CALIFORNIA
DEPARTMENT OF JUSTICE

Immigration Detention in California

A Review of Conditions of Confinement

2026

Immigration Detention Facility Review Team

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1. Executive Summary

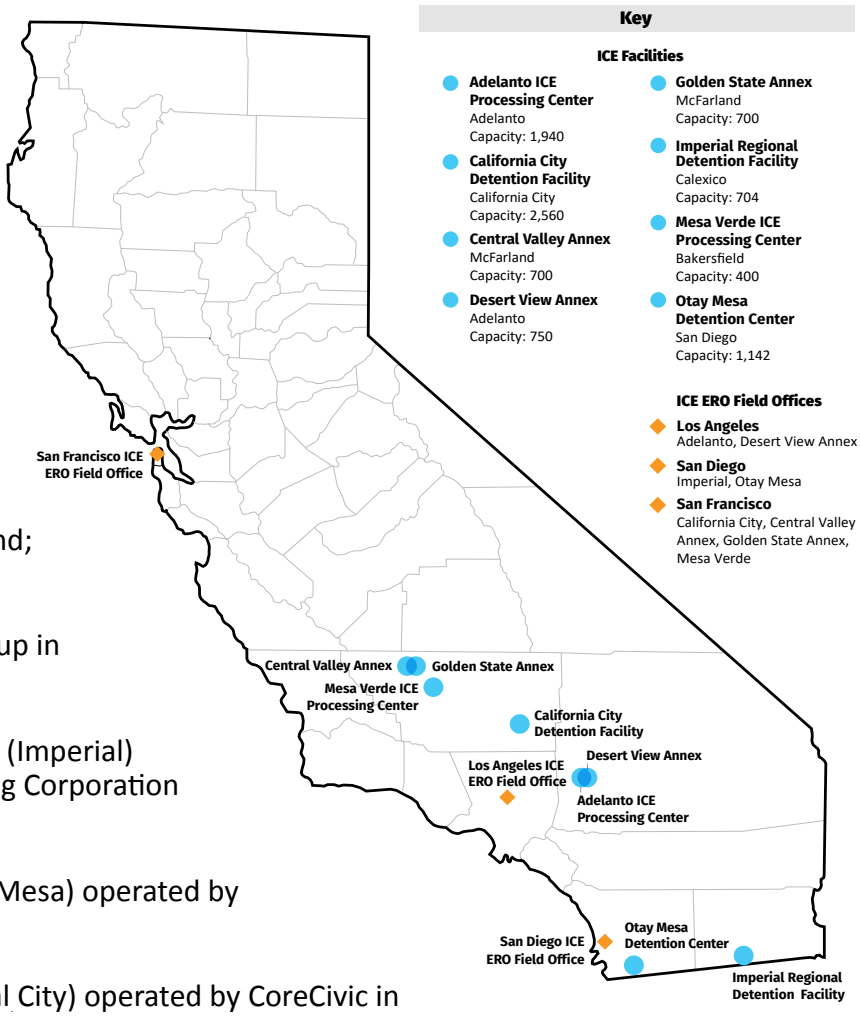
Enacted in response to growing concerns for the health and safety of people in civil immigration detention, Assembly Bill 103 (2017) (AB 103) requires the California Department of Justice (Cal DOJ) to review and report on civil immigration detention facilities operating within the State of California. This mandate has been a critical source of transparency for the public and policymakers regarding conditions in these facilities across California. Cal DOJ has previously issued four reports on conditions in immigration detention facilities in California in 2019, 2021, 2022, and 2025, identifying and documenting substandard and inhumane conditions that fail to meet U.S. Immigration and Customs Enforcement's (ICE) own applicable standards.

In 2025, Cal DOJ found that many of these conditions worsened as the current administration's mass deportation campaign led to overcrowding and strained resources at new and existing facilities. Tragically, there were six deaths of detained individuals between September 2025 and March 2026, four at the Adelanto ICE Processing Center and two at the Imperial Regional Detention Center—the highest number since Cal DOJ started conducting AB 103 reviews. These deaths raise serious concerns about these facilities' ability to safely detain a growing detainee population and highlight the need for greater accountability and oversight.

For its fifth report, Cal DOJ inspected all seven facilities active in 2025 in California operating pursuant to contracts with ICE, including the newly opened California City Detention Facility:

1. Adelanto ICE Processing Center (Adelanto) operated by The GEO Group, Inc. (GEO Group) in Adelanto;
2. Desert View Annex (Desert View) operated by GEO Group in Adelanto;
3. Golden State Annex (Golden State) operated by GEO Group in McFarland;
4. Mesa Verde ICE Processing Facility (Mesa Verde) operated by GEO Group in Bakersfield;
5. Imperial Regional Detention Facility (Imperial) operated by Management & Training Corporation (MTC) in Calexico;
6. Otay Mesa Detention Center (Otay Mesa) operated by CoreCivic in San Diego; and
7. California City Detention Facility (Cal City) operated by CoreCivic in California City.

Immigration Detention Facilities in California



Most of these facilities are located in remote parts of the state that are difficult for family members and attorneys to access. An eighth facility, Central Valley Annex, began to hold ICE detainees in April 2026 as Cal DOJ was finalizing publication of this report. This report does not include a review of conditions at Central Valley Annex.

Since Cal DOJ's 2023 inspections, there has been an unprecedented surge of the population in civil immigration detention facilities within the state, which grew approximately 162% from 2,303 detainees at the time of Cal DOJ's 2023 site visits to 6,028 at the time of site visits in 2025. This population growth included a notable increase of about 268% in the number of female detainees, from 170 at the time of Cal DOJ's 2023 site visits to 626 as of the 2025 visits. Notably, many of these individuals had no criminal history and were classified as low security, a significant divergence from our 2023 findings.

Table 1 shows for each facility Cal DOJ visited: the maximum number of beds for ICE detainees; the contractual guaranteed minimum number of beds for which ICE has agreed to pay regardless of the actual detainee count; and for Cal DOJ's 2023 and 2025 visits, the date of Cal DOJ's visit, the detainee count on the date of Cal DOJ's 2023 and 2025 visits based on roster data provided by the facility, and the average length of stay (LOS) in days for the detained population on the day of Cal DOJ's 2023 and 2025 visits based on rosters provided by the facilities.

Table 1. Facility Capacity and Population Data 2023-2025

Facility	Max. ICE Bed Capacity	Guaranteed Minimum Beds	Cal DOJ 2023 Visit			Cal DOJ 2025 Visit		
			Date[1]	Detainee Count	Avg. LOS (days)	Date	Detainee Count	Avg. LOS (days)
Adelanto	1,940	640	11/14/23	7	1,492	7/7/25	1,570	38.6
Desert View Annex	750	480	11/14/23	417	68.4	7/7/25	517	64.1
Golden State Annex	700	560	5/2/23	159	183	9/23/25	569	82.8
Mesa Verde	400	400	5/1/23	41	254.7	9/25/25	370	29.2
Imperial	704	640	6/13/23	492	61.7	10/2/25	627	133.7
Otay Mesa	1,142	750	9/19/23	1,187	58.9	10/6/25	1,433[2]	126.5
Cal City	2,560	Unknown[3]	N/A	N/A	N/A	11/19/25	942	45.6

Cal DOJ's inspections focused on emerging dangerous conditions resulting from surging detainee populations, including around conditions of confinement and access to medical care.[4] Cal DOJ staff — with support from a team of correctional and health care experts — toured each facility, reviewed and analyzed logs, policies, detainee records, and other documentation, and interviewed detention staff and detained individuals across the seven detention facilities. These inspections demonstrated that civil immigration detention facilities in California are failing to meet applicable federal detention standards given the significant influx of detainees, creating worsening conditions to the detriment of detainees' health and constitutional rights.

1 The dates for 2023 and 2025 represent the date each roster was created by each facility. In some instances, the date the roster was created was one or two days before Cal DOJ's site visit. Imperial's 2025 roster was generated four days before our site visit.
2 The facility appears to be housing more ICE detainees than they are contractually obligated to, as discussed in the Housing Units section of the Otay Mesa chapter herein. Otay Mesa has additional capacity in which it normally holds individuals detained by the U.S. Marshals Service; however detainees also reported that cots were added in housing units during population surges.
3 The guaranteed minimum number of beds in Cal City's contract with ICE is not publicly available.
4 This report is based on Cal DOJ's inspections as indicated herein and publicly available facts and information available as of early 2026.

ICE has established two sets of detention standards: (1) the Performance-Based National Detention Standards 2011 (as amended in 2016) (PBNDS), which state that "[b]ecause ICE exercises significant authority when it detains people, ICE must do so in the most humane manner possible with a focus on providing sound conditions and care,"[5] and apply to all facilities reviewed in this report except Cal City; and (2) the National Detention Standards (2025) (NDS), which are designed to "ensure that detainees are treated humanely; protected from harm; provided appropriate medical and mental health care; and receive the rights and protections to which they are entitled,"[6] and which contractually apply to Cal City.

Cal DOJ identified multiple violations of ICE's detention standards (both PBNDS and NDS) relating to conditions of confinement and basic medical health care at all seven active facilities in 2025. As the detained population increased in 2025, most facilities' intake processes and other operations were overwhelmed and violated numerous detention standards. Cal DOJ found declining conditions for detainees who were experiencing inadequate medical care, delay in medical treatment, overcrowding, inadequate food, excessive use of force by detention facility guards, and inadequate clothing, violating standards such as those guaranteeing nutritious meals, an adequate environment, reasonable uses of force, and adequate medical care.[7] Detainee health has been a persistent area of concern for Cal DOJ, with the last two reports focusing on mental health and COVID-19 response, and medical care lapses are ongoing. PBNDS 4.3 and NDS 4.3 require that each facility must provide "medically necessary and appropriate medical, dental and mental health care and pharmaceutical services."[8]

Cal DOJ's review of conditions of confinement, how those conditions affect due process, and the standard of care available to detainees at the seven facilities, identified the following key findings, which are presented in the order Cal DOJ visited the facilities:

At **Adelanto and Desert View**, which are next to each other and share staff, Cal DOJ found:

- Adelanto, and to a lesser extent, Desert View, were overwhelmed by the rapid increase of detainees brought to the facilities in June and the first week of July 2025. Adelanto went from having seven detainees during Cal DOJ's November 2023 site visit to 1,570 detainees during Cal DOJ's most recent site visit on July 8, 2025. Desert View's detainee population increased from 417 to 517 during the same period, an approximately 24% increase.[9]
- After Cal DOJ's site visit, Cal DOJ learned of four deaths of detainees held at Adelanto allegedly associated with substandard medical care.
- Medical and detention staffing levels failed to meet the needs of the surge of detainees housed at both facilities. In interviews conducted by Cal DOJ's staff during the July 2025 site visit, detainees reported that they were unable to access requested medical appointments and did not receive necessary and timely medical treatment, even for emergency medical care.
- The staff at Adelanto failed to timely and consistently conduct the medical, dental, and mental health screening that the PBNDS require at detainee intake.

5 See ICE, Performance-Based National Detention Standards 2011 (rev. Dec. 2016), Preface, p. i <https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf> (as of Apr. 1, 2026) [hereafter ICE, PBNDS 2011].

6 ICE, National Detention Standards (rev. 2025), Foreward, p. 2 <https://www.ice.gov/doclib/detention-standards/2025/nds2025.pdf> (as of May 13, 2026) [hereafter ICE, NDS 2025]. The NDS purportedly streamline and condense certain requirements, eliminate redundant standards, and reduce the burden on ICE's local law enforcement partners. They also were amended in 2025 to align with the Executive Order, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to The Federal Government" issued on January 20, 2025, discussed in the Standards Applicable to Civil Immigration Detention Facilities and Recent Policy Changes chapter.

7 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety; Part 2.5 Use of Force and Restraints; Part 4.1 Food Service; Part 4.3 Medical Care.

8 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § A, p. 260; ICE, NDS 2025, Part 4.3 Medical Care, Part II, § A, p. 112.

9 The percentage increase of Adelanto's population is a less meaningful figure given that the facility was closed to new intakes for an extended period.

- The facility failed to consistently provide detainees with chronic and acute medical conditions with necessary referrals for follow-up medical care within the facility and to outside medical providers, as also required by the PBNDS.

- Detainees reported that the facilities were serving undercooked food at inconsistent times, occasionally conflicting with detainees' scheduled recreation times. Detainees also reported that the facility provided insufficient drinking water.

- Facility records and detainee reports reflected uses of force that included concerning uses of pepper spray.

At **Golden State**, Cal DOJ found:

- Since Cal DOJ's last site visit in May 2023, the population at the facility increased from 159 detainees to 569 detainees, an approximately 258% increase. The facility's total capacity is 700 detainees.

- Detainees reported low quality and insufficient portions of food.

- Some detainees experienced lengthy periods of segregation in the restricted housing unit, including periods of 100 to over 200 days. The PBNDS recommend that such periods generally not exceed 30 days.

- The facility had language access deficiencies. Its language line offered access to only seven languages and the facility relied on detainees to interpret for other detainees even though ICE expressly prohibits this practice. The detainee handbook, which includes facility rules and procedures that detainees must understand and follow, was only available in English and Spanish at the time of Cal DOJ's visit.

- Detainees appeared not to understand facility rules and procedures due to inadequate orientation. Detainees consequently did not understand how the facility worked and did not understand different options for submitting requests, such as on tablets.

- Uses of force were appropriately reviewed by supervisors, who showed willingness to acknowledge when a use of force was not warranted and to take remedial action.

- Medical care provided to detainees was delayed in many instances. The facility had not increased staffing in response to population growth and was not equipped to handle the increased population. Particular areas of concern include continuity of care for detainees arriving at the facility with existing medical needs, and consistency of referrals to needed specialty care.

At **Mesa Verde**, Cal DOJ found:

- The facility experienced a tremendous population surge since Cal DOJ's last site visit in May 2023; the population increased from 41 detainees to 370 detainees (around 802%). The facility is again housing female detainees, which was not the case at the time of Cal DOJ's previous review.

- Detainees reported a chaotic, overcrowded, overwhelming, and unsanitary intake process.

- Detainees reported low quality and insufficient portions of food, and poor access to clean drinking water. Detainees reported that food was served late, tasted bad, consisted primarily of beans and bread, and for some detainees, upset their stomachs and caused diarrhea. The PBNDS require that facilities provide appetizing meals that meet detainees' nutritional needs.

- Medical care delays, including specialty care and referrals, were widespread and appeared to be caused by delays in approvals by ICE Health Service Corps and cancelled or dropped referrals due to transfers between facilities.

- Mental health and female reproductive health intake assessments did not occur and/or did not meet the timelines mandated by the relevant sections of the PBNDS.

- The facility lacked a proper quality assurance process to identify and improve problems in health care operations.

At **Imperial**, Cal DOJ found:

- The detainee population increased since Cal DOJ's last visit in June 2023 from 492 to 627, an approximately 27% increase. The facility is again housing female detainees, which had occurred in the past but was not the case at the time of Cal DOJ's 2023 review.

- Health care staffing has improved compared to Cal DOJ's site visit in 2023. Imperial has a high sick call volume but draws on stable and experienced senior nursing staff and an increased number of as-needed nursing staff available. At present the staff seems able to respond promptly to requests.

- However, in September 2025 and January 2026, two detainee deaths occurred reportedly due to seizure and heart issues.

- Detainees reported delays or problems obtaining referrals for specialists and getting care for chronic conditions such as diabetes and liver conditions as the PBNDS require.

- File review revealed two cases of detainees receiving mental health care who experienced extended stays in restrictive housing of over 200 days. Cal DOJ observed similar occurrences in the 2023 inspection.

- In their interviews with Cal DOJ, detainees in general reported that they had better living conditions at Imperial as compared to other facilities.

At **Otay Mesa**, Cal DOJ found:

- Overcrowding was a significant issue. The facility's population was 1,433 when Cal DOJ visited in October 2025, as compared with 1,187 at the time of Cal DOJ's 2023 visit, an approximately 21% increase. The facility has experienced multiple temporary population surges in which additional detainees are packed into housing bays on cots or "boats." Detainees reported surges resulted in prolonged intake experiences under poor conditions. The PBNDS provide that under most circumstances, facilities should not hold a greater number of detainees in a room or cell than its stated capacity.

- Overcrowding impacted the cleanliness of the units and put additional strain on resources. For example, in at least some of the housing units, the number of available toilets per detainee was insufficient and did not comply with PBNDS. Due to the high volume of people in each unit, detainees reported that the toilet and shower facilities were often dirty.

- Detainees reported poor quality and insufficient portions of food, both during intake surges and in general.

- Otay Mesa had improved medical staffing since Cal DOJ's 2023 site visits. However, medical recordkeeping was disorganized and violated PBNDS requirements, resulting in lapses in basic care. For example, referrals for essential specialty medical care are inadequately tracked and as a result do not always occur.

- Otay Mesa is the only facility in California with a policy and practice to strip search detainees after each non-legal contact visit. Detainees reported that this practice has an overwhelming negative impact on the mental health and dignity of detainees.

- San Diego County funds a commendable Attorney of the Day program at Otay Mesa, through which unrepresented detainees can obtain legal advice.

At **Cal City**, Cal DOJ found:

- The facility opened prematurely and was not ready to accept detainees. Cal City was inadequately staffed, including detention staff and healthcare staff, in violation of NDS. Lack of staffing negatively impacted facility operations.

- One impact of insufficient staffing was that Cal City did not allow detainees to have contact visits, that is, visits in the same physical space allowing for physical touch or easy shared viewing of documents, as the NDS encourage. This policy negatively impacts detainees' ability to maintain normal parenting or other familial relationships.

- Detainees reported that Cal City was being run like a prison as opposed to a civil detention facility even though the majority of detainees were classified as low security.[10] Detainees spent unnecessarily long periods locked down in their cells for excessive headcounts by facility staff, who did not uniformly have clear written orders describing the duties of their positions, and who reportedly yelled at detainees excessively.

- The NDS require the facility to maintain appropriate temperatures. However, detainees described experiencing extremely cold temperatures, with leaks during rainy periods, and that weather-appropriate clothing was substandard. Detainees, especially older detainees, reported suffering and detainees wept when describing these conditions. To protect themselves from the cold, detainees modified socks to improvise sleeves and covered air vents in their cells with sheets of paper. They reported being written up when they did so.

- Healthcare infrastructure and systems at this new facility were inadequate and some intakes were conducted in a vacant housing pod. Comprehensive intake medical assessments were not consistently completed within National Detention Standard time frames or were dropped altogether.

- Cal DOJ observed crisis-level health care understaffing. For example, there was only one physician providing care, and no backup physician consistently available to provide coverage when the single physician was unavailable. Health care records and detainee interviews also revealed multiple instances of failures to give detainees access to outside specialists.

10 See *Jones v. Blanas* (9th Cir. 2004) 393 F.3d 918, 931-935 (civil detainees may not be housed in punitive conditions).

- Mental health staffing and systems appeared superior to other medical resources available at Cal City, although the facility opened before mental health staff were fully onboarded. The Health Services Administrator appeared to be making an effort to improve care.

- Detainees reported inadequate food quantities and needing to purchase additional food at the commissary to fulfill nutritional needs.

- Recreation and outdoor access were not adequate, and female detainees were provided less access to both recreation and outdoor areas than male detainees.

- For detainees who had been held at different facilities, Cal DOJ received repeated detainee reports that conditions were consistently worse at Cal City than other facilities where they had been housed.

Cal DOJ also heard countless stories from detainees—and experts observed in facility records—that transfers, which are bringing many detainees into facilities within California and causing significant movement between facilities in the state, are adversely affecting detainees' conditions of confinement and the quality of medical and mental health care that they receive at facilities located in California. The impact of transfers on detainees' due process rights has been documented through court filings in which attorneys seek to prevent the transfer of their clients so that they are able to maintain contact and adequately represent their clients.[11] Detainees also lamented losing personal items and commissary monetary balances as they were moved from facility to facility. Access to healthcare became more difficult as detainees were moved; Cal DOJ's medical expert found lapses in healthcare, particularly in referrals to outside care because detainees are required to restart the referral process after being transferred.

Against this alarming backdrop, in addition to its regular AB 103 reporting, Cal DOJ has written directly to the federal government and detention facility operators to share information consistent with what is contained in this report and Cal DOJ's previous reports with the intention of enabling their use of this information to make necessary improvements that recognize both their legal and contractual obligations as well as the safety, health, and dignity of those in their custody.[12] This report shares Cal DOJ's findings at these facilities in greater detail exposing the desperate need for corrective action. We call on the operators of each of the immigration detention facilities in California to take these findings as an opportunity to make necessary improvements and follow ICE's own detention standards, and we call on the federal government to engage in effective oversight to make sure the operators comply with these obligations and uphold detainees' civil rights.

11 Cheney, *How ICE Defies Judges' Orders to Release Detainees, Step by Step*, Politico (Feb. 10, 2026) <https://www.politico.com/news/2026/02/10/ice-immigration-detention-court-orders-00771727> (as of Mar. 19, 2026).

12 See, e.g., Attorney General Rob Bonta, letter to Hon. Alejandro Mayorkas, Dec. 3, 2024, on file with Cal DOJ. See also Rob Bonta, letter to Hon. Kristi Noem, Dec. 19, 2025 <https://oag.ca.gov/system/files/attachments/press-docs/2025.12.19%20-%20CA%20AGO%20Letter%20to%20DHS%20re%20California%20City%20Detention%20Facility.pdf> (as of Mar. 19, 2026).

2. Glossary of Terms

AB 103	California Assembly Bill 103 (2017)
Cal DOJ	California Department of Justice
DHS	U.S. Department of Homeland Security
DON	Director of Nursing
ERO	ICE Enforcement and Removal Operations
FFY	Federal Fiscal Year
FTE	Full-time Equivalent
HSA	Health Services Administrator
ICE	U.S. Immigration and Customs Enforcement
IGSA	Intergovernmental Service Agreement
IHSC	ICE Health Service Corps
INA	Immigration and Nationality Act
LOP	Legal Orientation Program
LOS	Length of (Detention) Stay
LVN	Licensed Vocational Nurse
NDS	National Detention Standards (2025)
ODO	ICE Office of Detention Oversight
OIDO	DHS Office of the Immigration Detention Ombudsman
PBNDS	Performance-Based National Detention Standards (2011, rev. 2016)
PREA	Prison Rape Elimination Act
RHU	Restrictive Housing Unit
USMS	U.S. Marshals Service

3. Introduction

U.S. Immigration and Customs Enforcement (ICE) detains immigrants in publicly and privately operated facilities throughout the United States, including private detention facilities in California, for purposes of civil immigration proceedings. In 2017, the California State Legislature enacted Assembly Bill 103 (AB 103), codified at Government Code section 12532, in response to growing concerns about the health and safety of people that the federal government detains pending civil immigration proceedings.[13] These included concerns regarding housing people in disciplinary or administrative segregation, the quality and accessibility of health care, suicide risk, and access to counsel. AB 103 requires the Attorney General to review and report on the conditions of confinement, the standard of care, and how conditions of confinement affect due process rights at locked civil immigration detention facilities through July 1, 2027.[14] AB 103 is designed to bring increased transparency about the conditions in the facilities where immigrants are detained. The California Department of Justice (Cal DOJ) has issued four reports since 2019 pursuant to AB 103.

