumatic brain injury while detained at ECDF. Documents and communication records obtained through FOIA requests by the New York Times (NYT) and American Civil Liberties Union (ACLU) show that, prior to his death, Mr. Bah suffered a skull fracture and was left "in an isolation cell without treatment for more than 13 hours before an ambulance was called." Documents show that officials planned to discharge Mr. Bah from custody via "humanitarian release" in order to avoid medical care costs and media exposure. Also according to the NYT and ACLU, officials even circulated the idea of reinstating Mr. Bah's work permit in order to use Medicaid benefits instead of ICE funds to finance his medical tre atment. Mr. Bah ultimately died days before his scheduled release from ICE custody. The same month as Mr. Bah's death, the Nakamoto group, a private company contracted by ICE to conduct third party inspections of its facilities, conducted an inspection of ECDF and didn't note any medical care deficiencies or mention Mr. Bah's death. An August 2008 ICE's Office of Detention Oversight (ODO) inspection indicated that medical care was "well managed" and likewise failed to refer to Mr. Bah's death. (Note: DHS' OIG has released a report in June 2018 documenting how inspections of ICE facilities do not lead to meaningful improvements in conditions).

On September 2011, Victor Ramirez-Reyes, an Ecuadorian national <u>died</u> of treatable cardiovascular disease. A 2011 ERO <u>inspection</u> shows that Mr. Ramirez-Reyes went 20 days without proper medication before his death. A 2012 ERO <u>investigation</u> on Mr. Ramirez-Reyes' death found that in the weeks leading up to his death, medical staff dosed Mr. Ramirez-Reyes' with double his normal daily amount of medication. According to the 2012 inspection, a sick call slip from Mr. Ramirez-Reyes' was never forwarded to medical staff, resulting in a afailure to document his symptoms. The 2012 inspection concluded that lack of sufficient nighttime staffing, insufficient medical monitoring, and nursing staff that was ill-equipped to respond to cardiac arrest contributed to Mr. Ramirez-Reyes' death.



Credit: US Immigration & Customs Enforcement

#### Resources

<u>First Friends of New</u>
<u>York and New Jersey</u>

#### **Areas of Concern**

- Medical neglect leading to death
- Poor & unsanitary food quality
- Lack of hygiene resources
- Suicide attempts
- · Verbal abuse
- Access issues
- Solitary confinement

The 2012 inspection concluded that lack of sufficient nighttime staffing, insufficient medical monitoring, and nursing staff that was illequipped to respond to cardiac arrest contributed to Mr. Ramirez-Reyes' death. Documented Abuses A 2016 0D0 inspection found 20 deficiencies, including in areas of sexual assault prevention protocols and safe communications. A 2018 report by Human Rights First (HRF) documented complaints of poor air quality, causing many of those detained to suffer from allergies or asthma. The report also cited lack of sufficient outdoor recreational spaces, maggots and worms found in the shower and bathroom areas, and poor food quality, with meals often consisting of spoiled, expired, or raw products. The report documents medical neglect and verbal abuse from the facility's medical staff, including reports of discrimination and harassment of non-English speakers and mocking and threatening returning patients. Detained individuals also reported insufficient mental health services to HRF. Although the facility claims to screen individuals at intake for mental health concerns, nobody interviewed by HRF reported that they believed that they had been screened at intake. Additionally, some reported to HRF that their requests for sessions with a mental health professional were ignored. Advocate groups have also cited concerns regarding the use of disciplinary segregation and high commissary costs for basic supplies. According to a 2019 report by Immigrant Advocates Response Collaborative (I-ARC), individuals reported being held in isolation for days without receiving a disciplinary hearing, instead of the required 24 hours. I-ARC also details additional reports from detained individuals that disciplinary segregation is the standard response to requests and grievances, even requests for medical assistance. According to the same report, detained people are forced to spend high amounts of money at the commissary in order to offset the insufficient amount of food, water, and hygiene products they are g