For this fifth report, Cal DOJ staff supported by a team of experts reviewed each of the seven civil immigration detention facilities in operation in the state, all of which are privately operated. This report provides members of the public and policymakers with information about the living conditions of people in civil immigration detention facilities in California. It focuses on how the influx of detainee populations in 2025 has impacted conditions of confinement including intake processing, detainees' access to food and water, housing conditions, detainee safety, detention staffing levels, contact with attorneys and family, and how these conditions impact due process rights. The report also addresses detainees' access to health care, including the adequacy of medical staffing levels, quality of services, referrals to needed outside care, and the impact of the growing population on the provision of care.

This report contains 13 sections: **Section 1** is the Executive Summary; **Section 2** is the Glossary of Terms; **Section 3** is this Introduction; **Section 4** covers Standards Applicable to Civil Immigration Detention Facilities and some recent federal policy changes impacting conditions of confinement; **Section 5** covers the Methodology and data analysis used; and **Section 6** discusses Detained Populations, including the recent changes to the release on bond policy, and relevant demographic data. **Sections 7-12** cover each facility, including Adelanto and the connected Desert View Annex, Golden State, Mesa Verde, Imperial, Otay Mesa, and California City, respectively, and a brief conclusion comprises **Section 13**.

At the time of Cal DOJ's site visits to these seven facilities, there were 6,028 detained individuals from over 120 countries. The most represented countries were Mexico, India, Guatemala, El Salvador, China, Russia, Cuba, Colombia, Venezuela, and Honduras. Many of these individuals are California residents and many others are relatives of California residents. The transparency afforded through information

13 Immigrant Legal Resource Center, *California's New Budget Adopts Groundbreaking Changes Concerning Immigration Detention* (June 15, 2017) <https://www.ilrc.org/sites/default/files/pressrelease_dndsb87-v2.pdf> (as of Mar. 19, 2026); Ulloa, *California Lawmakers Attempt to Increase Oversight and Restrictions on the Detention of Immigrants*, L.A. Times (June 17, 2017) <https://www.latimes.com/politics/la-pol-ca-immigrant-detention-centers-oversight-20170617-story.html> (as of Mar. 19, 2026); see also California Coalition for Universal Representation, *California's Due Process Crisis: Access to Legal Counsel for Detained Immigrants* (June 2016) pp. 8-9 <https://www.nilc.org/wp-content/uploads/2016/06/access-to-counsel-Calif-coalition-report-2016-06.pdf> (as of Mar. 4, 2026); Long 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> (as of Mar. 19, 2026); Linthicum, *Citing Neglect, Lawmakers Urge Halt to Migrant Detention Center Expansion*, L.A. Times (July 14, 2015) <https://www.latimes.com/local/lanow/la-me-ln-adelanto-immigrant-detention-20150713-story.html> (as of Mar. 19, 2026) (including link to July 2015 congressional letter to ICE about Adelanto detention facility conditions and inadequate medical care and detainee deaths).

14 AB 103 also directs the Attorney General's office to review circumstances surrounding the apprehension and transfer of detainees. Gov. Code, § 12532, subd. (b)(1)(C). However, following litigation brought by the federal government to challenge AB 103, the Ninth Circuit held that the United States was likely to succeed on its claim that this provision violated the law. *United States v. California* (9th Cir. 2019) 921 F.3d 865, 870, cert. den. (2020) 141 S.Ct. 124.

in this report is critical for understanding the health and welfare of every person in California, including people who are detained.

Contracts and New Facilities

When Cal DOJ published its last AB 103 report in April 2025, ICE was operating six immigration detention facilities in California. As of this report's publication, there are eight facilities operating in California, seven of which are reviewed for this report. CoreCivic opened the seventh facility, Cal City, on August 27, 2025, with a capacity of 2,560 beds.[15] The facility opened after ICE issued a sole source justification and approval notice in March 2025 to allow CoreCivic to use a facility it already owned in California City for civil immigration detention purposes.[16]

While finalizing its current report, Cal DOJ became aware that an eighth facility, Central Valley Annex, began to receive ICE detainees in April 2026.[17] The Central Valley Annex, a former state prison with a bed capacity of 700, was added to GEO Group's Mesa Verde contract along with Golden State Annex on December 19, 2019.[18] Since then GEO Group had used Central Valley Annex to hold federal inmates through a contract with the U.S. Marshal Service.[19]

Reports suggest ICE may seek to open additional facilities beyond Cal City and Central Valley Annex. In August 2024, the U.S. Department of Homeland Security (DHS) issued a Request for Information for facilities that could be used for detention in ICE's San Francisco Enforcement and Removal Operations (ERO) Field Office's jurisdiction, which includes the Central Valley and Northern California regions.[20] In September 2024, GEO Group submitted a proposal to use its McFarland Detention Center—which would be its third facility in McFarland—to further expand ICE's available detention space in Kern County, but further action on this proposal has not yet been publicly reported.[21] There also have been reports that the Trump Administration is considering (or has considered) other locations in California to hold civil immigration detainees including the Federal Correctional Institution at Dublin and even a military base.[22]

15 Hendricks, *California's Newest Immigration Facility is Also its Biggest. Is it Operating Legally?*, KQED (Sept. 4, 2025) <https://www.kqed.org/news/12054544/californias-newest-immigration-facility-is-also-its-biggest-is-it-operating-legallyhttps://tinyurl.com/2uwsxx9e> (as of Mar. 19, 2026); Black, *Trump Admin Spends Millions to Reopen Private California Prison*, SFGate (Sept. 9, 2025) <https://www.sfgate.com/centralcalifornia/article/trump-admin-reopen-private-california-prison-21037836.php> (as of Mar. 19, 2026).

16 ICE, *Class Urgent and Compelling Justification for Multiple Detention Facilities Supporting ICE* (Mar. 7, 2025) <https://sam.gov/opp/e9aa4c41a123404fbfa22773026cdc99/view#description> (as of Mar. 19, 2026).

17 Wendy Fry, *ICE Quietly Opens Another Detention Center in a Former California Prison*, Cal Matters (Apr. 23, 2026) <https://calmatters.org/justice/2026/04/new-ice-detention-center-mcfarland/> (as of Apr. 24, 2026).

18 Rebeca Pelvin, *ICE Signs Long-Term Contracts Worth Billions for Private Detention Centers, Dodging New State Law*, The Desert Sun (Dec. 20, 2019) <https://www.desertsun.com/story/news/2019/12/20/ice-signs-long-term-contracts-private-detention-centers-two-weeks-ahead-state-law/2713910001/> (as of Appr. 23, 2026); see also GEO Group, Inc., *Mesa Verde, Central Valley, Golden State – Current ICE Contract*, signed Dec. 19, 2019.

19 GEO Group, Inc., *Locations: Central Valley Annex* <https://www.geogroup.com/facilities/central-valley-annex/> (as of Apr. 23, 2026) (listing the U.S. Marshals Service as the client for CVA, with a 700-bed capacity).

20 DHS, *ICE West Coast Multi-State RFI* (Aug. 14, 2024) <https://sam.gov/opp/b062f46b8208474f807af0a75e0d320f/view> (as of Mar. 19, 2026).

21 *ACLU FOIA Litigation Reveals Information About Plans to Expand ICE Detention Facilities Nationwide*, ACLU (April 11, 2025) <https://www.aclu.org/press-releases/aclu-foia-litigation-reveals-information-about-plans-to-expand-ice-detention-facilities-nationwide> (as of Mar. 19, 2026).

22 Gokhale, *Alameda County Supes Oppose Reopening FCI Dublin as Detention Center, Prison*, NBC News (Apr. 8, 2026) <https://www.nbcbayarea.com/news/local/alameda-county-vote-fci-dublin/4065568> (as of Apr. 10, 2026); Hendricks, *Trump Administration's Plans for ICE Detention on Bay Area Military Base Are on Hold*, KQED (Sept. 12, 2025) <https://www.kqed.org/news/12055651/trump-administrations-plans-for-ice-detention-on-bay-area-military-base-are-on-hold> (as of Apr. 10, 2026).

4. Standards Applicable to Civil Immigration Detention Facilities and Recent Policy Changes

Key Confinement Condition Issues Detained Immigrant Individuals Face

In its prior reports, Cal DOJ identified significant concerns and deficiencies related to immigration detainees' conditions of confinement. Cal DOJ's 2023 and 2025 reports focused on healthcare in particular, with the 2023 report highlighting the detention facilities' response to the COVID-19 pandemic and the 2025 report exploring detainee access to mental health care and the interaction between mental health and the experience of detention generally. This 2026 report looks closer at how rapid growth in the detention population in California has impacted detainees' conditions of confinement.

Applicable Standards Related to Conditions of Confinement

Immigration detention facilities must operate in accordance with applicable standards, which are generally specified in contracts between ICE and facility operators. Such standards include constitutional requirements, federal and state law requirements, federal detention standards,[23] and applicable professional standards. Indeed, the contracts for these facilities and/or the contractual standards applicable to these facilities (PBNDS or NDS) include language requiring them to follow applicable federal, state, and local laws. In reviewing the facilities' conditions of confinement, Cal DOJ considered all relevant applicable standards.

The United States Supreme Court has held that when the government takes a person into custody, it must provide for that person's "basic human needs—*e.g.*, food, clothing, shelter, medical care, and reasonable safety" and, separately, that medical professionals in custodial settings may be held liable for decisions that constitute a "substantial departure from accepted professional judgment, practice, or standards."[24] The Ninth Circuit has found that civil detainees may not be housed in punitive conditions.[25]

All but one of the immigration detention facilities presently operating in California are bound by ICE's Performance-Based National Detention Standards (PBNDS), issued in 2011 with revisions in 2016.[26] Cal City is bound by ICE's National Detention Standards (NDS), issued in 2000 with revisions in 2025.[27] ICE has contractual authority to enforce its detention standards and has previously faced criticism for its failure to do so.[28]

Below is a summary of key elements of the PBNDS and NDS that apply to conditions of confinement, related to the following topics: 1) food and water, 2) housing conditions, 3) the intake process, 4) access to and continuity of healthcare, 5) legal and family visitation, and 6) detainee safety. Cal DOJ also notes recent policy changes related to legal orientation programs, services for transgender people, and claims processing for third-party providers that are impacting conditions of confinement.

23 ICE's Office of Detention Oversight (ODO), part of the Office of Professional Responsibility, conducts detention facility inspections for the federal government and reports on compliance with federal detention standards. See ICE, *ODO Facility Inspections* <https://www.ice.gov/foia/odo-facility-inspections> (as of Apr. 16, 2026); see also American Immigration Council, *Oversight of Immigration Detention: An Overview* (May 16, 2022) <https://www.ice.gov/foia/odo-facility-inspections> (as of Apr. 16, 2026).

24 *DeShaney v. Winnebago County Dept. of Social Services* (1989) 489 U.S. 189, 199-200; *Youngberg v. Romeo* (1982) 457 U.S. 307, 323.

25 *Jones v. Blanas* (9th Cir. 2004) 393 F.3d 918, 931-935; but see *Matherly v. Andrews* (4th Cir. 2017) 859 F.3d 264, 276 (declining to follow *Jones*).

26 ICE FY24 Detention Statistics (Oct. 2024), *supra*; ICE, PBNDS 2011.

27 ICE, NDS 2025.

28 See, e.g., U.S. House of Representatives, Committee on Homeland Security, Majority Staff Report, *ICE Detention Facilities: Failing to Meet Basic Standards of Care* (Sept. 21, 2020) <https://democrats-homeland.house.gov/imo/media/doc/Homeland%20ICE%20facility%20staff%20report.pdf> (as of Apr. 16, 2026).

Standards Related to Food and Water

PBNDS 4.1 and NDS 4.1 require that clean, potable drinking water is available to detainees at all times.[29] PBNDS 4.1 and NDS 4.1 also both require that detainees receive three meals per day, and that no more than 14 hours elapse between dinner and breakfast.[30] Both sets of standards also require that all food shall be properly prepared, washed, cooked or thawed, and stored for consumption.[31] PBNDS 4.1 and NDS 4.1 require that all food service employees are responsible for maintaining a high level of sanitation in the food service department.[32] This includes, but is not limited to, personal cleanliness and hygiene; sanitary methods of preparing; storing and serving food; and the sanitary operation, care and maintenance of equipment and facility.[33]

PBNDS 4.1 and NDS 4.1 also require that all facilities shall provide detainees requesting a religious diet a reasonable and equitable opportunity to observe their religious dietary practice.[34] Similarly, PBNDS 4.1 requires that detainees with certain conditions, including chronic, temporary, medical, dental, or psychological, shall be prescribed special diets as appropriate and be made available to the detainee by the next business day.[35] NDS 4.1 similarly requires that if a detainee is prescribed a medical diet, their medical diet takes precedence over the common-fare diet.[36]

Standards Related to Housing Conditions

PBNDS 1.2 and NDS 1.1 require that the facility cleanliness and sanitation shall be maintained at the highest level, in compliance with all applicable federal, state and local safety and sanitation laws and fire safety codes.[37] With regard to standards on cleaning frequency, PBNDS 1.2 places responsibility on the facility for developing and implementing policies, procedures, and guidelines to eliminate or control sources of injuries and modes of transmission of agents or vectors of communicable diseases.[38] This includes maintaining a high standard of facility sanitation and general cleanliness, performing monthly inspections to identify and eradicate rodents, insects, or other vermin, and collecting and removing garbage and refuse at least daily from common areas.[39] PBNDS 1.2 requires that garbage and hazardous waste disposal shall comply with applicable government regulations.[40] NDS 1.1 requires the same standards and requires that the facility ensure appropriate temperatures, lighting, noise levels, and living space.[41]

Detention standards also ensure detainees receive appropriate clothing. PBNDS 4.5 requires a facility to issue at least two sets of uniforms, including two pairs of socks, two pairs of underwear, and one pair of shoes per detainee.[42] NDS 4.4 similarly requires that at no cost to the detainee, all new detainees shall be issued clean, indoor/outdoor, temperature-appropriate, presentable clothing during intake and issued additional clothing as necessary for changing weather conditions or as seasonally appropriate.[43]

29 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232; ICE, NDS 2025, Part 4.1 Food Service, Part II, § C, p. 98.
30 *Ibid*.
31 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § F, pp. 234-237; ICE, NDS 2025, Part 4.1 Food Service, Part II, § E, p. 100.
32 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § J, pp. 243-245; ICE, NDS 2025, Part 4.1 Food Service, Part II, § I, pp. 103-105.
33 *Ibid*.
34 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § G, pp. 237-238; ICE, NDS 2025, Part 4.1 Food Service, Part II, § F, pp. 100-102.
35 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § H, p. 241.
36 ICE, NDS 2025, Part 4.1 Food Service, Part II, § G, p. 102.
37 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety, Part V, § A, pp. 20-21; ICE, NDS 2025, Part 1.1 Environmental Health and Safety, Part I, p. 1.
38 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety, Part V, § A, pp. 20-21.
39 *Id*. at pp. 21-22.
40 *Id*. at p. 22.
41 ICE, NDS 2025, Part 1.1 Environmental Health and Security, Part II, § I, pp. 6-8.
42 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part V, § B, p. 328.
43 ICE, NDS 2025, Part 4.4 Personal Hygiene, Part II, § B, p. 127.

PBNDS 5.4 requires that, if outdoor recreation is available at the facility, each detainee have access to at least one hour a day, seven days a week, at a reasonable time of day, and receive a schedule of available recreation times.[44] Standards differ for detainees who are housed with the general population and those who are placed in restrictive housing. PBNDS 5.4 requires that detainees in general population shall have access to outside recreation at least four hours a day, seven days a week, weather and scheduling permitted.[45] PBNDS 5.4 requires that detainees in restricted housing units must be offered at least one hour a day, seven times a week if under administrative custody, and at least one hour a day, five times per week if under disciplinary custody.[46] NDS 5.2 includes at least one hour per day, five days per week for detainees in general population and restricted housing units, with the alternative of six or more hours per day, at least four days per week for general population.[47]

Standards Related to the Intake Process

PBNDS 2.1 and NDS 2.1 require detention facilities to implement an orderly process for the intake and reception of newly arrived detainees.[48] PBNDS 2.1 and NDS 4.3 require that each detainee be medically screened upon arrival,[49] and that medical and mental health screenings including questions about acute or emergent medical conditions and suicide risk occur "as soon as possible, but no later than 12 hours after arrival."[50] Although ICE recently increased the requirement to 72 hours for ICE holding facilities, the 12-hour intake requirement remains in effect for immigration detention facilities including all seven facilities reviewed for this report.[51] NDS 2.5 requires that the rooms holding detainees while they move through the intake process are of appropriate size per detainee and offer appropriate seating, ventilation, and access to water and facilities, like toilets and showers.[52]

At intake, the detention facility must record a detainee's basic personal information as well as conduct a criminal history check, and a medical, dental, and mental health screening.[53] The facility must also assign detainees a security classification and a housing unit and provide clothing and personal hygiene items.[54] Security classification levels generally determine a detainee's housing assignment and are intended to protect detainees from harm by assigning detainees with similar backgrounds and criminal histories in the same housing unit.[55]

PBNDS 2.1 and NDS 2.1 require that all detention facilities provide an orientation and handbook to each detainee.[56] The orientation handbook at facilities subject to PBNDS must include details about the days and hours a detainee may contact the ICE Enforcement and Removal Operations (ERO) staff.[57]

44 ICE, PBNDS 2011, Part 5.4 Recreation, Part II, p. 370.
45 *Id*. at Part V, § B, p. 371.
46 *Id*. at Part II, p. 370.
47 ICE, NDS 2025, Part 5.2 Recreation, Part II, §§ A-D, pp. 152-153.
48 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part II, pp. 49-50; ICE, NDS 2025, Part 2.1 Admission and Release, Part I, Part II, § A, p. 18.
49 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § B, pp. 51-53; ICE, NDS 2025, Part 4.3 Medical Care, Part II, §§ A, B, D, E, pp. 112-114.
50 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, pp. 266-268; Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, § B, p. 333; ICE, NDS 2025, Part 4.3 Medical Care, Part II, §§ A, D, pp. 112-113.
51 ICE, *Memorandum for All ERO Field Office Directors*, *Nationwide Hold Room Waiver* (June 24, 2025) <https://iptp-production.s3.amazonaws.com/media/documents/2025.06.24_ICE_-_Nationwide_Hold_Room_Waiver.pdf> (as of Mar. 19, 2026); Immigration Policy Tracking Project, *ICE Waives 12-hour Holding Cell Limit, Allowing Detainees to be Held for 72 Hours* (June 24, 2025) <https://immpolicytracking.org/policies/ice-waives-the-12-hour-holding-cell-limit-allowing-detainees-to-be-held-for-72-hours> (as of Mar. 19, 2026).
52 ICE, NDS 2025, Part 2.5 Hold Rooms in Detention Facilities, Part II, § A, p. 31.
53 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § B, p. 51; Part 2.2 Custody Classification System, Part V, § D, p. 63; Part 4.3 Medical Care, Part V, § J, pp. 266-268.
54 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § D, p. 53; Part 2.2 Custody Classification System, Part V, § D, p. 63.
55 ICE, PBNDS, Part 2.2 Custody Classification System, Part I, p. 60, Part V, §§ D-G, pp. 63-65; ICE, NDS 2025, Part 2.2 Custody Classification System, Part I–Part II, §§ A-E, pp. 21-22.
56 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ F-G, pp. 55-57; ICE, NDS 2025, Part 2.1 Admission and Release, Part II, §§ H-I, pp. 19-20.
57 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § F, pp. 55-56.

PBNDS 2.1 requires a facility

to provide a translator or access to interpreter services if a detainee does not understand English or Spanish; NDS 2.1 requires similar standards for language access.[58]

Standards Related to Access to and Continuity of Health Care

The PBNDS and NDS address basic standards of confinement and medical health care. PBNDS 4.3 and NDS 4.3 require that each facility must provide "medically necessary and appropriate medical, dental and mental health care and pharmaceutical services."[59] These services include "comprehensive, routine and preventive health care, as medically indicated," emergency care, specialty health care, timely responses to medical complaints, and hospitalization as needed within the local community."[60] The PBNDS and NDS further lay out that mental health programs must include crisis intervention, referrals for evaluations, diagnosis and treatment by a competent mental health professional, and suicide prevention.[61]

Both the PBNDS and the NDS include standards to ensure facilities identify detainee medical needs in a timely fashion and provide responsive care according to professional standards. PBNDS 4.3 and NDS 4.3 both require that a comprehensive medical and mental health assessment occur within 14 days of arrival unless more immediate attention is required.[62]

For ongoing care during detention, the PBNDS and NDS require a procedure that allows detainees unrestricted opportunities to freely request medical and mental health services.[63] This procedure requires clear written policies and regularly scheduled sick call times that are communicated to detainees.[64] Per PBNDS 4.3 and NDS 4.3, medical personnel must receive and triage all sick call requests within 24 hours after a detainee submits the request, but in urgent situations, medical personnel must be notified immediately.[65] PBNDS 4.3 and NDS 4.3 require a physician be present at the facility or on call for emergency care.[66] A provider must evaluate detainees referred for mental health treatment within 72 hours, and PBNDS requires that each evaluation must consider any history of suicide attempts, illicit drug or alcohol use, or past mental health treatment.[67]

The PBNDS and NDS also include provisions for reasonable accommodations for detainees with disabilities, including cognitive disabilities.[68] PBNDS 4.1 and NDS 4.3 require that medical request slips must be provided in English and in the languages most commonly used by detainees at the facility; for detainees who do not speak these languages, the facility must provide services to assist the detainee to complete the request.[69]

58 *Id.* at §§ F-G, pp. 55-57; ICE, NDS 2025, Part 2.1 Admission and Release, Part II, § A, p. 18.
59 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § A, p. 260; ICE, NDS 2025, Part 4.3 Medical Care, Part II, § A, p. 112.
60 Id.
61 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, pp. 269-270; ICE, NDS 2025, Part 4.3 Medical Care, Part II, § S, p. 122.
62 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § M, p. 268; ICE, NDS 2025, Part 4.3 Medical Care, Part II, §§ A, B, E, pp. 112-114.
63 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § S, pp. 271-272; ICE, NDS 2025, Part 4.3 Medical Care, Part II, § I, pp. 115-116.
64 Id.
65 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § S, p. 271; ICE, NDS 2025, Part 4.3 Medical Care, Part II, § I, p. 116.
66 ICE, PBNDS 2011, 4.3 Medical Care, Part V, § T, p. 272; ICE, NDS 2025, Part 4.3 Medical Care, Part II, §§ J-K, p. 116.
67 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, pp. 269-270; ICE, NDS 2025, Part 4.3 Medical Care, Part II, § T, p. 124.
68 ICE, PBNDS 2011, Part 4.8 Disability Identification, Assessment, and Accommodation, Part II, pp. 344-345, Part V, §§ A-F, pp. 347-352; ICE, NDS 2025, Part 4.7 Disability Identification, Assessment, and Accommodation, Part II, § F, pp. 141-143.
69 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § S, pp. 271-72; ICE, NDS 2025, Part 4.3 Medical Care, Part II, §§ G, I, pp. 115-116.

PBNDS 4.3 and NDS 4.3 require that, upon transfer between ICE facilities or release or removal from ICE custody, detainees are provided medication, referrals to community-based providers as medically appropriate, and a detailed medical care summary.[70]

Standards Related to Legal and Family Visitation

Standards also ensure that detainees can maintain connections to their family and support networks outside of the facility, and to legal assistance. Regarding contact with friends and family, PBNDS 5.6 and NDS 5.4 require that detainees have reasonable and equitable access to reasonably priced telephone services.[71] PBNDS 5.7 and NDS 5.5 require each facility to establish written visiting procedures, including a schedule and hours of visitation, and make them available to the public.[72]

PBNDS 5.6 and NDS 5.4 also require that detainees and their legal counsel shall be able communicate effectively with each other, and the facility must ensure their privacy regarding legal matters.[73] PBNDS 5.7 and NDS 5.5 require that detainees be allowed to meet privately with current or prospective legal representation and their legal assistants for a legal visitation.[74] Legal visits may not be terminated for routine official counts under PBNDS and NDS.[75] Legal visits also shall be permitted seven days a week, including holidays, for a minimum of eight hours per day on regular business days, and a minimum of four hours per day on weekends and holidays.[76] PBNDS 6.3 and NDS 6.5 require that when requested and where resources permit, facilities shall provide detainees meaningful access to law libraries, legal materials, and related materials on a regular schedule and no less than 15 hours per week under PBNDS, and five hours per week under NDS.[77]

Standards Related to Detainee Safety

The PBNDS and NDS include provisions governing uses of force at facilities, prohibiting some uses of force and requiring training, recordkeeping, and reporting of permissible uses of force from detention officers on detainees.[78] PBNDS 2.15 and NDS 2.8 mandate that detention officers consult with appropriate medical or mental health staff prior to a calculated use of force involving a detainee with special needs, which include detainees with mental health conditions, that may impair their ability to understand their situation.[79]

PBNDS 6.2 and NDS 6.2 also require detainees have the ability to file formal or informal grievances and receive a timely resolution and require the facility to keep accurate records of filed grievances and resolutions in a grievance log and detainee detention file.[80] Facility grievance procedures and correspondence shall be communicated to the detainee in a language or manner the detainee can understand.[81]

70 ICE, PBNDS 2011, 4.3 Medical Care, Part V, §§ Z, BB, pp. 276, 278-279; ICE, NDS 2025, Part 4.3 Medical Care, Part II, § Q, pp. 120-21.
71 ICE, PBNDS 2011, Part 5.6 Telephone Access, Part V, § A, p. 386; ICE, NDS 2025, Part 5.4 Telephone Access, Part II, § A, p. 158.
72 ICE, PBNDS 2011, Part 5.7 Visitation, Part V, §§ A-B, pp. 393-394; ICE, NDS 2025, Part 5.5 Visitation, Part V, §§ A-G, pp. 163-167.
73 ICE, PBNDS 2011, Part 5.6 Telephone Access, Part V, § F, p. 389; ICE, NDS 2025, Part 5.4 Telephone Access, Part II, §§ J-K, p. 161.
74 ICE, PBNDS 2011, Part 5.7 Visitation, Part V, § J, p. 398; ICE, NDS 2025, Part 5.5 Visitation, Part I, p. 163, Part V, § G, p. 166.
75 ICE, PBNDS 2011, Part 5.7 Visitation, Part V, § J, p. 398; ICE, NDS 2025, Part 5.5 Visitation, Part V, § G, p. 168.
76 ICE, PBNDS 2011, Part 5.7 Visitation, Part V, § J, p. 398; ICE, NDS 2025, Part 5.5 Visitation, Part V, § G, p. 166.
77 ICE, PBNDS 2011, Part 6.3 Law Libraries and Legal Materials, Part II, p. 21, Part V, §§ A, C-G, I-K, pp. 422-427; ICE, NDS 2025, Part 6.3 Law Libraries and Legal Materials, Part II, §§ A-L, pp. 185-188.
78 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, pp. 201-213; ICE, NDS 2025, Part 2.8 Use of Force and Restraints, Part I-II, pp. 44-52.
79 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, § I, p. 206; ICE, NDS 2025, Part 2.8 Use of Force and Restraints, Part II, § B, p. 45.
80 ICE, PBNDS 2011, Part 6.2 Grievance System, Part II, pp. 414-415; ICE, NDS 2025, Part 6.2 Grievance System, Parts I-II, pp. 182-184.
81 ICE, PBNDS, Part 6.2 Grievance System, Part V, Part §§ A-B, pp. 415-416; ICE, NDS 2025, Part 6.2 Grievance System,

Policy Changes Impacting Conditions of Confinement

The Trump Administration has enacted several policy changes since January 2025 that have impacted conditions of confinement for detainees. This section discusses: 1) cancelled legal orientation programs, 2) removing services for transgender people, and 3) claims processing for third-party providers.

Legal Orientation Programs (LOPs)

Legal Orientation Programs (LOPs) are federally funded programs that provide people in removal proceedings with information about their rights and the immigration process. LOPs are critical in providing immigrants with essential information about their rights as many immigrants are unrepresented. On January 20, 2025, President Trump signed Executive Order 14159, which among other things ordered immediate review of all agreements providing federal funding to non-governmental organizations supporting or providing services to immigrants.[82] Following this Executive Order, the U.S. Justice Department instructed nonprofits on January 22, 2025, to stop work immediately on LOPs.[83] On January 31, 2025, a coalition of nonprofit groups filed a lawsuit challenging the order and sought to restore immediate access to LOPs.[84] In response, on April 10, 2025, President Trump terminated funding for LOPs and other programs providing due process protections for immigrants.[85] The U.S. District Court of D.C. denied the plaintiffs' request for a preliminary injunction and granted partial summary judgement for the government on July 6, 2025.[86] On July 14, 2025, plaintiffs appealed the case to the D.C. Circuit Court; oral arguments were held on October 14, 2025, and the case remains pending.[87] Meanwhile, fewer detained individuals have access to basic information about their legal rights while the mass deportation of individuals is on the rise in California.

Protections for Transgender People

Federal prison and jail standards, which also cover civil immigration detention facilities, were created to keep transgender, intersex, and gender-nonconforming people safe from sexual violence and harassment. However, on January 20, 2025, President Trump issued Executive Order 14168 requiring federal inmates, including individuals in civil immigration detention, to be placed in facilities based on their sex assigned at birth instead of their gender identity.[88] In response to this directive, the Trump Administration has rolled back a number of protections and data-tracking mechanisms for transgender people. On February 4, 2025, ICE began excluding congressionally-mandated data on transgender people in immigration detention from its biweekly statistical reports.[89] ICE also removed its 2015 Transgender Care Memorandum from its website and amended at least three contracts with detention facilities, including facilities in Florida and New York and one county jail holding detainees in Michigan, to remove transgender care requirements.[90]

Part II, §§ A, H, pp. 182, 184.

82 Exec. Order No. 14159, *Protecting the American People Against Invasion*, 90 Fed. Reg. 8443, 8447 (Jan. 20, 2025).

83 *Amica Ctr. for Immigrant Rights v. U.S. DOJ* (D.D.C. Jan. 31, 2025, No. 1:25-cv-00298) ECF No. 1, at p. 36.

84 *Amica Ctr. for Immigrant Rights v. U.S. DOJ* (D.D.C. Jan. 31, 2025, No. 1:25-cv-00298) ECF No. 1.

85 *Amica Ctr. for Immigrant Rights v. U.S. DOJ* (D.D.C. July 6, 2025, No. 1:25-cv-00298) 2025 WL 1852762, at *4.

86 *Id.* at *1.

87 *Amica Ctr. for Immigrant Rights v. U.S. DOJ* (D.D.C. July 14, 2025, No. 1:25-cv-00298) ECF No. 85; *Amica Ctr. for Immigrant Rights v. U.S. DOJ* (D.C. Cir. Oct. 14, 2025, No. 25-5254) ECF No. 2140010.

88 Exec. Order No. 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615, 8616-8617 (Jan. 20, 2025); Vera Institute of Justice, *ICE is Excluding Data on Transgender People in Detention* (June 30, 2025) <https://www.vera.org/news/ice-is-excluding-data-on-transgender-people-in-detention> (as of Mar. 19, 2026).

89 Vera Institute of Justice, *ICE is Excluding Data on Transgender People in Detention* (June 30, 2025) <https://www.vera.org/news/ice-is-excluding-data-on-transgender-people-in-detention> (as of Mar. 19, 2026).

90 *Id.*; Sledge, *ICE is Erasing Rules that Protect Trans Immigrants*, The Intercept (Mar. 27, 2025) < https:/theintercept.com/2025/03/27/ice-trans-immigrant-detainees> (as of Mar. 19, 2026); ICE, *Memorandum, Further Guidance Regarding the Care of Transgender Detainees* (June 19, 2015) <https://web.archive.org/web/20250203042149/http:/www.ice.gov/sites/default/files/documents/Document/2015/TransgenderCareMemorandum.pdf> (as of Feb. 24, 2026).

Claims Processing for Third-Party Providers

Facility health providers refer detainees to third-party providers for care that the facility cannot provide. ICE reportedly has not paid any third-party providers for medical care for detainees since October 3, 2025.[91] At that time, ICE terminated its processing of all ICE Health Service Corps (IHSC) managed care claims, which the Veterans Affairs Financial Services Center (VAFSC) had been processing.[92] IHSC reportedly has found a new claims processing third-party administrator, Accentra Health, and while IHSC initially estimated that claims processing would resume April 30, 2026, the administrator is now estimating that claims processing will resume during the second quarter of calendar year 2026.[93] This interruption, even if temporary, has caused widespread disruption in the provision of appropriate medical care at facilities in California.

91 Legum, *ICE has Stopped Paying for Detainee Medical Treatment*, Popular Information (Jan. 20, 2026) <https://popular.info/p/ice-has-stopped-paying-for-detainee> (as of Mar. 6, 2026); ICE, *IHSC-Managed Care, Important Notifications* (Mar. 2, 2026) <https://www.ice.gov/detain/ice-health-service-corps/ihs-managed-care> (as of Mar. 19, 2026).

92 Id.

93 Compare ICE, *IHSC-Managed Care, Important Notifications* (Jan. 13, 2026) <https://www.ice.gov/detain/ice-health-service-corps/ihs-managed-care> (as of April 27, 2026); Acentra Health, *ICE Health Service Corps-Frequently Asked Questions* <https://ihsc-dhs.acentra.com/faq/> (as of April 27, 2026).

5. Methodology

The findings presented in this report are the result of a multi-faceted methodology and extensive data analysis. Cal DOJ's review includes researching publicly available information; obtaining and reviewing documents from facility operators for all seven facilities reviewed for this report; consulting with subject matter experts about health care and immigration detention standards; and conducting focused, two-day visits to each facility to inspect and review files and to interview staff and immigration detainees. In addition to subject matter experts, Cal DOJ's review team consisted of attorneys, staff, and law clerks from the Civil Rights Enforcement Section, and a senior research associate from Cal DOJ's Research Services Branch.

Review of Publicly Available Information

In preparing the report, Cal DOJ consulted relevant publicly available government and nongovernmental entity reports, news articles, and legal filings related to the facilities.

Consultation with Experts

Cal DOJ retained one medical expert (Dr. Lisa Anderson) and one immigration detention expert (Dr. Dora Schriro) to assist in the reviews contained in this report. Since AB 103 does not impose substantive requirements on the facilities, the experts evaluated the seven facilities reviewed for this report in accordance with best practices and in consultation with the PBNDS, NDS, and professional and industry standards.

Site Visits

Cal DOJ's review process targeted three AB 103 focus areas: conditions of confinement, the standard of care, and how conditions of confinement affect due process for individuals detained in immigration detention facilities in California. The review for each facility consisted of an assessment of: (1) requested documentation including rosters and logs;[94] (2) facility tours; (3) on-site records review; and (4) interviews with facility staff and detainees.

Document Review

Cal DOJ requested preliminary documentation from all seven facilities reviewed for this report prior to each site visit and reviewed additional documentation onsite. As detailed throughout this report, not all facilities provided the requested information, and some failed to provide complete information. Cal DOJ summarized the data collected, and prepared tables and charts included throughout this report. Cal DOJ's retained experts also conducted reviews of detainee records (detention files and health care records) onsite during each site visit based on their subject matter expertise.

Staff Interviews

Cal DOJ and its experts interviewed facility leaders such as facility administrators and health care services administrators, and mid-level rank and file staff who either had expertise in particular functions–such as intake and classification–or who had significant detainee contact. Although most facility operators required that facility counsel be present for interviews, Cal DOJ advised staff that their participation was voluntary, that they would not be named in Cal DOJ's report, and that they would not be subject to retaliation for participating in the interviews.

94 Each facility maintains records differently, as reflected in different sections of this report.

Detainee Interviews

Cal DOJ interviewed 194 detainees across the seven reviewed detention facilities. The detainees participated in interviews led by Cal DOJ staff consisting of questions pertaining to their own background and to facility conditions in the following areas: (i) due process and visitation; (ii) intake; (iii) medical, mental health, and dental care; (iv) access to food and water; (v) conditions of housing; and (vi) detainee and staff relations.

Cal DOJ generally identified detainees for interviews based on their presence on interview sign-up sheets placed in housing units before the date of Cal DOJ's visit and/or detainee rosters provided by each facility. Cal DOJ chose individuals from these two sources by selecting a sampling of detainees covering different housing units with a range of arrival dates and lengths of stay, countries of origin, languages spoken, custody levels, and usage of health care services. All interviewed detainees provided verbal consent to be interviewed by Cal DOJ following an initial explanation regarding the purpose of the review and why they were being interviewed.

Interview spaces and privacy levels varied by facility. At Mesa Verde and Golden State, interviews were conducted through a plexiglass barrier, requiring detainees and Cal DOJ staff to speak and listen to each other through an attached telephone that was not always operable or via an opening in the plexiglass. Interviews at Adelanto, Desert View, Imperial, Otay Mesa, and Cal City took place in an individual and private setting in the facilities' attorney visitation rooms, dining halls, and designated conference rooms or offices, and with Cal DOJ staff and detainees present in the same room.

Cal DOJ interviewed detainees in their preferred language. The languages used during the interviews included: Arabic, Armenian, English, French, Garre, Haitian-Creole, Hindi, Korean, Lao, Mandarin, Nepali, Pashto, Persian, Portuguese, Punjabi, Russian, Sign Language, Spanish, Turkish, Urdu, and Vietnamese. Overall, the detainees with whom Cal DOJ spoke came from 49 different countries, with the greatest number of interviewees coming from Mexico, India, Russia, China, Colombia, Venezuela, El Salvador, Guatemala, Afghanistan, Belize, Iran, and Turkey. For a full list of all countries of origin for all detainees across all seven facilities reviewed in 2025, please see **Figure 6** in the *Detained Populations* section and **Table 22** in the **Appendix** to this report.

Cal DOJ analyzed the data obtained from each of the methods described and the results were integrated into the discussion of each of the topics that are the focus of this report. The retained experts analyzed the data obtained from file review and the interviews they conducted, and Cal DOJ integrated those findings into the reviews of the facilities.

6. Detained Populations

The number of civil immigration detainees has drastically increased since Cal DOJ's last report. This section provides an overview of the federal government's refusal to release detainees on bond, which has significantly increased the number of those detained, and of related litigation. The second part discusses demographic information about the detainees who were held at the seven facilities across California at the time when Cal DOJ inspected them in July through November of 2025.

i. Expansion of Detention Through the Elimination of Bond

The Immigration and Nationality Act (INA) granted the U.S. Attorney General authority to arrest and detain noncitizens who immigration officials allege may be subject to removal from the United States and hold them in custody while a decision on whether they may be ordered removed is pending.[95] For nearly 30 years, both ICE and the Board of Immigration Appeals interpreted the immigration statute as authorizing release of persons who had previously entered the United States without inspection through bond.

The Trump Administration and Board of Immigration Appeals changed that interpretation to reduce the availability of bond and increase mandatory detention. This change has been met with numerous lawsuits and habeas corpus petitions nationwide. Pursuant to Executive Orders issued by President Trump in January 2025 laying out a roadmap for the expansion of civil immigration detention,[96] ICE began to restrict officers' discretion in using bond or other forms of conditional release.[97] In addition, the Laken Riley Act became law on January 29, 2025, adding new criminal convictions to the list of those that trigger mandatory detention.[98] For the first time, under this act, detention was mandated based on arrest alone, regardless of whether the arrest resulted in criminal charges or convictions.[99] Simultaneously, critical federal oversight offices within DHS were shuttered.[100]

The Board of Immigration Appeals has also issued decisions resulting in reduced availability of bond for detained immigrants. In May 2025, the Board of Immigration Appeals decided *Matter of Q. Li*,[101] ruling that those released by Border Patrol after crossing the border are subject to mandatory detention and may not seek release on bond. As a result, when the Trump Administration began the policy of "re-arresting"[102] migrants who had been released on bond years earlier and had spent years living inside the United States, they were unable to seek release on bond.[103] Then in August 2025, the Board of Immigration Appeals in *Matter of Yajure Hurtado* adopted the Trump Administration's interpretation and made immigrants categorically ineligible for bond because they crossed the border

95 8 U.S.C. § 1226. Under the Homeland Security Act of 2002, which created the Department of Homeland Security (DHS), these responsibilities were transferred to the Secretary of DHS. 6 U.S.C. §§ 542, 557.

96 Exec. Order 14159, 90 Fed. Reg. 8443 (Jan. 20, 2005); Exec. Order No. 14165, 90 Fed. Reg. 8467 (Jan. 20, 2025); Exec. Order 14169, 90 Fed. Reg. 8619 (Jan. 20, 2025).

97 Shaw, *Trump's ICE Limits Illegal Immigrant Releases Amid Moves to Shake Off Biden "Hangover"*, Fox News (Feb. 6, 2025) <https://www.foxnews.com/politics/trumps-ice-limits-illegal-immigrant-releases-amid-moves-shake-off-biden-hangover> (as of Feb. 11, 2026).

98 See 8 U.S.C. § 1226(c).

99 *Id*.

100 Economic Policy Inst., *Trump Administration Closes Three DHS Offices Focused on Civil Rights and Oversight* (Apr. 3, 2025) <https://www.epi.org/policywatch/trump-administration-closes-three-dhs-offices-focused-on-civil-rights-and-oversight/> (as of Apr. 10, 2025).

101 *Matter of Q. Li*, 26 I&N Dec. 66 (BIA 2025).

102 In May 2025, ICE began the policy of "re-arresting", meaning taking into custody people who had previously been encountered either by ICE or by CBP, and had been released and permitted to attend court hearings outside of detention. These individuals were arrested as they attended immigration court hearings and check-ins with ICE. Am. Immi. Council, *Immigration Detention Expansion in Trump's Second Term* (Jan. 2026) at pp. 16-17, <https://www.americanimmigrationcouncil.org/wp-content/uploads/2026/01/immigration-detention-report.pdf> (as of Mar. 19, 2026).

103 *Id*. at p. 22 (citing Clinic Legal, *What Is Going on at the BIA? Is a Release From Detention at the Border Considered Parole or Not?* (June 26, 2025) <https://www.cliniclegal.org/resources/what-going-bia-release-detention-border-considered-parole-or-not> (as of Mar. 24, 2026)).

without inspection, overturning nearly 30 years of precedent.[104] Previously, undocumented immigrants arrested within the country were eligible for bond regardless of their manner of entry. Now millions of undocumented immigrants are subject to mandatory detention.[105]

Numerous challenges to the Trump Administration's new interpretation of the availability of bond have emerged throughout the country, through a nationwide class action, multiple regional class actions, and hundreds of individual habeas petitions.[106] In *Bautista v. Santacruz Jr.*, a California district court granted partial summary judgement to a group of individuals detained by ICE without a bond hearing and ordered individualized bond hearings for plaintiffs.[107] The court also vacated *Matter of Yajure Hurtado* as contrary to law under the Administrative Procedure Act.[108] At the time of this report's publication, the ruling is on appeal at the Ninth Circuit, and is currently stayed pending the federal government's appeal of the class certification and of the lower court order vacating *Matter of Yajure Hurtado*.[109]

In part as a result of the change in interpretation of the availability of bond, the average number of individuals held each day in civil immigration detention facilities across California has more than doubled over the past year.[110]

ii. Detainee Demographics Snapshot

Facilities provided various information about the active detainee population, including demographic characteristics, in rosters sent to Cal DOJ shortly before site visits. Facilities varied in what information they provided, but rosters generally included detainee sex, age, security classification, arrival date, and country of origin. The following sections present analyses of key information based on these rosters. Specifically, these snapshots summarize information about active detainees including sex, security classification, length of stay, and country of origin as assessed by Cal DOJ.

Table 2 provides the count of detainees by facility at the time of Cal DOJ's site visits, the date when each detainee roster was generated, and the detainee arrival date range for all active detainees at the time of the site visits.

104 *Matter of Yajure Hurtado*, 29 I&N Dec. 216 (BIA 2025); Am. Immi. Law. Assn., *ICE Memo: Interim Guidance Regarding Detention Authority for Applications for Admission* (July 8, 2025) <https://www.aila.org/library/ice-memo-interim-guidance-regarding-detention-authority-for-applications-for-admission> (as of Apr. 10, 2026).

105 Am. Immi. Council, *Detention Expansion in Trump's Second Term* (Jan. 2026) <https://www.americanimmigrationcouncil.org/wp-content/uploads/2026/01/immigration-detention-report.pdf> p. 23 (as of Mar. 26, 2026).

106 *Id.* at p. 22 (explaining that while "[o]ver 300 federal judges, appointed by every living president, have weighed in on the government's interpretation; just 14 have ruled in favor of it.").

107 *Bautista v. Santacruz Jr*. (C.D.Cal. Nov. 20, 2025, No. 5:25-cv-01873-SSS-BFM) ECF No. 81; *Bautista v. Santacruz Jr*. (C.D.Cal. Nov. 25, 2025, No. 5:25-cv-01873-SSS-BFM) ECF No. 84.

108 *Bautista v. Santacruz Jr*. (C.D.Cal. Feb. 18, 2025, No. 5:25-cv-01873-SSS-BFM) ECF No. 116.

109 *Bautista v. DHS* (9th Cir. Mar. 31, 2026, No. 26-1044, Dkt. 17). Other circuits have also addressed this issue. See, e.g., *Cunha v. Freden* (2nd Cir. Apr. 28, 2026, No. 25-3141); *Buenrostro-Mendez v. Bondi* (5th Cir. 2026) 166 F.4th 494; *Herrera-Avila v. Bondi* (8th Cir. Mar. 25, 2026, No. 25-3248).

110 Miranda, *California ICE Detention Doubles in One Year. One Center Surges From 3 to 1,800*, The Sacramento Bee (Feb. 6, 2026) <https://www.sacbee.com/news/california/article314596167.html> (as of Feb. 12, 2026) (showing that as of January 2026, 6,412 beds of the approximately 8,500 available in California are filled, up from roughly 3,000 in January 2025).

Table 2. Count of Detainees by Facility and Date Span of Data Provided by Facilities

Detention Facility	Count of Detainees	Date Roster was Generated	Detainee Arrival Date Range
Adelanto	1,570	July 7, 2025	March 16, 2020 to July 7, 2025
Desert View	517	July 7, 2025	April 26, 2024 to June 21, 2025
Golden State	569	September 23, 2025	May 5, 2022 to September 22, 2025
Mesa Verde	370	September 25, 2025	June 10, 2025 to September 25, 2025
Imperial	627	October 2, 2025	November 14, 2023 to October 2, 2025
Otay Mesa	1,433	October 6, 2025	June 12, 2024 to October 5, 2025
Cal City	942	November 19, 2025	August 27, 2025 to November 19, 2025

Detainee Sex

All facilities provided information about detainee sex. Some facilities used the term "gender" to describe this category, but "sex" appears to be a more suitable characterization given the use of sex terminology (e.g. female/male vs. woman/man) throughout records. We use "sex" throughout this report to describe this characteristic. Facilities did not provide information about gender identity (e.g. woman, man, nonbinary) or trans status (e.g. cisgender, transgender)[111] in the rosters.

Table 3 shows the detainee population, by sex, throughout all facilities on the dates of Cal DOJ's site visits. Two individuals at Mesa Verde were classified as "IN", which Cal DOJ assumes is an abbreviation for intersex, although Mesa Verde has not confirmed this understanding. Sex information was not specified for 10 detainees at Mesa Verde. **Table 3** incorporates that intersex assumption, as well as the number of detainees for which sex information was missing.

Table 3. Distribution of Detainee Population by Sex Throughout All Reviewed Facilities as of Cal DOJ's Site Visits

Sex	Count	Percent
Female	815	13.6%
Male	5,177	86.2%
Intersex	2	<0.1%
Missing Data	10	0.2%

111 The term *cisgender* refers to people whose gender identity ideologically aligns with the sex they were assigned at birth (e.g. cisgender women, cisgender men). This term contrasts with *transgender*, which describes people whose gender identity does not ideologically align with the sex they were assigned at birth (e.g. transgender women, transgender men).

Excluding the intersex and missing sex information from Mesa Verde, **Figure 1** shows the distribution of female versus male detainees throughout each facility on the dates of Cal DOJ's site visits.

Figure 1. Distribution of Female vs. Male Detainees by Facility as of Cal DOJ's Site Visits

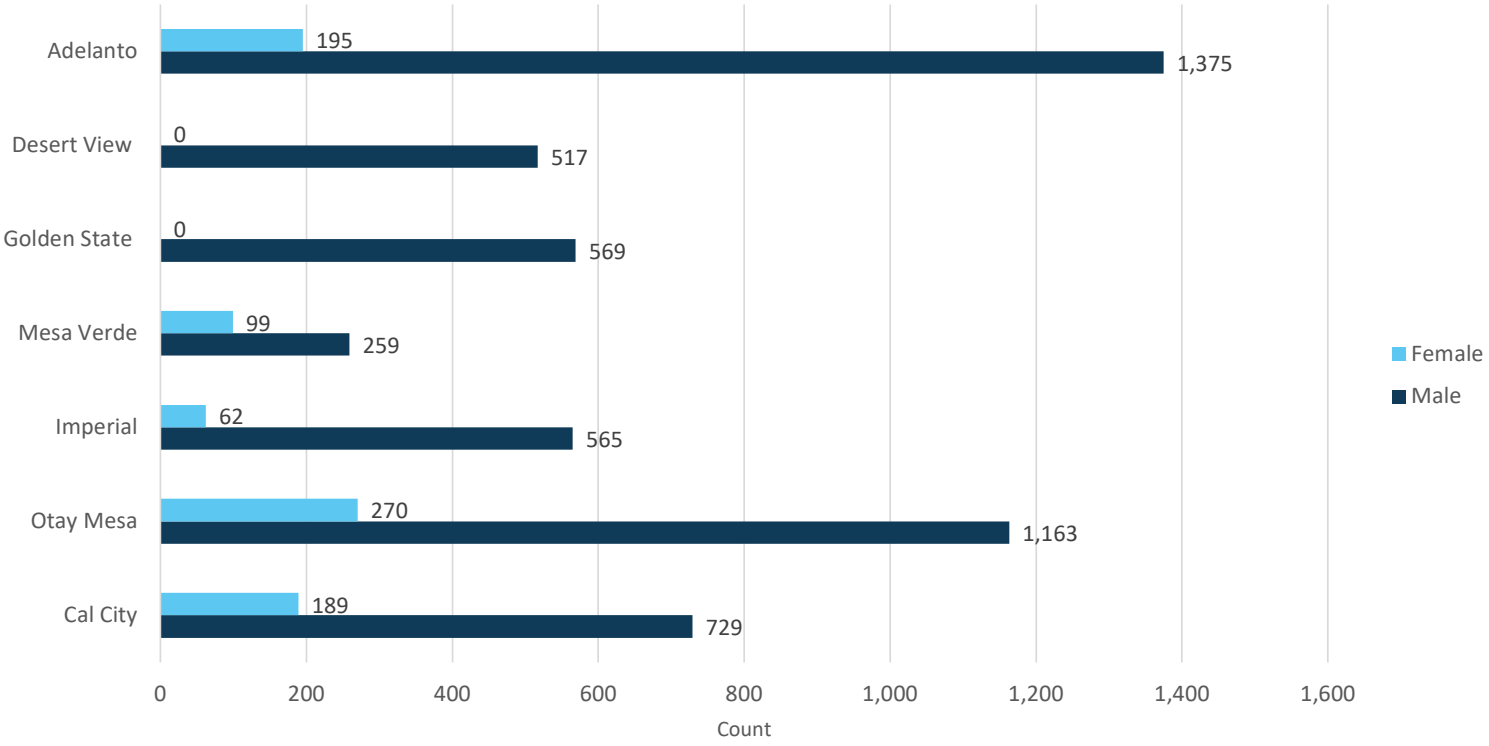
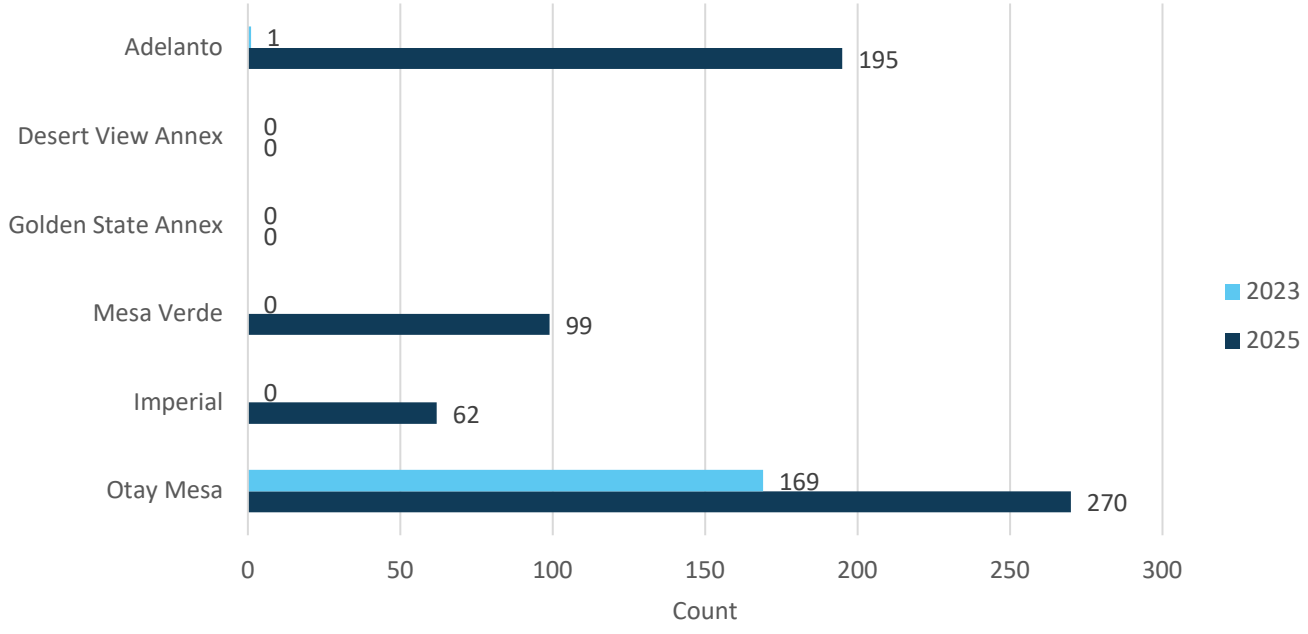


Figure 2 compares the number of female detainees housed at each applicable facility during Cal DOJ's 2023 site visits versus the 2025 site visits. Cal City is not included in this figure because this facility was not operating during the 2023 site visit. The figure demonstrates that the number of female detainees increased between site visits at the applicable facilities.

Figure 2. Comparison of the Number of Female Detainees Between Cal DOJ's 2023 and 2025 Site Visits



In 2023, only two of the six active facilities at that time (Adelanto and Otay Mesa) reported a population of female detainees. At the time of Cal DOJ's 2025 site visits, five out of the seven facilities active in 2025 reported female detainees.

Detainee Security Classification

Each facility must develop and implement a system for classifying detainees.[112] In making classification determinations, each facility reviews information such as detainees' criminal histories, perceived threat levels, and perceived vulnerabilities.

The names of security classifications vary across facilities. Adelanto, Desert View, Golden State, and Mesa Verde use (abbreviations of) intensity terminology, including "Low", "Medium Low", "Medium High" and "High". These facilities did not use a "Medium" category. Imperial uses a mix of color and intensity terms. Otay Mesa and Cal City report ICE threat levels. For **Table 4** and **Figure 3**, and other analyses related to security classification, Cal DOJ synthesizes these disparate systems into a unified set of intensity terms: "Low", "Medium Low", "Medium", "Medium High", and "High".

Table 4. Detainee Security Classifications Across All Facilities on the Date of Cal DOJ's 2025 Site Visits

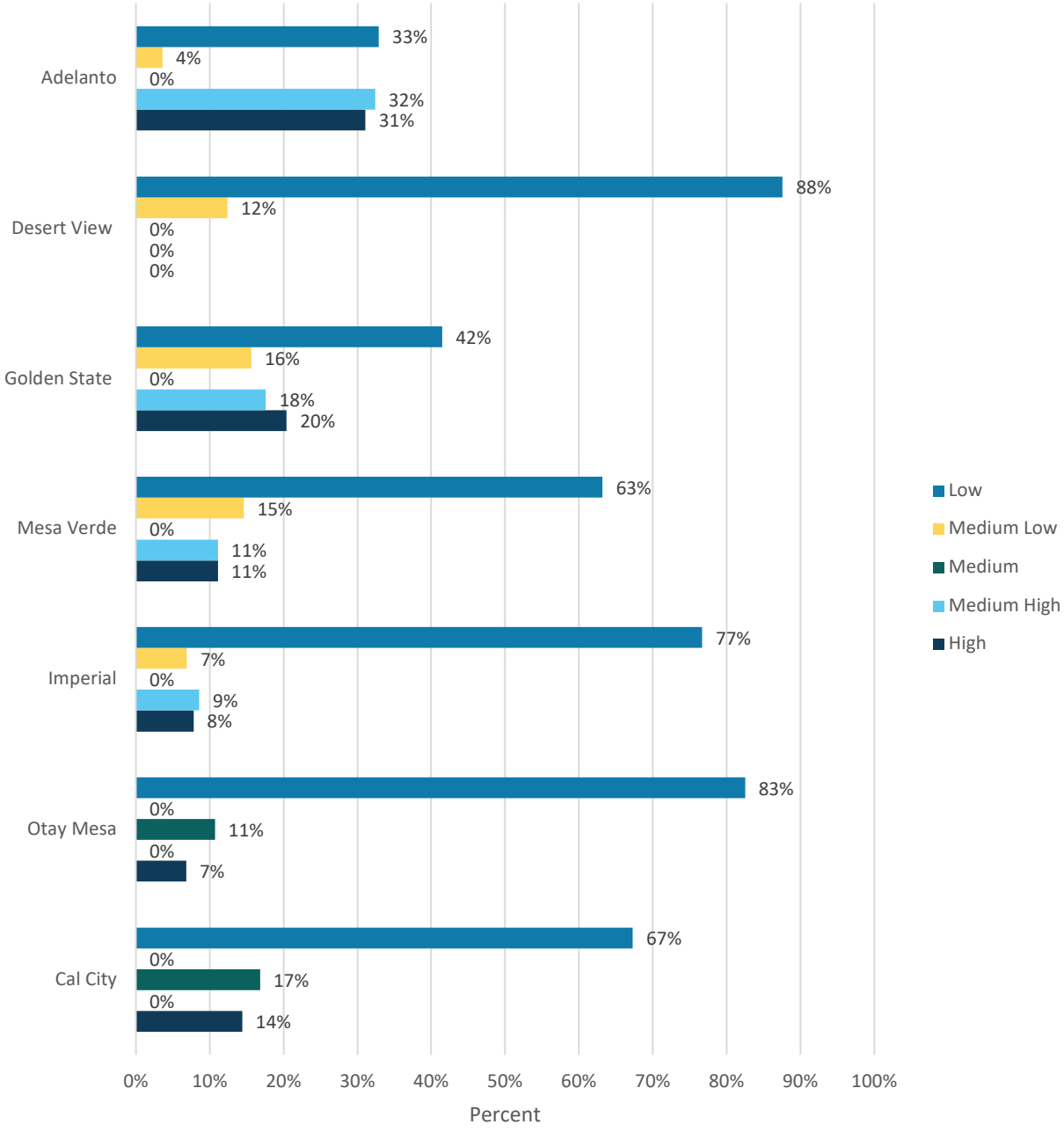
Security Classification	Count	Percent
Low	3,721	62.0%
Medium Low	306	5.1%
Medium	307	5.1%
Medium High	703	11.7%
High	925	15.4%
Unclear or Missing Data	42	0.7%

Table 4 shows the percentage of detainees assigned to each security classification across all reviewed facilities on the date of Cal DOJ's site visits. **Figure 3** shows the percentage of detainees assigned to each security classification at each facility as of the date of Cal DOJ's site visit.

Some detainees are excluded from **Table 4** and **Figure 3** because their security classification was not specified or unclear. Golden State did not provide security classification information for 28 detainees. At Cal City, the security classification was coded as "detainee" for 14 individuals, such that their ICE threat level is unclear.

112 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § A, pp. 61-62; ICE, NDS 2025, Part 2.2 Custody Classification System, Parts I-II, p. 21.

Figure 3. Percent of Detainees by Security Classification at Each Facility as of Cal DOJ's 2025 Site Visits



Individuals classified as "Low" accounted for the largest percentage of detainees at all facilities. Over half of all detainees were classified as "Low" at all facilities except Adelanto and Golden State. Adelanto had the highest percentage of detainees classified as "High".

Detainee Length of Detention

Table 5 provides descriptive statistics of detainee length of detention in days by facility. Length of detention was calculated by Cal DOJ as the time elapsed between a detainee's arrival date and the date the roster was created.

Table 5. Detainees' Length of Detention in Days for Each Facility

Facility	Minimum	Maximum	Mean	Median	Standard Deviation
Adelanto	0	1,939	38.6	28	78.7
Desert View	16	437	64.1	32	59.3
Golden State	1	1,237	82.8	43	133.6
Mesa Verde	0	107	29.2	14	32.2
Imperial	0	688	133.7	82	127.8
Otay Mesa	1	481	126.5	89	105.9
Cal City	0	84	45.6	41	28.6

The longest stays in detention were associated with detainees housed at Adelanto and Golden State. The highest average (mean) and median stays in detention were associated with Imperial and Otay Mesa. The highest standard deviations were associated with Golden State and Imperial, indicating that there was more variability in detainees' lengths of detention at these facilities.

Detainee Countries of Origin

All facilities provided information about detainees' citizenship or nationality (country/countries of origin hereafter). However, for some records this information was missing or ambiguous. "Missing" in this context refers to records where this characteristic was left blank. "Ambiguous" here refers to records where the country was unclear. For example, there were records where only "Congo" was entered, such that it is ambiguous whether the intended meaning was the Democratic Republic of Congo or the Republic of Congo. In this and similar cases, the analyses presented in this section count each representation separately, e.g., "Congo", "Democratic Republic of Congo", and "Republic of Congo" are distinct values. Finally, the analyses exclude 148 records that did not indicate a country (i.e. "Africa", "None", "Other or Not Listed", "Stateless", and missing data).

Approximately 127 countries were identified as detainees' countries of origin across facilities using this method. Cal DOJ's analysis indicates that Adelanto detainees were associated with 87 countries, Desert View with 50 countries, Golden State with 61 countries, Mesa Verde with 44 countries, Imperial with 71 countries, Otay Mesa with 86 countries, and Cal City with 74 countries. **Figure 4** displays the top 10 countries across facilities. The most frequently identified countries were Mexico, India, and Guatemala. For a full list of all countries of origin across all reviewed facilities, please see **Figure 6** in this chapter and **Table 22** in the **Appendix** to this report.

Figure 4. Top 10 Countries of Origin Reported Across All Facilities Based on Cal DOJ's 2025 Site Visits

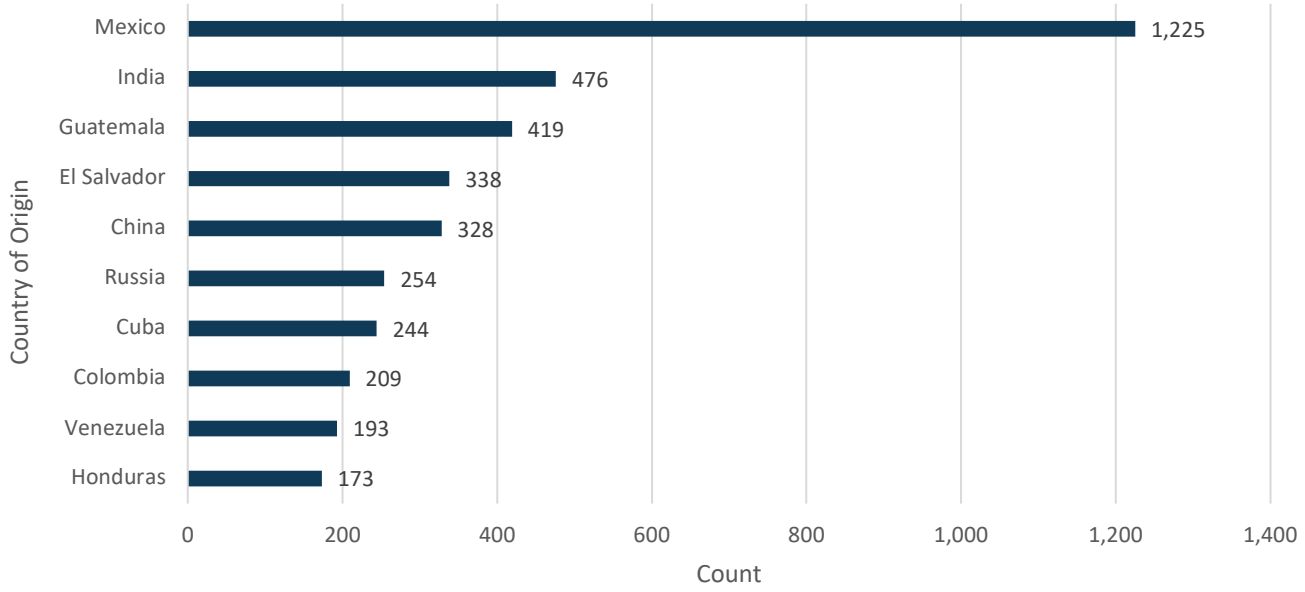


Figure 5 compares the number of distinct detainee countries of origin between Cal DOJ's 2023 and 2025 site visits. Cal City is excluded from this figure because this facility was not operating in 2023. The figure indicates that the diversity of detainees' countries of origin increased at each applicable facility except Desert View between 2023 and 2025.

Figure 5. Comparison of the Number of Detainee Countries of Origin Between Cal DOJ's 2023 and 2025 Site Visits

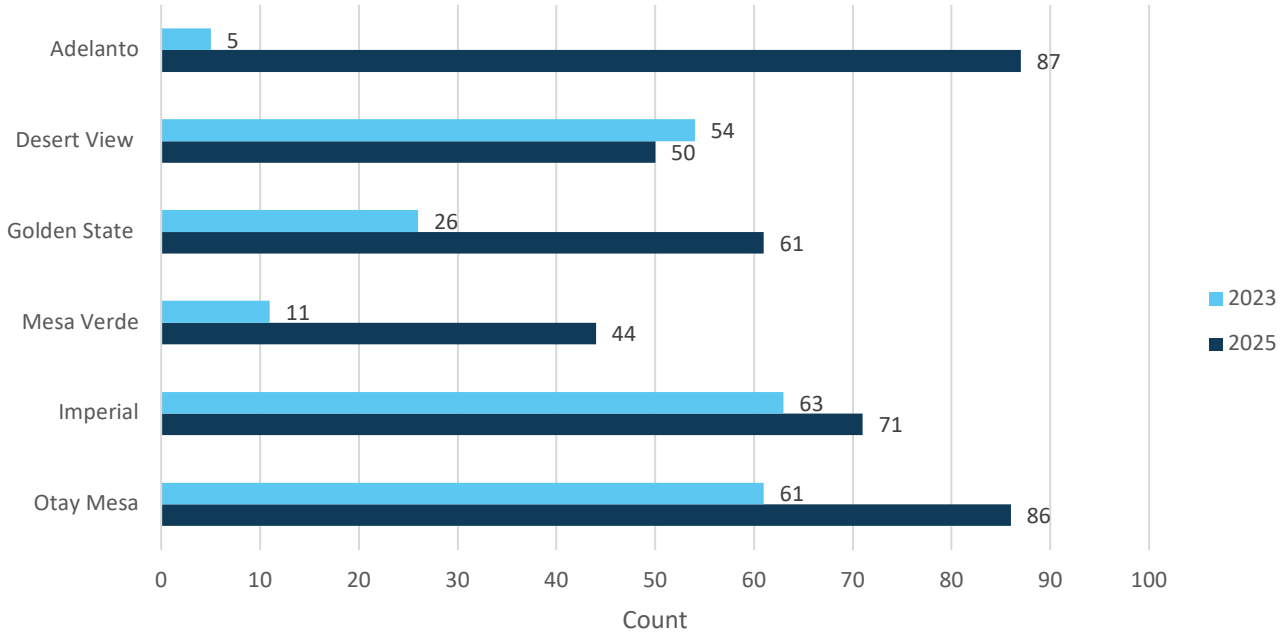
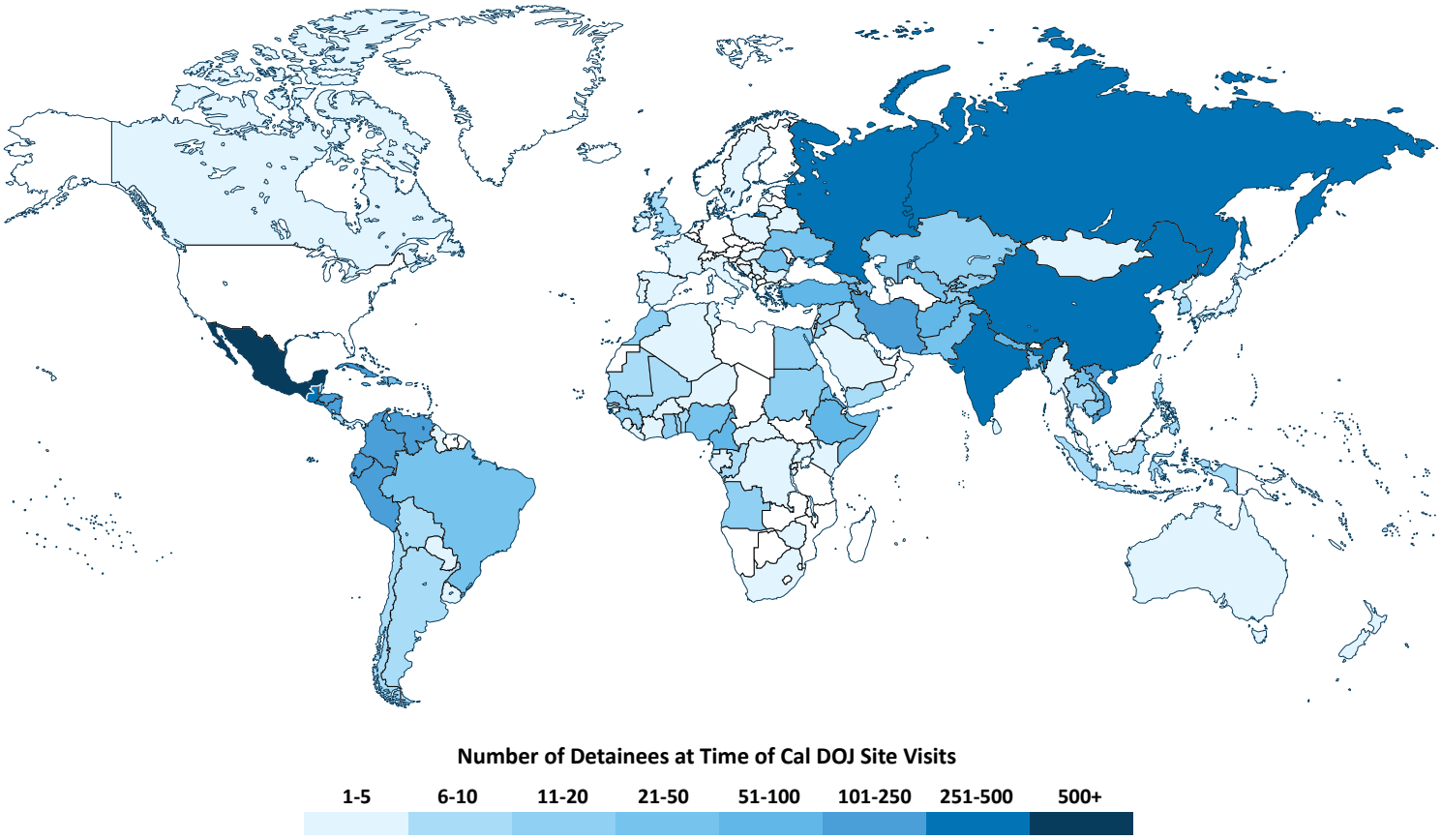


Figure 6 is a color-coded map indicating all countries of origin listed for all facilities. Countries are shaded according to number of detainees listed as having that country of origin according to the above method, with darker shades corresponding to higher numbers of detainees in the population at the time of Cal DOJ's site visits.

Figure 6. All Countries of Origin Across All Facilities (Map)



7. Adelanto ICE Processing Center & Desert View Annex

I. Introduction and Summary of Key Findings

Cal DOJ conducted a site visit of the Adelanto ICE Processing Center (Adelanto) and the Desert View Annex (Desert View) on July 8-9, 2025. This report discusses both facilities together because they share most of the same staff and essentially operate together.

The visits to these facilities followed reports of "poor" and "inhumane" conditions at the facilities as a result of a large influx of immigrants being housed there.[113] The population of Adelanto increased from 7 in 2023 to 1,570 by early July 2025 after a court gave final approval of a settlement in a lawsuit that had temporarily limited the population at Adelanto.[114] The substantive increase in the population levels at both Adelanto and Desert View also coincided with the marked increase in immigration enforcement in Southern California that led to the federalization of the California National Guard.[115] Over half of the detainees we interviewed during our site arrived at the facility in June or July of 2025.

The substantive increase in detainees at Adelanto adversely impacted the conditions at both facilities. The observations and interviews at Adelanto and Desert View paint a picture of an understaffed facility overwhelmed with detainees and unprepared to provide basic necessities. Key findings discussed in this report include:

- Adelanto, and to a lesser extent, Desert View, were overwhelmed by the rapid increase of detainees brought to the facilities in the first weeks of June and July. Between June 5-8, 2025, 621 detainees arrived at both facilities. Detainees reported unpredictable intake conditions during this time. Additionally, detainees did not consistently receive adequate clothing and blankets.

- Based on expert review and detainee reports, medical and detention staffing levels were inadequate to meet the needs of the surge of detainees housed at Adelanto and Desert View.

- All detainees were classified as "Low" or "Medium Low" at Desert View. At Adelanto, 573 detainees (about 36%) were classified at these levels.

- According to detainee interviews, the staff at Adelanto failed to consistently conduct the medical, dental, and mental health screening required at detainee intake. According to detainee interviews and review of detainee medical files, Adelanto medical staff frequently failed to conduct necessary follow up for those who did receive medical screenings.

- In interviews conducted by Cal DOJ's staff, detainees reported that they were unable to access requested medical appointments and did not receive necessary and timely medical treatment, even for emergency medical care.

113 See, e.g., Jarvie & Solis, *Moldy Food, Dirty Towels: Critics Warn of Inhumane Conditions at California's Largest Detention Center*, L.A. Times (June 20, 2025) <https://www.latimes.com/california/story/2025-06-20/unsanitary-overcrowded-and-inhumane-red-flags-raised-about-conditions-in-adelanto-detention-center> (as of Mar. 19, 2026); Juarez, *California Congress Members Concerned About 'Poor Conditions' Inside Adelanto ICE Facility*, ABC7 (June 17, 2025) <https://abc7.com/post/california-congressmembers-concerned-poor-conditions-inside-adelanto-ice-processing-center/16778053/> (as of Apr. 2, 2026).

114 See *Roman v. Wolf* (C.D.Cal. June 2, 2025, No. 5:20-cv-00768-TJH) ECF No. 2704.

115 See, e.g., Duara et al., *Gavin Newsom Asks Trump to Withdraw Troops From Los Angeles as Protests Intensify*, Cal Matters (June 8, 2025) <https://calmatters.org/justice/2025/06/national-guard-los-angeles> (as of Mar. 19, 2026); Martinez, *Photos Show National Guard with Rifles on ICE Enforcement Missions*, ABC News (June 11, 2025) <https://abcnews.com/Politics/photos-show-national-guard-rifles-ice-enforcement-missions/story?id=122729129> (as of Mar. 19, 2026).

- Detainees at Adelanto and Desert View with chronic and acute medical conditions were not consistently provided necessary referrals for follow up medical and dental care within the facility or to outside medical providers. Cal DOJ's medical expert concluded that these lapses in medical care could be expected to rise without an increase in staffing commensurate to an increase in detainees.

- There were four detainee deaths at Adelanto between September 2025 and March 2026. In all four cases, the families of the deceased allege medical care deficiencies.

- Detainees at Adelanto and Desert View reported that the facilities were serving improperly cooked food at inconvenient and inconsistent times occasionally conflicting with detainees' scheduled recreation times. Detainees also reported poor water quality and insufficient water during intake surges.

- Uses of force at times included inappropriate or concerning uses of pepper spray, including in confined areas.

II. Facility Background

Adelanto. Adelanto is a facility located in Adelanto, California in San Bernardino County, that is owned and operated by The GEO Group, Inc. (GEO Group). GEO Group purchased the facility, formerly a state prison, from the City of Adelanto in 2010 and through a subcontract started housing civil immigrant detainees in 2011.[116] In December 2019, ICE entered a new contract with GEO Group that included Desert View, which opened in 2021 and operates in a former state prison adjacent to Adelanto's East building.[117] In September 2024, ICE exercised a five-year option extending its Adelanto contract, including Desert View, with GEO Group through December 19, 2029.[118] The PBNDS apply to Adelanto and Desert View.[119]

Adelanto has an official capacity of 1,940 beds.[120] ICE pays GEO Group a guaranteed minimum of 640 beds at Adelanto.[121] Adelanto is separated into an east wing, which primarily consists of dorms, that holds both female and male detainees, and a west wing holding only male detainees in two- to eight-person cells.

116 Lindstrom, *Adelanto Seals City-Owned Prison Sale for $28 Million*, Victorville Daily Press (Mar. 30, 2010) <https://www.vvdailypress.com/story/news/2010/03/29/adelanto-seals-city-owned-prison/37089771007/> (as of Mar. 24, 2026); ICE, Office of Detention Oversight, *Adelanto ICE Processing Center Inspection* (Sept. 16-18, 2025) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/AdelantoProcessingCenterAdelantoCA-September-16-18-2025.pdf> (as of Mar. 26, 2026).

117 ICE, Detention Facility Contractor Contract with the GEO Group and Amendment (2019) <https://www.ice.gov/doclib/foia/detFacContracts/70CDCR20D00000009_org_AdelantoDetFac_AdelantoCA.pdf> (as of Mar. 26, 2026).

118 ICE, Detention Facility Contractor Contract with the GEO Group Amendment (2024) <https://www.ice.gov/doclib/foia/detFacContracts/70CDCR20D00000009_P00020-21_AdelantoDetFac_AdelantoCA.pdf> (as of Mar. 26, 2026).

119 ICE, *Adelanto ICE Processing Center Inspection* (Sept. 2025), p. 4.

120 The GEO Group, Inc., *Locations: Adelanto ICE Processing Center* <https://www.geogroup.com/facilities/adelanto-ice-processing-center/> (as of Mar. 24, 2026)

121 ICE, *Detention Management* (Mar. 23, 2026) <https://www.ice.gov/detain/detention-management> (as of Mar. 24, 2026). Cal DOJ reviewed ICE FY25 Detention Statistics (Jul. 7, 2025) to assist with this preparation of this analysis. ICE, Detention Management, Fiscal Year 2025 National Detention Statistics (Jul. 7, 2025) (as of Mar. 24, 2026) ("ICE FY25 Detention Statistics (Jul. 2025)").

Table 6. Key Data Points, Adelanto ICE Processing Center

Facility:	**Adelanto ICE Processing Center**
Operator:	GEO Group
Housing Detainees Since:	2010
Bed Capacity:	1,940
Type(s) of Detainees Facility Can Hold:	Female and Male Civil Adult Detainees

Prior to Cal DOJ's visit, the last reported full inspection of Adelanto had been conducted by the Department of Homeland Security Office of Detention Oversight (ODO) in February 2024.[122] In this inspection, ODO assessed the facility's compliance with 29 PBNDS standards, finding one deficiency: facility supervisors did not punctually sign the shift logs in 13 out of the 66 logs inspected.[123] ODO conducted a follow-up inspection in July 2024, at which time it assessed the facility's compliance with 18 PBNDS standards and found no deficiencies.[124]

In September 2025, two months after Cal DOJ's visit, ODO inspected Adelanto.[125] In this inspection, ODO assessed Adelanto's compliance with 29 PBNDS standards and found six deficiencies in three PBNDS standards: ODO found that facility staff did not always complete reclassification within 24 hours before a detainee left the Special Management Unit;[126] that the facility did not always secure detainee property bags or return detainee property on their release; and that the facility's detainee grievance appeal board did not always provide a decision within five days of an appeal, did not always note the outcome of the decision, and did not always provide the decision or supporting documentation to the facility administrator.[127] According to ODO, the "sudden influx" of detainees to Adelanto may have contributed to these deficiencies.[128]

On January 26, 2026, the Coalition for Humane Immigrant Rights (CHIRLA) and four detainees seeking to represent a class of all detainees at Adelanto filed a complaint against ICE, DHS, and officials at those agencies.[129] In the complaint, the plaintiffs described the medical care at Adelanto as "grossly inadequate and dangerous," and that detainees face "shocking levels of medical neglect" partly attributed to staffing shortages impacting the provision of medical and mental health care of the facility.[130] The plaintiffs allege that: 1) the conditions of confinement and insufficient medical care at the facility deprive detainees of their due process rights under the Fifth Amendment to the U.S. Constitution; 2) disabled detainees are not provided reasonable accommodations due to them under the federal Rehabilitation Act; and 3) ICE is not properly enforcing the PBNDS standards at the facility in violation of the Administrative Procedure Act.[131]

122 ICE, Office of Detention Oversight, *Adelanto ICE Processing Center Unannounced Compliance Inspection* (Feb. 6-8, 2024) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/adelantoIPC_AdelantoCA_Feb6-8_2024.pdf> (as of Mar. 19, 2026).
123 *Id.* at p. 8.
124 ICE, Office of Detention Oversight, *Adelanto ICE Processing Center Follow-up Compliance Inspection* (July 16-18, 2024) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/2024-AdelantoIPC-AdelantoCA-July.pdf> (as of Mar. 26, 2026).
125 ICE, *Adelanto ICE Processing Center Inspection* (Sept. 2025), *supra*, p. 4.
126 Special Management Units, as defined by the PBNDS, are units in detention facilities that segregate certain detainees from the general population, including detainees who are separated for disciplinary or administrative reasons, or detainees who have been placed in protective custody. ICE, PBNDS 2011, Part 2.12 Special Management Units, Part II, p. 171. Facility staff are required to complete a special reclassification of any detainee in the twenty-four hours before a detainee leaves the Special Management Unit. ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § H, p. 65.
127 ICE, *Adelanto ICE Processing Center Inspection* (Sept. 2025), *supra*, pp. 6-7 (the number of instances for each deficiency is redacted).
128 *Id*. at p. 7.
129 *L.T. v. ICE* (C.D.Cal. Jan. 26, 2026, No. 5:26-cv-00322) ECF No. 1.
130 *Id*. at pp. 24-25.
131 *Id*. at pp. 54-61.

At the time of this publication, four detainees who arrived at Adelanto after Cal DOJ's visit died while in the custody of GEO Group: Ismael Ayala Uribe on September 22, 2025, Gabriel Garcia Aviles on October 23, 2025, Alberto Gutierrez Reyes on February 27, 2026, and Jose Guadalupe Ramos-Solano on March 25, 2026.[132]

Desert View. ICE pays GEO Group a guaranteed minimum of 480 beds at Desert View.[133] The last reported inspection of Desert View was conducted by ODO in February 2025.[134] In this review, ODO assessed the facility's compliance with 28 PBNDS standards and found one deficiency: none of the seven holding rooms at the facility had floor drains.[135]

Table 7. Key Data Points, Desert View

Facility:	**Desert View**
Operator:	GEO Group
Housing Detainees Since:	2021
Bed Capacity:	750
Type(s) of Detainees Facility Can Hold:	Male Adult Civil Detainees

III. Methodology and Limitations

Cal DOJ staff and experts, including a medical expert and an immigration detention expert, visited Adelanto and Desert View on July 8-9, 2025. The site visit was planned in response to reports of the rapid increase in the number of detainees at Adelanto in particular and focused on the impacts of the population increase on conditions of confinement. Cal DOJ collected data and observed conditions at the facilities, interviewed detainees and facility staff, and reviewed relevant documents.

Cal DOJ and its medical expert usually interview the Medical Director, Health Services Administrator, and other health care staff to complete its review of detainee medical and mental health care. During this site visit, however, the Medical Director and the Director of Nursing were not available for interviews. Cal DOJ instead interviewed GEO Group's Regional Health Services Director and a facility physician.

Cal DOJ also interviewed individuals detained at the facilities, chosen by selecting a sampling of detainees from different housing units with a range of intake dates and countries of origin. In addition, Cal DOJ interviewed detainees who signed up to speak with Cal DOJ on notices posted in dormitories during the week preceding the site visit. In total, Cal DOJ interviewed 23 detainees at Adelanto and 15 detainees at Desert View over the course of the two-day visit. These interviews took place in a private setting with either one or two Cal DOJ team members. Cal DOJ interviewed detainees in their preferred language, either by Cal DOJ staff who were proficient in the language or through a telephone interpretation service. The languages used during the interviews included English, Hindi, Mandarin, Russian, Spanish, and Urdu.

132 ICE, *Detainee Death Reporting* (Mar. 4, 2026) <https://www.ice.gov/detain/detainee-death-reporting> (as of Apr. 14, 2026) (ICE database containing detainee death reports for any deaths occurring in ICE custody). ICE refers to detainees as "illegal aliens" in its death reports and press releases. Cal DOJ does not use this terminology to refer to detainees.
133 ICE FY25 Detention Statistics (Sept. 2025), *supra*.
134 ICE, Office of Professional Responsibility, *Desert View Modified Community Correctional Facility Inspection* (Feb. 25-27, 2025) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/DesertViewModifiedCommCorrFac_AdelantoCA_Feb25-27_2025.pdf> (as of Mar. 19, 2026).
135 *Id.* at p. 7.

IV. Detained Population

Adelanto. At the time of Cal DOJ's July 2025 visit, 195 female detainees and 1,375 male detainees were held at Adelanto; about 37% of detainees came from Mexico or Guatemala. The detainees at Adelanto represented approximately 87 different countries.[136] The top 10 countries of origin were Mexico (432 detainees), Guatemala (151), Cuba (138), El Salvador (126), Colombia (64), Honduras (58), Russia (56), China (54), Venezuela (47), and Iran (46). [137]

Table 8. Snapshot of Detainees Housed at Adelanto ICE Processing Center on July 7, 2025

No. of Countries of Origin:	**87**
No. of Female Detainees:	195
No, of Male Detainees:	1,375
Average Age:	Data Not Provided
Average Length of Detention:	39 Days
Longest Length of Detention:	1,939 Days

Settlements Impacting the Number of Detainees at Adelanto.

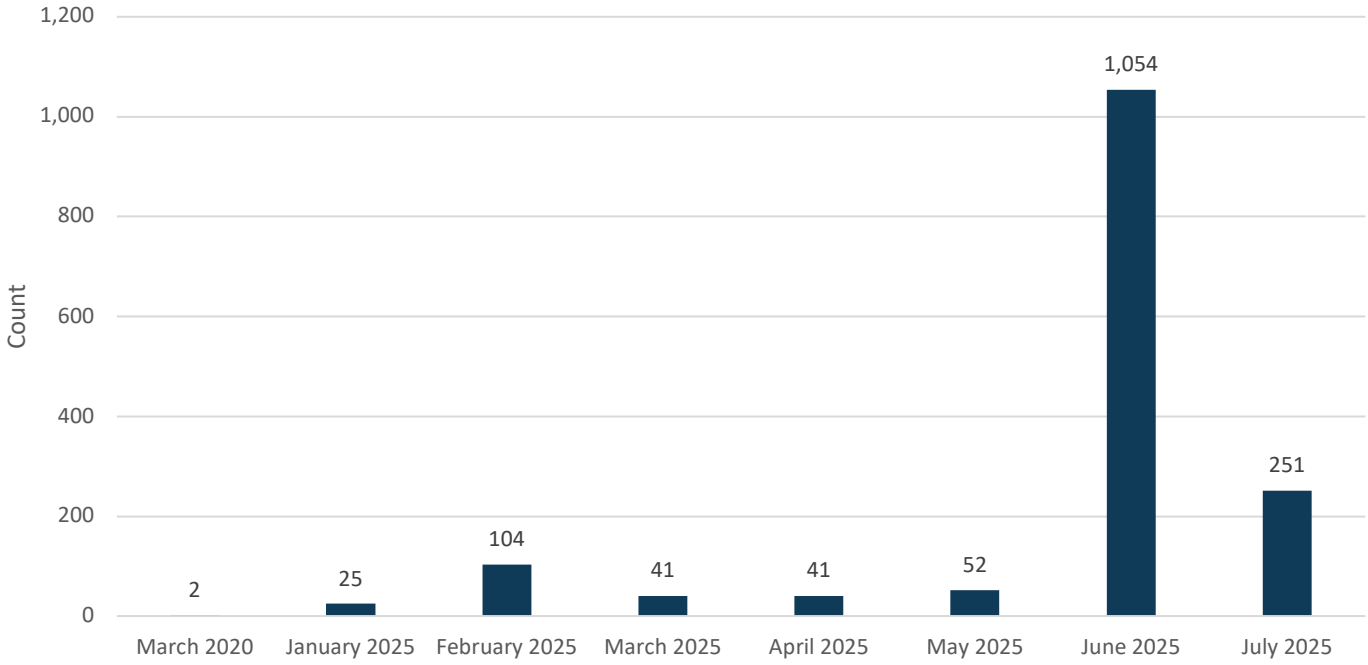
Adelanto's detainee population of 1,570 at the time of Cal DOJ's site visit represents an increase of 1,563 detainees since Cal DOJ's site visit in November 2023, when Adelanto held only seven detainees.[138] According to the roster provided to Cal DOJ by GEO Group, only two Adelanto detainees present on July 7, 2025, arrived at the facility before 2025.

Following a lawsuit over a dangerous outbreak of COVID-19 at Adelanto, in April 2020, a federal judge ordered the release of some detainees, a suspension of new intakes, and a reduction of Adelanto's detainee population.[139] As a result of the court's order, Adelanto held only seven detainees when Cal DOJ visited Adelanto in November 2023.[140] The parties reached a settlement agreement in late 2024. Following preliminary approval of the settlement, the court ordered a temporary lift of the ban on new intakes on January 24, 2025, allowing Adelanto to house up to 475 detainees.[141] The final approval of the settlement agreement was granted on June 2, 2025, allowing Adelanto to once again house up to 1,950 detainees.[142]

ICE increased its immigration enforcement efforts in Los Angeles shortly after the settlement removed the cap on detainees in June 2025. As a result of this surge in enforcement efforts and transfers from other facilities, the population in Adelanto at the time of Cal DOJ's visit on July 8 and 9 was approximately 1,570. **Figure 7** shows the distribution of arrivals by month and year for detainees held at Adelanto as of July 7, 2025. Forty-seven detainees arrived on January 31 and February 1, many of whom were moved over from Desert View. These were among the first new detainees at Adelanto.

136 GEO Group produced to Cal DOJ a roster of detainees dated July 7, 2025.
137 Seventy-five detainees (4.8%) on the Adelanto roster provided by GEO Group did not have a country of citizenship listed.
138 Cal Dept. of Justice, Office of the Attorney General, *Immigration Detention in California* (Apr. 2025) <https://oag.ca.gov/system/files/media/immigration-detention-2025.pdf?> p. 26 (as of Apr. 1, 2026).
139 *Roman v. Wolf* (C.D.Cal. Apr. 23, 2020, No. 5:20-cv-00768-TJH) ECF No. 55.
140 *Immigration Detention in California* (Apr. 2025), *supra*, p. 26.
141 *Roman v. Wolf* (C.D.Cal. Dec. 23, 2024, No. 5:20-cv-00768-TJH) ECF No. 2636 (settlement agreement and release); see *Roman v. Wolf* (C.D.Cal. Jan. 24, 2025, No. 5:20-cv-00768-TJH) ECF No. 2670 (temporarily lifting ban on new detainee intakes at Adelanto, pending final approval of the settlement agreement); see also Castillo, *Once on the Brink of Closure, Adelanto Facility Will Resume Detaining Immigrants*, L.A. Times (Jan. 29, 2025) <https://www.latimes.com/california/story/2025-01-29/adelanto-immigration-facility-to-resume-housing-migrants> (as of Mar. 19, 2026).
142 *Roman v. Wolf* (C.D.Cal. June 2, 2025, No. 5:20-cv-00768-TJH) ECF No. 2704.

Figure 7. Arrival Month of Detainees on July 7, 2025 Roster at Adelanto



As shown in **Table 9**, a review of arrival dates of those held at the facility as of July 7, 2025, indicates that Adelanto experienced a surge of daily intakes starting on June 4, 2025, following the increase of enforcement efforts in Los Angeles in June.

Table 9. Arrival Dates of Detainees at Adelanto present on July 7, 2025: June 1-10, 2025

Date	Number of Arrivals
June 1, 2025	3
June 2, 2025	0
June 3, 2025	2
June 4, 2025	76
June 5, 2025	33
June 6, 2025	157
June 7, 2025	59
June 8, 2025	109
June 9, 2025	105
June 10, 2025	69

These numbers are not a complete account of the numbers of detainees arriving at the facility in 2025; they only reflect the population as of July 7, 2025, and not all detainees entering and exiting the facility between January and July 7, 2025.

Desert View. Desert View had 517 detainees at the time of Cal DOJ's visit, a population increase of 100 detainees compared to Cal DOJ's site visit in November 2023, when Desert view held 417 detainees.[143] The detainees at Desert View at the time of Cal DOJ's visit represented about 50 different

143 *Immigration Detention in California* (Apr. 2025), *supra*, p. 27.

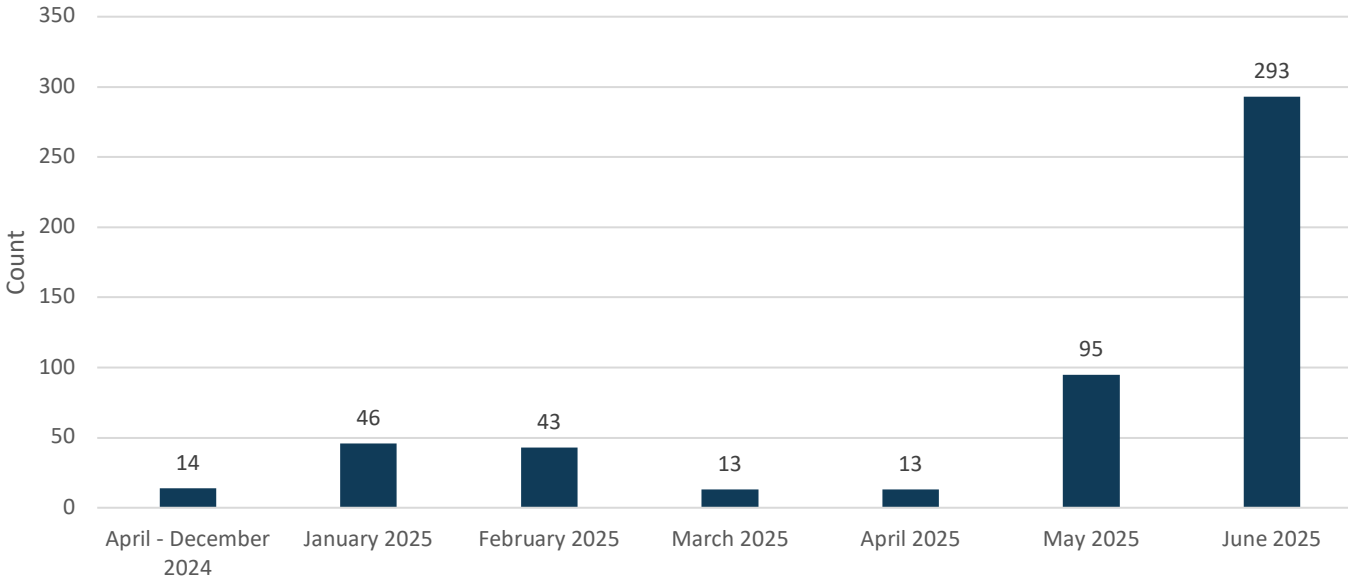
countries; around 30% of detainees were from Mexico and Guatemala.[144] The top 10 countries of origin were Mexico (88 detainees), Guatemala (65), China (41), India (38), Nicaragua (25), El Salvador (24), Venezuela (21), Colombia (19), Cuba (19), and Nepal (17).

Table 10. Snapshot of Detainees Housed at Desert View Annex on July 8, 2025

No. of Countries of Origin[145]:	**50**
No. of Female Detainees:	0
No. of Male Detainees:	517
Average Age:	Data Not Provided
Average Length of Detention:	64 Days
Longest Length of Detention	437 Days

According to facility staff, all detainees classified as high were moved from Desert View to Adelanto when Adelanto's population cap was lifted.[146] **Figure 8** provides a breakdown of when the 517 detainees held at Desert View at the time of Cal DOJ's site visit arrived at the facility.

Figure 8. Arrival Month of Detainees on July 7, 2025 Roster at Desert View



263 of the 517 detainees at Desert View on July 7, 2025, arrived at the facility over the course of four days in June 2025: June 5 to June 8. As for all facilities discussed in this report, these numbers only reflect the detainees who were at the facility as of Cal DOJ's July 7, 2025 site visit, and not all persons detained at Desert View from April 2024 to July 7, 2025 and who may have been released, transferred, or deported prior to Cal DOJ's site visit.

V. Conditions of Confinement

Conditions of confinement consist of various factors, policies, and protocols that affect the experiences of detainees, including the provision of health care and mental health. The conditions reviewed below include 1) intake and orientation process; 2) food, nutrition, and access to water; 3) housing units; 4)

144 Nine detainees on the Desert View roster provided by GEO did not have a country of citizenship listed.
145 This figure is from GEO Group's roster of detainees provided to Cal DOJ on July 7, 2025. Nine detainees did not have a country of origin listed.
146 *Roman v. Wolf* (C.D.Cal. Jan. 24, 2025, No. 5:20-cv-00768-TJH) ECF No. 2670.

detention and safety; and 5) access to social and programming opportunities. Cal DOJ found several deficiencies, including an unpredictable intake process where detainees reported waiting days or even weeks before assignment to a housing unit, improperly cooked food, and uses of force that at times included inappropriate or concerning uses of pepper spray, including in confined areas.

A. Intake and Orientation

1. Intake Process

The influx of detainees at Adelanto and Desert View in early June 2025 appears to have created a chaotic environment in which the facility failed to comply with PBNDS standards relating to intake. Detainees reported waiting days and even weeks before receiving a classification and housing assignment, and in many cases, not receiving a medical screening at all.

Generally, a detainee's first point of contact with the facility is in the intake area. For all new arrivals at Adelanto and Desert View, intake for male detainees is at Adelanto West; those being housed at Desert View are moved there after the intake process. Female detainees are processed through the intake area at Adelanto East. Each wing of Adelanto has around eight holding rooms in the intake area, each of which held one to 10 detainees at the time of Cal DOJ's tour during the visit, and two examination rooms for health examinations. Each holding room contains a flat surface for sitting or sleeping, and one toilet. Cal DOJ did not observe showers in any of the holding rooms or in the intake area. A third-party contractor handles fingerprinting, issuance of A numbers, and interviews for asylum-seekers. Desert View has a similar intake area, with five holding rooms.

PBNDS 2.1 requires detention facilities to implement an orderly process for the intake and reception of newly arrived detainees. This process, which includes recording a detainee's basic personal information, a criminal history check, and a medical, dental, and mental health screening, should take no longer than 12 hours.[147] Thus, within 12 hours of arriving at the facility and before placement in a housing unit, detainees must receive an initial medical, dental, and mental health screening, be assigned a security classification, receive clothing and personal hygiene items, and be assigned to a housing unit.[148] During this time, detainees still in the intake process are to be kept separated from the detainee population that has already been assigned a permanent housing unit. ICE's stated reason for the initial separation is to protect the "safety, security and good order of the facility."[149] Depending on when they arrived at Adelanto, detainees reported waiting in the intake area from several hours to several days before being assigned to a housing unit. Two detainees reported staying in the intake area for two nights, and one detainee for four days. Five interviewed detainees reported staying in the intake area overnight.

Three detainees who arrived at the beginning of June reported being required to sleep on the floor of a dining room for several days, without receiving a medical screening or receiving a housing unit assignment through the classification process and after spending the night shackled in a van. Other detainees reported that they were not provided blankets or pillows and had to use trash bags as blankets. These detainees further detailed how they were temporarily transferred to a housing unit, where they stayed for up to two weeks, and then taken back to the intake area for the formal intake process.

147 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part II, pp. 49-50, Part V, § A, pp. 49-51.
148 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ A-B, pp. 50-51; Part 2.2 Custody Classification System, Part V, § D, p. 63; Part 4.3 Medical Care, Part V, § J, p. 266.
149 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § A, p. 50.

Figure 9. Dining Hall Used for Uniform Sorting at Adelanto

One detainee reported that, while detainees were awaiting the intake process in a dining area with no blankets or pillows, a detention officer pepper sprayed the detainees, filling a room which contained about 50 detainees. This detainee reported that the detainees were then moved to a housing unit, but still reported eye and skin irritation for days after the incident. While this incident is concerning on its own, it is especially noteworthy because GEO Group has been sued in the past for pepper spraying detainees as a control measure in enclosed areas at Adelanto.[150] Although Cal DOJ could not definitively confirm that this incident occurred in the manner described by the detainee, a use of force incident report prepared by facility staff at around the same time the detainee stated the incident occurred specified that facility staff deployed pepper spray to subdue multiple detainees in the dining room. This report blamed the incident on a detainee striking a detention officer in a struggle over food.

At Desert View, four detainees who arrived in June reported waiting in the intake area from six to 12 hours, with multiple detainees stating that they waited a full day before being processed.

2. Orientation

PBNDS 2.1 requires that all detention facilities provide an orientation and handbook to each detainee.[151] Adelanto and Desert View facility staff stated that they provide know-your-rights materials and handbooks in English or Spanish to detainees. PBNDS 2.1 requires a facility to provide a translator or access to interpreter services if a detainee does not understand English or Spanish.[152] Cal DOJ requested a list of languages in which the handbooks are provided at Adelanto and Desert View; GEO Group provided English and Spanish handbooks only, consistent with detainee and staff reports. Cal DOJ did observe some handouts posted in languages other than Spanish and English but did not see evidence of in-depth materials being offered in additional languages.

150 *Rivera Martinez v. GEO Group* (C.D.Cal. May 25, 2018, No. 5:18-cv-01125) ECF No. 1 (Complaint). The suit, filed by eight Adelanto detainees, was settled in January 2020. *Rivera Martinez v. GEO Group* (C.D.Cal. Jan. 30, 2020, No. 5:18-cv-01125) ECF No. 205 (Notice of Conditional Settlement); see Plevin, *Asylum-Seekers Allegedly Pepper-Sprayed at Adelanto Detention Center Settle with GEO Group*, Palm Springs Desert Sun (Feb. 6, 2020) <https://www.desertsun.com/story/news/2020/02/06/asylum-seekers-allegedly-pepper-sprayed-adelanto-detention-center-settle-geo-group/4680659002> (as of Mar. 16, 2026).

151 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ F-G, pp. 55-57.

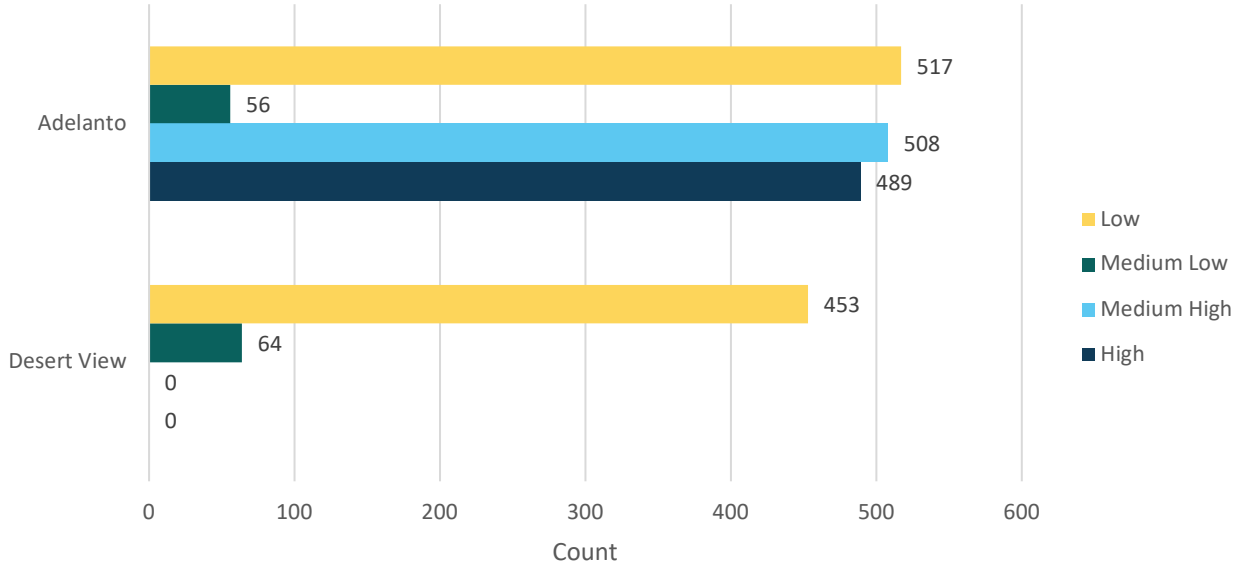
152 Id. at pp. 55-56.

3. Security Classification System

Detention facilities are required to implement a formal classification process for "managing and separating detainees based on verifiable and documented data."[153] When detainees are assigned to Adelanto or Desert View, they are given a security classification level: High, Medium-High, Medium-Low, and Low. These classification levels are assigned by the facility based on a detainee's documented current or past criminal offenses, institutional disciplinary history, medical information, and other objective credible evidence, and should not be based on the personal opinion of classification staff.[154] The security classification level determines, among other things, a detainee's housing assignment. The classification system is intended to protect detainees from harm by assigning detainees to housing with persons of similar backgrounds and criminal histories.[155]

Figure 10 displays the distribution of active detainee security classification levels at Adelanto and Desert View.

Figure 10. Adelanto and Desert View Detainees by Security Classification as of July 7, 2025



In its 2021 and 2025 reports, Cal DOJ identified concerns with GEO Group's classification systems. The systems for custody level assignment and housing placement of detainees designated as gang-affiliated were opaque and assignments did not always match the information received from GEO Group.[156]

During the July 2025 site visit, Cal DOJ was not able to conduct an in-depth review of the facilities' security classification processes. As part of the site visit, Cal DOJ requested a review of a sampling of detainee custody files, which includes classification and intake records. Several of the files presented to Cal DOJ by GEO Group were incomplete, and missing classification records and intake forms. As a result, Cal DOJ was unable to complete its review of the custody classification systems based on detainee files. Additionally, during the period when Cal DOJ was scheduled to review detention files, facility staff were printing intake records and appeared to be assembling files, suggesting the records were not already maintained. Cal DOJ is concerned that the poor maintenance of detainee records could lead to misclassification, among other problems.

153 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part I, p. 60.
154 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, §§ C-D, pp. 62-63.
155 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part II, p. 60, Part V, §§ D-G, pp. 63-65.
156 *Immigration Detention in California* (Apr. 2025), *supra*, pp. 45-46; Cal Dept. of Justice, Office of the Attorney General, *Immigration Detention in California* (Jan. 2021) <https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2021.pdf> pp. 22-23 (as of Apr. 1, 2026).

In interviews, two detainees expressed concern with their custody level assignments. One detainee reported being assigned a Low-Level security threat classification at a previous detention facility but being re-classified as Medium-High upon arrival at Adelanto; the detainee was not given an explanation for why they had been reassigned to a higher custody level. This detainee expressed concern that his appearance in a bond hearing could be prejudiced by the orange uniform he is required to wear as a result of his higher custody level.

4. Initial Medical Care (Intake Screening and Comprehensive Health Assessment)

PBNDS 4.3 requires that detention facility health care staff conduct an initial medical, dental, and mental health screening of new detainees as soon as possible, but no later than 12 hours after a detainee's arrival to the facility.

At Adelanto, only four detainees who were asked about this screening (17%) reported they received all the required components within 12 hours. In contrast to detainees at Adelanto, most detainees at Desert View who were asked this question reported that they received the screening (13; 87%). Many detainees reported that they did not receive a dental screening. An Adelanto detainee who received a medical screening reported only receiving it after spending 24 hours in the intake area. Another detainee reported that they did not receive a medical screening until a week after they arrived.

5. Departures

In interviews with Cal DOJ, facility staff estimated that they were processing an average of 40 detainees per day while releasing about 15-20 detainees per week from the facilities. At the time of Cal DOJ's tour of the facilities, Cal DOJ personnel observed over 20 detainees in intake holding rooms in Adelanto West. In Adelanto East, eight female detainees were waiting to be processed into and five female detainees waiting to be processed out of both Adelanto and Desert View. Twelve male detainees were waiting to be processed out of Desert View.

B. Food, Nutrition, Access to Water

Meals

PBNDS 4.1 requires that three meals are served to every detainee per day, and that no more than 14 hours elapse between dinner and breakfast.[157] Facility staff reported that breakfast is served starting at 5:00 a.m., lunch is served starting at 11:00 a.m., and dinner is served starting at 4:30 p.m. Every detainee reported receiving three meals per day, but nearly everyone commented that food is delivered to the housing units at irregular hours. According to the detainees, breakfast can arrive between 5:00 a.m. and 9:00 a.m., lunch between 11:00 a.m. and 3:00 p.m., and dinner between 7:00 p.m. and 10:00 p.m.

Detainees reported disruptions to meal service practices impacting both meals and other access to health-promoting activities. Facility staff reported that prior to the influx of detainees at Adelanto in early June 2025, meals were served at the dining areas of both facilities but were delivered from the kitchen and served in the housing areas at both facilities after the influx occurred. Additionally, detainees reported that the irregular mealtimes at both facilities sometimes conflicted with the limited recreation time detainees are offered. Meals were sometimes delivered when a housing unit was called for recreation in the recreation yard. One detainee reported that meals have arrived late at night after bedtime and during population counts, when all detainees must be in their cells or by their beds. In those situations, the detainee reported being instructed to take their meals and eat in bed.

157 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232.

Almost every detainee interviewed at both facilities complained about the quality of the food. According to detainee reports, meat often appears undercooked or rotten. One detainee reported that they are not consistently provided silverware and have to keep using the same spoon for days at a time. Meals are reportedly cold by the time they are delivered to the housing unit, and four detainees had multiple complaints about the blandness and quality of the food. One detainee at Desert View reported that food quality declined, meal portions shrank, and meals were delivered at more inconsistent times relative to before the influx of detainees to the facility. Detainees also reported that they were unable to acquire salt or other seasonings from the kitchen or commissary.

During staff interviews, the facility reported that 20-24 staff members are split between the kitchens of each facility, with no detainees working in the kitchen at Adelanto and one detainee working in the Desert View kitchen, washing dishes and cleaning.

During the facility tour, Cal DOJ's medical expert observed that all dietary modifications (i.e., religious diets, medical diets, and food allergy diets) were posted in the kitchen, showing all dietary modifications by unit. Food allergy diets were displayed with other diet options. Cal DOJ's medical expert recommends that the facility separate out food allergy diet modifications to highlight the allergy diets and increase food service safety for those detainees who are allergic to certain foods.

Figure 11. Kitchen at Adelanto

Water

PBNDS 4.1 requires that clean, potable drinking water is available to detainees at all times.[158] However, detainees reported problems with both water quality and availability.

Detainees at both facilities reported that the water from the tap is murky, dirty, and white. Cal DOJ staff observed murky water in the tap of the female housing unit at Adelanto. Detainees in the female unit also approached Cal DOJ staff during the tour to advise that they did not have adequate drinking water.

158 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232.

Each housing unit (housing around 80 detainees when at full capacity) is provided with two water coolers. Detainees interviewed by Cal DOJ stated that the water coolers were not re-filled frequently enough to meet demand, and one reported being told that there is not enough staff at the facility to ensure that the water coolers are refilled. Several detainees reported that at times the water coolers were not filled for periods of five to twelve hours, or even until the next day. One detainee at Adelanto reported that the water coolers were refilled at a sufficient rate prior to the surge but were not being refilled more frequently to account for the increase in detainees per housing unit. Another detainee described that detainees have found ways to protest in support of receiving more water, primarily by refusing to join the detainee counts until water is refilled. Another described being unable to take medications at times due to lack of adequate water supply.

The facility reported that the water coolers are provided at facility discretion during the summer months and replenished once during each of the three staffing shifts and took the position that the tap water is sufficient for detainees.

C. Housing Units

Adelanto has two wings—east and west. Each wing is divided into housing units, and each housing unit is divided into four parts. The east wing consists of dorms and is divided into two housing units. At the time of Cal DOJ's visit, female detainees were housed in one housing unit in the east wing. All female detainees with Medium-High and High security classification levels (and one detainee with a Medium-Low classification level) were assigned to one section of the unit; the female detainees designated with Low and Medium-Low classification levels were assigned to two other sections of the housing unit. All the detainees in the east wing male housing unit were assigned to two sections of the housing unit and had security classifications of Low or Medium-Low. The west wing of Adelanto consists of two- to eight- person cells and is divided into five housing units. Four of the housing units held male detainees with a security classification of Medium-High or High. Three sections of the fifth housing unit held male detainees with a security classification of Low or Medium-Low, with the fourth section housing male detainees with a security classification of High or Medium-High.

Desert View is divided into two dorm housing units, and, at the time of Cal DOJ's visit, only held male detainees with low and medium-low security classifications.

1. General Condition of Facility and Housing Units

PBNDS provides that facility staff must ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness, which includes daily dusting, mopping and trash disposal,[159] but detainees are only required to maintain their immediate living areas by making the bed, stacking loose papers and keeping the floor around their spaces neat.[160] Cal DOJ's site visit occurred several weeks after Cal DOJ had initially requested access. Detainees reported that housing unit conditions were worse before Cal DOJ visited. For example, three detainees interviewed, one in each wing of Adelanto and one from Desert View, described extremely dirty facility conditions such as bags of trash piling in the hallways, dirty surfaces in the housing units, and bathrooms and hallways and tables covered in debris and dirt. One of these three, along with two other detainees reported never seeing the hallways and housing units cleaned until the days prior to Cal DOJ's visit or visits by other reviewing entities such as GEO Group management. At least one detainee complained of strong fumes from the products used for cleaning the showers, which are cleaned by the detainees.[161]

159 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety, Part V, § A, p. 21.
160 ICE, PBNDS 2011, Part 5.8 Voluntary Work Program, Part V, § C, p. 406.
161 GEO Group was sued in 2023 by a class of detainees alleging harm caused by toxic chemicals in a disinfectant, HDQ Neutral. And, in 2021, the U.S. Environmental Protection Agency issued a Notice of Warning to GEO Group over the use of HDQ Neutral at Adelanto and later filed an administrative complaint in June 2024 over the continued use of that disinfectant. *In the Matter of The GEO Group, Inc.* (2024) U.S. E.P.A. Region IX, No. FIFRA-09-2024-0066. The EPA complaint was withdrawn in June 2025. See Lerner & Song, *EPA Drops Legal Case Against the GEO Group, a Major*

One detainee at Adelanto stated that the lights-out and lights-on times are inconsistent, describing patterns that would make it difficult to maintain a normal sleep schedule. They reported that detention officers turn the lights on at unpredictable times that can be as late as 10 a.m. and turning off the lights at times as late as 1 a.m. One Desert View detainee reported that the last count of the night is generally around 1 a.m. and detainees are woken up at 5 a.m. in their housing unit.

2. Access to Basic Needs

Detention facilities have an obligation to provide basic necessities to the detainees they hold. PBNDS 4.5 requires a facility to issue at least two sets of uniforms, including two pairs of socks, two pairs of underwear, and one pair of shoes.[162] When shoes are worn out or damaged, they must be replaced at no cost to the detainee.[163] Detainees are also entitled to a daily change of socks and underwear and an exchange of uniforms at least twice per week (with a maximum of 72 hours between changes).[164]

According to 12 detainee accounts, neither facility met the clothing requirements set by the PBNDS. Detainees reported that prior to the first week of June, they received at least two uniforms, including three pairs of underwear, shower sandals, a pair of shoes, sheets, a pillow, and a blanket. Two detainees who arrived in May and June 2025 reported that they received only one pair of underwear and one uniform. Facility staff stated that when there are shortages in clothing issued during intake, more uniforms are issued after detainees were placed in their housing units.

One detainee reported that they were held in the intake area for four days and did not receive any clothes, blankets, or pillows during their time in intake. Another detainee, who was sent directly to a housing unit without going through the classification and intake process, reported not receiving any pillows, blankets, uniform, clothes, or soap. As a result, they wore the same clothes they had on when they were apprehended for two weeks. After two weeks, they were processed at intake, where they received one new set of clothes.

Other detainees stated that they did not receive new or laundered clothes for weeks and had to make do with the one set of clothes that they were provided, which at times did not fit them. One detainee at Adelanto described having to resort to handwashing their own clothes and underwear due to the lack of clean clothes. Other detainees told Cal DOJ that the shoes they initially received had fallen apart and had not been replaced by the facility, such that they appeared for the interview in their one pair of sandals or in borrowed shoes.

D. Detention and Safety

1. Staffing

The PBNDS require staffing levels at each facility that ensure sufficient supervision for those detained.[165]

In preparation for the site visit, Cal DOJ submitted a request to GEO Group for relevant records and documents from the facilities. At that time Cal DOJ requested staffing information including the facility organization chart for both detention and health care staff, the current detention and health care staff roster, and information about scheduling and vacancies. GEO Group produced most of the requested documents but did not produce information on staffing levels, claiming that the information is proprietary and confidential information that implicates security and operational concerns.

Trump Donor, Over Its Misuse of Harmful Disinfectant in an ICE Facility, ProPublica (June 10, 2025) <https://www.propublica.org/article/epa-legal-complaint-geo-group-trump> (as of Mar. 19, 2026).

162 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part V, § B, p. 328.

163 Ibid.

164 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part V, § H, p. 330.

165 ICE, PBNDS 2011, Part 2.4 Facility Security and Control, Part V, § A, p. 82; Part 2.11 Abuse and Assault Prevention and Intervention, Part IV, § E, p. 151.

During an interview at the facility on July 8, 2025, the Facility Administrator told Cal DOJ he would provide the numbers of full-time staff and vacancies. On July 24, 2025, Cal DOJ reiterated the request for the facility organization chart and current staff roster including vacancies. To date, GEO Group has not produced requested documents related to staffing. In its inspection in September 2025, two months after Cal DOJ's visit, the ODO reported that the facility employed 439 "support personnel," a term not defined in the ODO report.[166] Staffing levels at these facilities are of particular concern, as the total number of detainees in the two facilities dramatically increased over the course of just a few months, and the facilities generally share health care and administrative staff.

Information from interviews indicates staffing shortages at the time of the site visit. Facility staff stated that the facility was short-staffed because of the increase in detainees and that detention staff at the facilities were required to work overtime. They also said that GEO Group had to bring in temporary staff, around 40 staff members, from other facilities and from GEO Group corporate headquarters to temporarily fill the vacancies.

Detainees reported that the level of detention staff appeared inadequate for the population level at the facility and described dynamics between detention officers and detainees that made daily life tasks difficult. Several detainees expressed concern that the facilities did not hire more detention officers after the detainee population increased. One detainee reported having been mocked by detention officers for not speaking English.

Detainees at both facilities frequently attributed the issues with food, recreation time, and grievances to insufficient staff at the facilities. One detainee reported that they did not see an increase in detention officers in conjunction with the increase of detainees in the first week of June 2025. These reports are consistent with facility staff's reports that each housing unit has one officer per shift; staff did not report changing this practice based on the number of beds or custody level of detainees housed in the housing unit.

2. Use of Force

Upon request, GEO Group provided logs of instances of force used by its staff on detainees. From January 1 through July 7, 2025, GEO Group logged 11 uses of force at Adelanto (nine involved one detainee, one involved two detainees, and one involved six detainees) and five uses of force at Desert View (all involving one detainee). Eight of the 11 incidents at Adelanto occurred in the month of June, after the increase in detainees. Of the 11 incidents at Adelanto, facility staff used pepper spray in six of them, and in two of the five incidents at Desert View.

Cal DOJ's immigration detention expert reviewed multiple use of force incidents at Adelanto. Two of these incidents involved detainees who appeared to be experiencing mental health episodes. In one incident, detention officers used calculated force[167] to remove a detainee from the facility and transport him to an outside mental health facility. Detention officers used pepper spray on the detainee and did not report that they summoned or consulted mental health staff before or during the incident. PBNDS 2.15 mandates that detention officers consult with appropriate medical or mental health staff prior to a calculated use of force on a detainee with special needs, including detainees with mental health conditions, that may impair their ability to understand their situation.[168] In another incident, a detainee consumed a handful of unidentified pills and ignored officers' commands to stop. Detention officers used pepper spray on this detainee, placed them in mechanical restraints, and transferred them to the medical unit. PBNDS 4.3 mandates that restraints for medical or mental health purposes may be authorized only by the facility's designated Clinical Medical Authority or initiated by qualified medical

166 ICE, *Adelanto ICE Processing Center Inspection* (Sept. 2025), *supra*, p. 3.
167 In calculated uses of force, facility personnel have some advance warning and are able to make preparations and obtain needed authorizations. See ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, §§ A, B, I, pp. 201-202, 206-207.
168 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, § F, p. 205.

personnel with an authorization soon after the restraint.[169] The report for this incident did not indicate that mental health or medical personnel were consulted or utilized in the restraint of the detainee.

E. Access to Social and Programming Opportunities

1. Non-legal Visitation and Phone Calls

Access to communication with family members, recreation, and programming opportunities has a significant effect on a detainee's experience at detention facilities. PBNDS requires facilities to provide "reasonable and equitable access" to telephones, with certain restrictions, including "orderly facility operations" to prevent interference with counts and scheduled detainee movements.[170]

Detainees at Adelanto reported difficulties communicating with their loved ones. Cal DOJ observed about eight phones per housing unit for detainee use. Two detainees reported that phone calls are limited to only a few minutes, mainly because several phones in each housing unit do not work and the volume of detainees in each housing unit who need to use the phones limits the time each person can talk. Detainee reports also indicated that phones are disconnected at random times of the day. One detainee reported being told by facility staff that the phones are disconnected when a detainee is being transferred out of the facility. In one instance, a detainee reported that in one housing unit, phones were turned off one afternoon and not turned back on until the following morning. During Cal DOJ's tour of Adelanto, several detainees reported that the phones in their housing unit do not work all morning until around noon from Monday through Thursday, and all day on Fridays; these detainees had been at the facility for two months. During Cal DOJ's tour, detainees noted to Cal DOJ that all of the phones in one housing unit were disconnected at the time; Cal DOJ staff picked up several phones in this unit and confirmed that they were not working. Detainees reported similar difficulties when making personal calls.

Facility staff confirmed that phones are turned off throughout the facility when detainees are departing the facility. One staff member confirmed that the ratio of phones to detainee beds has been the same since 2019.

A limited number of tablets are available for detainees to make monitored video calls, to submit medical requests, or grievances and to access programming, if available. However, detainees told Cal DOJ that only a few tablets worked in housing units of 80 detainees and that detention officers frequently fail to keep the tablets charged.

2. Programming and recreation

PBNDS 5.4 requires that, if outdoor recreation is available at the facility, each detainee has access for at least one hour a day, seven days a week, at a reasonable time of day. It also requires that recreation schedules be provided to detainees. At both Adelanto and Desert View, detainees reported that recreation time was inconsistent. Three detainees reported that recreation was not available every day at Adelanto, one of whom reported receiving only a half-hour of recreation in a day. However, Cal DOJ observed that male detainees in at least one Adelanto housing unit had consistent access to a small outdoor space.

169 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § Y, p. 275.
170 ICE, PBNDS 2011, Part 5.6 Telephone Access, Part V, § D, p. 387.

Figure 12. Caged in Basketball Area at Adelanto

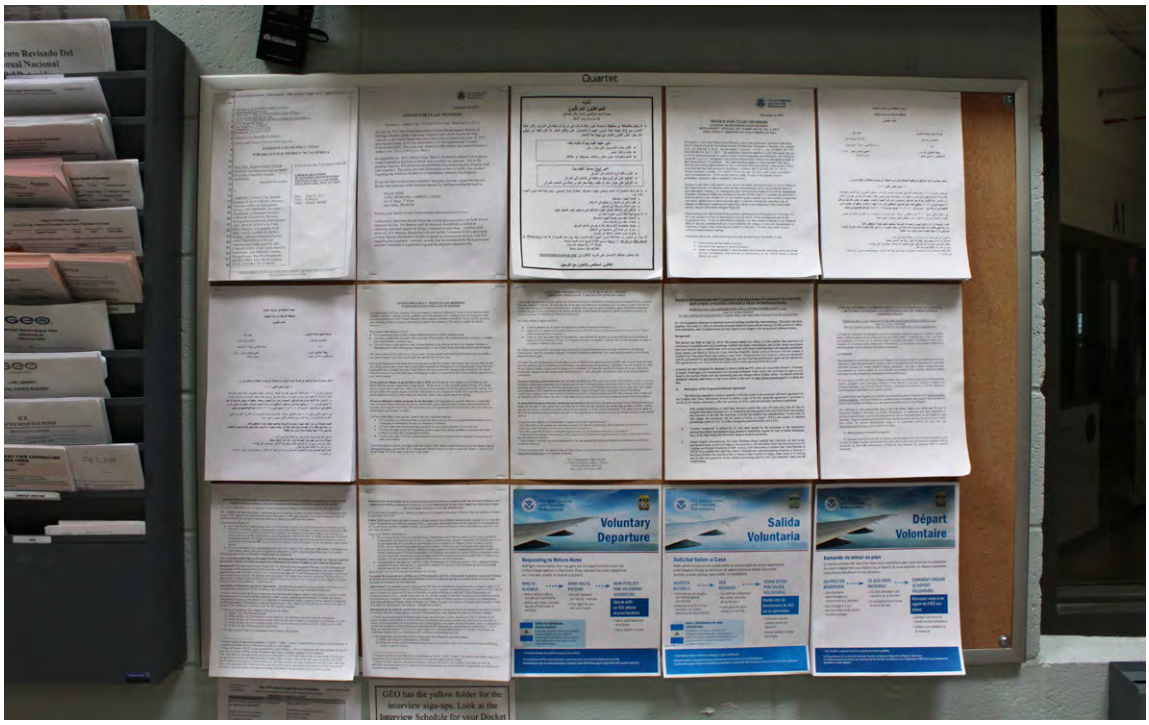
VI. Due Process

Cal DOJ evaluated due process rights of detainees held at Adelanto and Desert View. PBNDS 6.3 requires that facilities give detainees access to legal materials, legal calls, and mail, provide the ability to access legal services and representation, and facilitate a detainee's attendance in court.[171] Each facility had a library with legal material, but Cal DOJ was unable to confirm the content of the material during its tour. Various legal settlements were posted to corkboards in the housing units. Cal DOJ, however, did not identify any posting of the terms of the *Franco-Gonzalez* settlement agreement in a public area of the facility accessible by detainees, as required by the terms of the agreement.[172]

171 ICE, PBNDS 2011, Part 6.3 Law Libraries and Legal Material, Part V, §§ A-N, pp. 422-428.

172 The permanent injunction under *Franco-Gonzalez v. Holder* provides that detainees diagnosed with certain mental health disorders be appointed an attorney, among other processes, and that facilities post information notifying detainees of the settlement. *Franco-Gonzalez v. Holder* (C.D.Cal. Apr. 23, 2013, No. CV-10-02211-DMG (DTBx)) 2013 WL 8115423; *Franco-Gonzalez v. Holder* (C.D.Cal. Oct. 29, 2014, No. CV-10-02211-DMG (DTBx)) 2014 WL 5475097.

Figure 13. Notice Board at Adelanto



In 2020, a district court in the class action lawsuit *Torres v. U.S. Department of Homeland Security* entered a preliminary injunction allowing Adelanto detainees and attorneys to request, among other things: 1) that detainee calls to counsel phone numbers allow detainees to leave voice mail messages; 2) that calls between counsel and detainees are confidential and not monitored; and 3) that counsel's phone numbers be set to unmonitored, unrecorded, and free status from housing unit phones.[173] The parties reached a settlement in August 2025, after Cal DOJ's most recent visit, and dismissed the case in October 2025, dissolving the preliminary injunction.[174] The settlement institutes a process by which free confidential legal calls can be arranged, including outside regular telephone hours, and Adelanto detainees are allowed to make unrecorded and unmonitored phone calls from their housing units.[175]

Around half of the detainees interviewed at Adelanto (14; 61%) and Desert View (6; 40%) had an attorney at the time of their interview. Thirteen of the represented detainees interviewed at Adelanto reported they had been able to contact their attorneys. However, three detainees described having difficulty reaching their attorneys. One detainee's attorney was unable to schedule phone calls through the facility and was only able to visit the detainee in person; the other two detainees reported that they had difficulty reaching their attorney because the phones were shut off when detainees were removed from the facility, as described in the Non-legal Visitation, Phone Calls, and Mail section, above. Two detainees interviewed at Desert View reported they had been unable to contact their attorneys but did not ascribe this issue to the facility.

VII. Health Care

As with other conditions of confinement at these facilities, the quality of medical care appeared to suffer in part because of the rapid influx of detainees. Although GEO Group medical leadership reported that additional health care staff were in the process of being hired and onboarded, the amount of health care staff at the time of Cal DOJ's visit did not appear to be sufficient to address

173 *Torres v. DHS*, (C.D.Cal. Apr. 24, 2020, No. 5:18-cv-2604) 2020 WL 3124305, p. *1; ICE, *Legal Notices 2020-Torres v. DHS* (Apr. 11, 2020) <https://www.ice.gov/legal-notices> (as of Mar. 19, 2026).
174 *Torres v. DHS*, (C.D.Cal Oct. 15, 2025, No. 5:18-cv-2604) ECF No. 233.
175 *See* Immigration Defenders Law Center, *Settlement Protects Access to Counsel and Phone Calls in Immigration Detention* (Aug. 20, 2025) <https://www.immdef.org/blog/torres-v-noem-aug-20-2025> (as of Mar. 19, 2026).

detainee needs. Cal DOJ's medical expert reviewed patient records and identified lapses in care attributable to the increase in demand for health care services.

A. Intake Assessments, Evaluations and Diagnoses

PBNDS 4.3 requires that detention facility health care staff conduct an initial medical, dental, and mental health screening of new detainees as soon as possible, but no later than 12 hours after a detainee's arrival to the facility.[176] Facility staff are required to ask detainees for information regarding any known acute or emergent conditions.[177] If a detainee identifies such a condition, staff must refer the detainee to a qualified, licensed health care provider as soon as possible, but in no later than two working days.[178] Additionally, if a detainee arrives with a prescription or reports a prescription, that detainee must be evaluated within 24 hours, and the facility must make a plan to acquire and provide the necessary medication.[179] Regardless of the results of the screening, the detention facility's health care provider must conduct a comprehensive health assessment of each detainee within 14 days of the detainee's arrival.[180]

Cal DOJ's medical expert reviewed 14 patient files; for four of these patients, facility staff identified acute, chronic, or emergent medical conditions at the patients' initial screenings but did not provide the two-day referral required by the PBNDS. One patient was referred for a next day medical assessment after their initial screening and was not seen by a doctor for eight days. Another patient with a chronic condition waited nine days for an appointment with the physician and was referred for lab work for medication management. At the time of Cal DOJ's visit, thirty days after the referral, their lab work had still not been drawn.

Detainees at Adelanto likewise experienced delays in receiving their full medical evaluations, if they received one at all. Only six detainees interviewed at Adelanto (26%) reported receiving a comprehensive health assessment within 14 days. Detainees at Adelanto additionally reported that they did not receive necessary medication, or only received it after excessive delays, with delays ranging from one week to one month.

B. Sick Call and Medical Care

Immigration detention facilities are required to have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services.[181] All sick call requests must be received and triaged by medical personnel within 24 hours after a detainee submits the request, but in urgent situations, medical personnel must be notified immediately.[182] Medical request slips must be provided in English and in the languages most commonly used by detainees at the facility; for detainees who do not speak these languages, the facility must provide services to assist the detainee to complete the request.[183] At Adelanto and Desert View, detainees can seek medical services through paper requests. Tablets were available in the past for requesting medical care; however, Cal DOJ's medical expert was unable to verify how many functional tablets were in circulation.

Detainees at Adelanto and Desert View described difficulties receiving medical care after they requested it. Eight detainees interviewed by Cal DOJ at Adelanto and Desert View reported requesting medical appointments for concerns such as chest and stomach pain, skin issues, special medical diets, a knee brace that had been removed during apprehension and never replaced, severe foot pain,

176 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, p. 266.
177 *Id*. at pp. 266-267.
178 *Id*. at p. 266.
179 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § U, p. 273.
180 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § M, p. 268.
181 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § S, pp. 271-272.
182 *Id*. at p. 271.
183 *Id*. at pp. 271-272.

an ear infection, broken glasses, persistent tooth pain, x-rays for a broken wrist, and treatment for thyroid disease and liver disease. According to these detainees, none of them had received a medical evaluation for their requests as of the time of Cal DOJ's site visit. Overall, of the 22 interviewed detainees at Adelanto who reported requesting medical services, only four (18%) reported that they had received the help that they needed. Many detainees who mentioned medical issues to Cal DOJ staff reported that they had been waiting for a medical appointment for weeks. For example, two detainees reported flu-like symptoms and told Cal DOJ that others in their housing units had similar symptoms. One detainee with these symptoms reported that they did not receive treatment until they started coughing up blood. **In a sampling of medical files, Cal DOJ's medical expert identified three cases of detainees with serious medical issues that did not receive timely emergency care.**

Detainees also described delays related to urgent mental health care. A detainee who reported having suicidal thoughts during detention reported having to wait for over four days for an appointment with a psychologist when requesting care for depression. A detainee who had reported they had repeatedly requested mental health appointments and an appointment with a physician for assessment of chest pain since arriving at the facility during the surge of detainees in early June did not receive appointments until two days before Cal DOJ's site visit in early July, approximately four weeks later.

Because the facilities do not have a dental hygienist on staff, detainees' access to dental cleanings depends on whether the dentist provides dental cleanings and the availability of the dentist. The medical doctor interviewed by Cal DOJ staff said that he urgently treated individuals with dental pain with medications but was not able to provide information on typical wait times for dental services. One detainee at Desert View who arrived in early June reported that they had received a dental examination and was told that they would have to have a tooth removed, but had not received a follow up appointment. One medical chart reviewed by Cal DOJ documented a different case in which the facility had initiated a timely referral for dental care two days after the detainee had made the request, and the detainee was placed on a waitlist for a tooth extraction. However, at the time of Cal DOJ's site visit several weeks later, there was no documentation in the detainee's chart indicating that they had received the extraction.

Detainees reported barriers to communication in medical contexts. Two detainees who did not speak English or Spanish reported difficulties in making health care requests in their language and one told Cal DOJ that they did not receive Russian interpretation services for their medical appointments.

PBNDS 4.3 requires a physician be present at the facility or on call for emergency care.[184] One detainee reported a concerning incident that occurred several weeks after arriving at the facility, when they experienced physiological symptoms that needed immediate medical attention. The detainee reported being placed in a cell in the medical observation area after notifying medical staff of the need for care, but that they did not receive a physician's examination that night. The detainee was able to see a physician three days after the episode, after symptoms had subsided.

Cal DOJ's medical expert reviewed detainee medical records, revealing concerning issues. One detainee reported that they were vomiting blood and received a referral for immediate care by the triage nurse. This detainee was not treated by any medical staff until they saw a physician one-and-a-half weeks later. Another detainee requested medical care for chest pain and was promptly attended to by a nurse, who noted that he should receive a physician sick call the following day; the detainee's medical record did not contain a physician note addressing this chest pain. This detainee was next attended to by medical staff 17 days later for neurological symptoms and was transferred to a hospital for treatment. GEO Group corporate staff lacked the information to provide an estimate of the frequency of medical emergency encounters or 911 calls when requested in an interview and did not believe that those calls were logged by the facility.

184 ICE, PBNDS 2011, 4.3 Medical Care, Part V, § T, p. 272.

C. Referrals to outside care

During interviews with Cal DOJ staff, one detainee at Adelanto and one at Desert View reported having a serious medical issue that required referrals to outside care, and that they did not receive that care. One detainee who arrived at Adelanto before June 2025 had a condition causing pain in their feet and torso. After requesting medical care several times, they were attended to by a medical specialist in April 2025 who told them that they would refer the detainee for outside care for steroid injections. The detainee reported that they had not yet received the necessary care as of the time of Cal DOJ's site visit, which was two to three months after the visit with the specialist.

Another detainee at Desert View reported that they had broken a leg in detention and requested emergency assistance but did not receive a response. The detainee reported that their leg started turning black after seven days without care. The detainee eventually received an X-ray and after five days, was attended to by a facility physician, and was told that they needed to be sent to the hospital. After two months, the detainee was finally treated by an outside specialist. The specialist was able to treat the detainee but informed the detainee that they should have been treated two months earlier.

In reviewing detainee medical files, Cal DOJ's medical expert identified several instances where detainees were provided referrals to outside care for necessary specialized treatment but never received the treatment. One detainee was referred for ophthalmology care three weeks prior to Cal DOJ's visit and had still not been seen. Another detainee had not been seen for a scheduled three-month follow-up from a neurosurgery visit four months prior to Cal DOJ's visit. One detainee with an infectious disease only received a referral for an infectious disease consultation[185] 24 days after arrival at the facility. Another detainee with the same infectious disease never received such a referral. Generally, the reviewed detainee medical files did not contain notes recording the steps taken by the facility medical staff to refer a detainee to outside care. As a result, it was difficult to determine the steps taken by the facility to ensure a referral for outside care is timely completed, creating a risk that a detainee's medical condition worsens while waiting for a response from outside medical providers.

D. Discharge Planning

Discharge planning was also of concern. PBNDS 4.3 requires that, upon transfer between ICE facilities or release or removal from ICE custody, detainees are provided medication, referrals to community-based providers as medically appropriate, and a detailed medical care summary.[186] The medical staff Cal DOJ interviewed indicated that medical records were only provided to detainees upon release from ICE custody if they request them; PBNDS requires that all detainees receive this information upon discharge.[187]

E. Staffing

Cal DOJ has concerns that Adelanto's health care staffing level is insufficient to ensure the health and safety of detainees housed at the facility. In interviews, facility staff told Cal DOJ that they were caught off guard by the number of detainees admitted to the facilities during the surge in immigration arrests in June 2025. As noted above in the Methodology and Limitations section, the Medical Director (who has served in this role at the facilities for approximately five years and was out of the country on leave at the time of the visit) and the Health Services Administrator (who, according to GEO Group, had been hired three weeks before Cal DOJ's visit and had just completed training) were not made available for interviews. Cal DOJ and its medical expert interviewed the Regional Health Services Director (a position that oversees health services at all GEO facilities in the region) and a part-time physician at

185 Best practices provide that these consultations are given to patients with infectious diseases to help manage their symptoms. These consultations are generally outside the scope of a primary care practitioner without specialized training and certification.
186 ICE, PBNDS 2011, 4.3 Medical Care, Part V, §§ Z, BB, pp. 276, 278-279.
187 Id. at pp. 278-279.

the facilities. The Regional Health Services Director gave conflicting answers about staffing changes, was not able to provide details on clinical workload tracking or staffing adjustments at Adelanto and Desert View. They were also not able to provide information on the certifications or specializations of physicians at the facilities. The Regional Director further stated that no corrective actions or changes in health services had been made in the prior several months despite the dramatic rise of the number of detainees at Adelanto. However, on further discussion, it did appear that some additional staff (five Registered Nurses and five Licensed Vocational Nurses) had been hired in response to the increase and about twenty additional nurses were undergoing the background check process with ICE and GEO Group. However, the Regional Director claimed that she had "no idea" who had made the request or decision to increase staff. Neither the Regional Director nor the part-time physician provided any further information on quality control other than noting a monthly quality control meeting attended by health care staff but not attended by either the Regional Director or the part-time physician.

A new Director of Nursing (DON) at the facilities had started about a month prior to the visit and was not made available for an interview with Cal DOJ. Before the new DON had been hired, the position at the facilities had been vacant for some time. The Regional Health Services Director estimated that the position had been vacant since approximately December 2024, which was around seven months prior to Cal DOJ's visit. They also reported that the previous Director of Nursing had left after only a few months in the position, with no reason given by GEO Group. Notably, the DON position was also vacant at the time of Cal DOJ's previous visit in November 2023.[188]

At the time of the site visit, the facilities had a staff of two full-time physicians, including the Medical Director, and one part-time physician for patient care. When interviewed during Cal DOJ's 2023 site visits, the Medical Director had previously described most of his time as spent reviewing charts and performing other administrative duties. The Medical Director previously reported that he was not board certified; board certification is a general standard for clinical directors but is not required by the PBNDS.[189] GEO Group reported three full-time and one part-time (on an as-needed basis) advanced practitioners (medical providers such as a physician's assistant or nurse practitioner); in November 2023, the facilities had three advanced practitioners and one vacant position.[190]

In its 2025 report following its 2023 site visit, Cal DOJ acknowledged that health care provision at Adelanto and Desert View had fewer problematic areas compared to other detention facilities.[191] However, at that time Cal DOJ identified gaps in targeted medical services, management of infectious diseases, and monitoring during hunger strikes.[192] At the time, Cal DOJ also identified concerns with mental health care and medical staffing levels. Specifically, Cal DOJ was concerned whether levels were adequate to serve the combined population of the two facilities, noting that several key positions in the medical staff were vacant at the time of the site visit and that if the combined detainee population increases any further, it should be a priority to fill mental health care positions to maintain the current level of care.[193] While the number of physicians and advanced practitioners increased between November 2023 and July 2025, these numbers are still less than what was reported during Cal DOJ's visit in February 2021, when GEO reported three full time physicians and five advanced practitioners for a population of 79 detainees. The combined population of both facilities, which shared health care staff, increased by 1,663 detainees between November 2023 and July 2025.[194] GEO Group did not provide assurances that staffing levels increased to correspond with the increase in detainee population. Cal DOJ renews these concerns with greater urgency to ensure the health and safety of the detainees in GEO Group's care.

188 *Immigration Detention in California* (Apr. 2025), *supra*, p. 40.
189 *Ibid.*
190 *Ibid*.
191 *Id.* at pp. 28, 34-36, 40.
192 *Id*. at p. 40.
193 *Id*. at p. 33.
194 *Id*. at p. 27.

F. Detainee Deaths

Four detainees who arrived at Adelanto after Cal DOJ's visit died while in the custody of GEO Group. All four deaths appear to involve detainees who received or attempted to receive medical services at Adelanto.

Ismael Ayala-Uribe died at age 39 on September 22, 2025, after one month of detention at Adelanto.[195] According to media reports, his family reported that Mr. Ayala-Uribe was relatively healthy when he entered the facility, but about two weeks after arriving, he told facility staff that he was feeling sick with a cough and fever.[196] Mr. Ayala-Uribe died in an external hospital days later after a transfer for surgery for an abscess.[197] On December 31, 2025, Mr. Ayala-Uribe's family sued GEO Group over the death, alleging that the facility operators were negligent in addressing Mr. Ayala-Uribe's medical needs.[198]

Gabriel Garcia Aviles died on October 23, 2025, at the age of 54, about a week after entering detention in Adelanto.[199] ICE reported that he died of natural causes and alcohol withdrawal.[200] According to media reports, Mr. Garcia Aviles' family stated that he had been healthy prior to his detention.[201] They also reported that he was intubated and had blood on his forehead and lips, broken teeth, a cut on his tongue, and bruising on his body when they visited him at the hospital shortly before his death.[202]

Alberto Gutiérrez Reyes died on February 27, 2026, at the age of 48, after reportedly submitting multiple requests for medical attention.[203] His family claims these requests were denied.[204] ICE reported that Mr. Gutiérrez Reyes had a fever and fainted before being hospitalized at Victor Valley Global Medical Center in Victorville, California, where he passed away.[205]

On March 25, 2026, Jose Guadalupe Ramos-Solano died at the age of 36.[206] ICE reported that facility staff discovered Mr. Ramos-Solano unconscious and unresponsive and immediately initiated life-saving procedures and transported him to Victor Valley Global Medical Center in Victorville, California.[207] Cal DOJ received a report, however, that at least one detainee heard Mr. Ramos-Solano say he was overheating and experiencing difficulty breathing; this report indicated that facility staff knew about Mr. Ramos-Solano's distress and prevented other detainees from assisting him and that medical staff did not take action until he was already unresponsive.

195 ICE, *Detainee Death Report: Ayala Uribe, Ismael* <https://www.ice.gov/doclib/foia/reports/ddrIsmaelUribeAyala.pdf> (as of Mar. 19, 2026).
196 Vives & Jarvie, *A Former DACA Recipient Died in ICE Custody. Did Officials Ignore his Pleas for Help?*, L.A. Times (Sept. 24, 2025) <https://www.latimes.com/california/story/2025-09-23/former-daca-recipient-dies-in-ice-custody-after-being-hospitalized> (as of Mar. 24, 2026).
197 *Ibid.*
198 *Ayala Roman v. GEO Group* (C.D.Cal. Dec. 31, 2025, No. 2:25-cv-12436) ECF No. 1; Nelson, *Family of Orange County Man who Died in ICE Detention Sues Prison Operator*, San Bernardino Sun (Jan. 6, 2026) <https://www.sbsun.com/2026/01/04/family-of-orange-county-man-who-died-in-ice-detention-sues-prison-operator> (as of Mar. 19, 2026). On January 7, 2026, the case was transferred within the Central District Court of California and renumbered as 8:25-cv-2893. See Ayala Roman v. GEO Group (C.D.Cal. Dec. 31, 2025, No. 2:25-cv-12436) at ECF No. 2.
199 ICE, *Detainee Death Report: Garcia Aviles, Gabriel* <https://www.ice.gov/doclib/foia/reports/dderGabrielGarciaAviles.pdf> (as of Mar. 19, 2016).
200 ICE, *Detainee Death Notifications* (Nov. 3, 2026) <https://www.ice.gov/news/releases/illegal-alien-dies-victorville-medical-center-california-after-complications-alcohol> (as of Apr. 17, 2026).
201 Ramirez, *Ten Days After Adelanto Internment, This Beloved Grandfather Died in Custody*, L.A. Taco (Nov. 4, 2025) <https://lataco.com/second-death-adelanto-custody> (as of Mar. 24, 2026).
202 *Ibid*.
203 ICE, *Detainee Death Notifications* (Mar. 4, 2026) <https://www.ice.gov/news/releases/criminal-illegal-alien-passes-away-california-hospital> (as of Apr. 14, 2026).
204 Ramirez, *Los Angeles Father Dies Under ICE Custody – 9th Death This Year*, L.A. Taco (Feb. 28, 2026) <https://lataco.com/los-angeles-father-dies-ice-9th-death> (as of Mar. 19, 2026).
205 Ortega, *Muere Inmigrante Mexicano en la Cárcel del ICE en Adelanto*, La Opinión (Mar. 1, 2026) <https://laopinion.com/2026/03/01/muere-inmigrante-mexicano-en-la-carcel-del-ice-en-adelanto> (as of Mar. 19, 2026).
206 ICE, *Detainee Death Notifications* (Mar. 30, 2026) <https://www.ice.gov/news/releases/criminal-illegal-alien-passes-away-ice-custody> (as of Apr. 14, 2026); Cota-Robles, *Los Angeles Family Demands Answers After Father Dies in ICE Custody*, ABC7 (Mar. 30, 2026) <https://abc7.com/post/los-angeles-family-demands-answers-father-dies-ice-custody/18811932> (as of Apr. 2, 2026).
207 Ramirez, *Another Death at Adelanto: Family Seeks Truth as L.A.'s Mexican Consulate Highlights 'Alarming Trend' of ICE Custody Fatalities*, L.A. Taco (Mar. 31, 2026) <https://lataco.com/death-adelanto-mexican-consulate> (as of Apr. 2, 2026).

8. Golden State Annex

I. Introduction and Summary of Key Findings

On September 24 and 26, 2025, Cal DOJ conducted a site visit of the Golden State Annex (Golden State) to assess the impact of increased detained populations across the state. Like other facilities, the detainee population at Golden State increased substantially from our last site visit in May 2023. At that time, the facility held 159 detainees compared to the 569 individuals detained at Golden State as of September 23, 2025. Cal DOJ learned that the reduction to 448 detainees occurred a few weeks prior to our visit, when the Cal City facility opened, and detainees from Golden State were transferred to the Cal City facility.

Golden State's facility leadership remained consistent in the year leading up to our visit and reported decades of experience in immigration detention. These factors seemed to contribute to the overall stability of the facility and staff. Facility leaders further highlighted Golden State's safety record when sharing that there had been no serious injuries or deaths among the detainee population since our last review and site visit in 2023.

When discussing conditions at Golden State, some detainees were reluctant to make demands or complain about conditions for fear of being transferred to Cal City. They believed that other detainees who were perceived as "troublemakers" were moved to Cal City. As discussed later in this report, when Cal DOJ conducted its site visit at Cal City in November 2025, the team encountered a number of individuals who were formerly detained at Golden State and who shared a similar belief.

At the time of Cal DOJ's site visit the increase of detainees appeared to adversely impact conditions of confinement, resulting in delays in intake processing, medical screening and care, classifications, and untimely responses to detainee grievances. Detainees also reported issues with facility orientation, food service, and clothing. Cal DOJ's review resulted in the following key findings:

- Since Cal DOJ's last site visit in May 2023, the population at the facility increased from 159 detainees to 569 detainees, an approximately 258% increase. Golden State saw a large number of detainees arriving during the summer of 2025, with 234 of the 569 detainees (41% of those present on roster) arriving between June 1 and August 31, 2025. ICE reported that the vast majority of detainees (528; 89%) had no criminal conviction.[208]

- Review of use of force files indicated that supervisors reviewed incidents with a balanced approach and showed willingness to assess some uses of force as unfounded and to take remedial action.

- Some detainees experienced lengthy periods of segregation. About 5 detainees (11%) in restricted housing spent more than 100 days there, and one detainee spent 295 days in segregation.

- Detainees consistently reported concerns with the quality and quantity of food, and needing to supplement their diet by purchasing food from the commissary.

- Medical staffing levels were inadequate to meet the needs of the surge of detainees housed at Golden State. Of particular concern, Golden State had only one part-time psychiatrist, which was insufficient to meet the expected level of need for the size of the population at the facility.

208 ICE FY25 Detention Statistics (Sept. 2025), *supra*, (showing Golden State's average daily population for FY 2025 totaled 596, and those classified as being "No ICE Threat Level," or having no criminal convictions, totaled 528).

- Detainees with existing or ongoing medical or mental health concerns experienced inconsistent access to timely medical care. Medication dosing was disrupted during the intake process and could also be disrupted when changes were made to prescriptions. At times, these interruptions affected insulin administration. In some cases, detainees did not receive timely access to specialty care despite receiving referrals from a medical provider on site, including in some cases where detainees required prompt attention for cancer screening or other urgent needs.

- There is minimal tracking of detainee grievances and resolutions, resulting in limited understanding of the number and nature of most grievances at the facility.[209]

- Language access was limited across several aspects of a detainee's experience, from orientation to tablet and phone access. Obstacles to language access also limited legal research resources available to any detainee who did not speak English.

II. Facility Background

Golden State is located in McFarland, California in Kern County.[210] Golden State is owned and operated by The GEO Group, Inc. (GEO Group).[211] Effective December 20, 2019, GEO Group entered into a contract with ICE[212] to hold immigrants at Golden State beginning in 2020 under the oversight of the Office of Enforcement and Removal Operation's Field Office Director in San Francisco.[213] The contract considers Golden State an annex to Mesa Verde, which is located nearly 26 miles away in Bakersfield.[214] The facility is subject to the PBNDS.[215]

Golden State has a maximum bed capacity of 700.[216] ICE pays GEO Group for a guaranteed minimum of 560 beds.[217] Although Golden State can house both male and female detainees, at the time of Cal DOJ's visit, it only housed male detainees. According to ICE, Golden State has only housed male detainees from fiscal years 2020 through 2025.[218]

209 ICE, Office of Detention Oversight, *Golden State Annex Unannounced Compliance Inspection* (Jan. 28-30, 2025), p. 10 <https://www.ice.gov/doclib/foia/odo-compliance-inspections/goldenStateAnnex_McFarlandCA_Jan28-30_2025.pdf> (as of Apr. 15, 2026) (finding that GSA did not log informal grievances nor informal grievance resolutions).
210 The GEO Group, Inc., *Golden State Annex* <https://www.geogroup.com/facilities/golden-state-annex/>(as of Mar. 19, 2026).
211 *Ibid.*
212 The GEO Group, Inc., *The GEO Group Signs Contract with U.S. Immigration and Customs Enforcement for Five Facilities in California Totaling 4,490 Beds* (Dec. 23, 2019) <https://investors.geogroup.com/node/6511/pdf> (as of Mar. 19, 2026).
213 This contract was created following the effective termination of GEO Group's contract with the California Department of Corrections and Rehabilitation. See Cal. Dept. of Corrections and Rehabilitation, *CDCR Announces State Prison Closure* (Sept. 25, 2020) <https://www.cdcr.ca.gov/news/2020/09/25/cdcr-announces-state-prison-closure/> (as of Mar. 19, 2026); Cal Dept. of Corrections and Rehabilitation, *Reduction/Closure Information: CDCR Institution Closure/Deactivation Timeline* <https://www.cdcr.ca.gov/prison-closures/> (as of Mar. 19, 2026).
214 Although Golden State is considered an annex to Mesa Verde, the population restrictions mandated by the court-ordered injunction in *Zepeda Rivas et al. v. Jennings et al.*, and discussed further in the Mesa Verde chapter, do not apply to Golden State. See *Zepeda Rivas v. Jennings* (N.D.Cal. 2020) 504 F.Supp.3d 1060.
215 ICE, *Golden State Annex Unannounced Compliance Inspection* (Jan. 2025), *supra*, p. 4.
216 The GEO Group Inc., *Golden State Annex* <https://www.geogroup.com/facilities/golden-state-annex> (as of Apr. 15, 2026).
217 ICE FY 2025 Detention Statistics (Sept. 2025), *supra*.
218 ICE, Detention Management, Fiscal Year 2020 National Detention Statistics (Oct. 4, 2020) <https://www.ice.gov/doclib/detention/FY20-detentionstats.xlsx> (as of Mar. 26, 2026) ("ICE FY20 Detention Statistics (Oct. 2020)"); ICE, Detention Management, Fiscal Year 2021 National Detention Statistics (Sept. 13, 2021) <https://www.ice.gov/doclib/detention/FY21-detentionstats.xlsx> (as of Mar. 26, 2026) ("ICE FY21 Detention Statistics (Sept. 2021)");ICE, Detention Management, Fiscal Year 2022 National Detention Statistics (Sept. 26, 2022) <https://www.ice.gov/doclib/detention/FY22-detentionStats.xlsx> (as of Mar. 26, 2026) ("ICE FY22 Detention Statistics (Sept. 2022)"); ICE, FY23 Detention Statistics (Oct. 2023), *supra*; ICE FY24 Detention Statistics (Oct. 2024), *supra*; ICE FY25 Detention Statistics (Sept. 2025), *supra*.

The Department of Homeland Security Office of Detention Oversight (ODO) last conducted an unannounced inspection of Golden State Annex in January 2025, found 17 total deficiencies, and issued the facility a rating of "acceptable/adequate", a downgrade from a rating of "good" issued in fiscal year 2024.[219]

Table 11. Key Data Points, Golden State Annex

Facility:	**Golden State Annex**
Operator:	The GEO Group, Inc.
Housing Detainees Since:	2020
Bed Capacity:	700
Type(s) of Detainees Facility Can Hold:	Female and Male Adult Civil Detainees

III. Methodology and Limitations

Cal DOJ staff and experts, including a medical expert and an immigration detention expert, visited Golden State on September 24 and 26, 2025. The site visit was planned in response to reports of the rapid increase in the number of detainees in detention in California and focused on the impact of this increase on conditions of confinement. Cal DOJ collected data and observed conditions at the facility, interviewed detainees and facility staff, and reviewed relevant documents. Cal DOJ and its medical expert interviewed the Medical Director, Health Services Administrator, and other health care staff to complete review of detainee medical and mental health care.

Additionally, Cal DOJ interviewed 32 individuals detained at the facility. Detainees were chosen for interviews by selecting a sampling of detainees from each housing unit with a range of intake dates and countries of origin. Cal DOJ also interviewed detainees who signed up to speak with Cal DOJ on notices posted in housing units preceding the site visit. Of the 32 detainees interviewed, six (19%) had a security classification of High custody. The interviews took place in a non-private setting with two Cal DOJ team members per interview. Cal DOJ interviewed detainees in their preferred language, either by Cal DOJ staff who were proficient in the language or through a telephone interpretation service. The languages used during interviews included Arabic, English, Haitian Creole, Hindi, Korean, Lao, Portuguese, Punjabi, Russian, Spanish, and Turkish.

Despite the ability and capacity of the facility to allow contact interviews, facility staff informed Cal DOJ that the ICE field office only allowed non-contact interviews with Cal DOJ during the site visit. Thus, interviews were conducted through plexiglass dividers and phones, in three side-by-side non-contact booths within the attorney interview room. Although a phone receiver was available to both Cal DOJ and the detainee on the other side of the glass, the sound was muffled on some receivers and there was background noise in the space generally that made it difficult to hear. For 11 detainees (34%) who required interpretation services through a language line, GEO Group management provided Cal DOJ team members with flip phones to contact interpretation services. Due to the size of the interview area and the number of booths, the private and confidential nature of Cal DOJ's interviews was compromised and may have affected a detainee's willingness to share personal details. The use of phone translation services was also compromised because the interpreter had difficulty hearing the detainees' responses.

219 ICE, *Golden State Annex Unannounced Compliance Inspection* (Jan. 2025), *supra*, p. 11.

IV. Detained Population

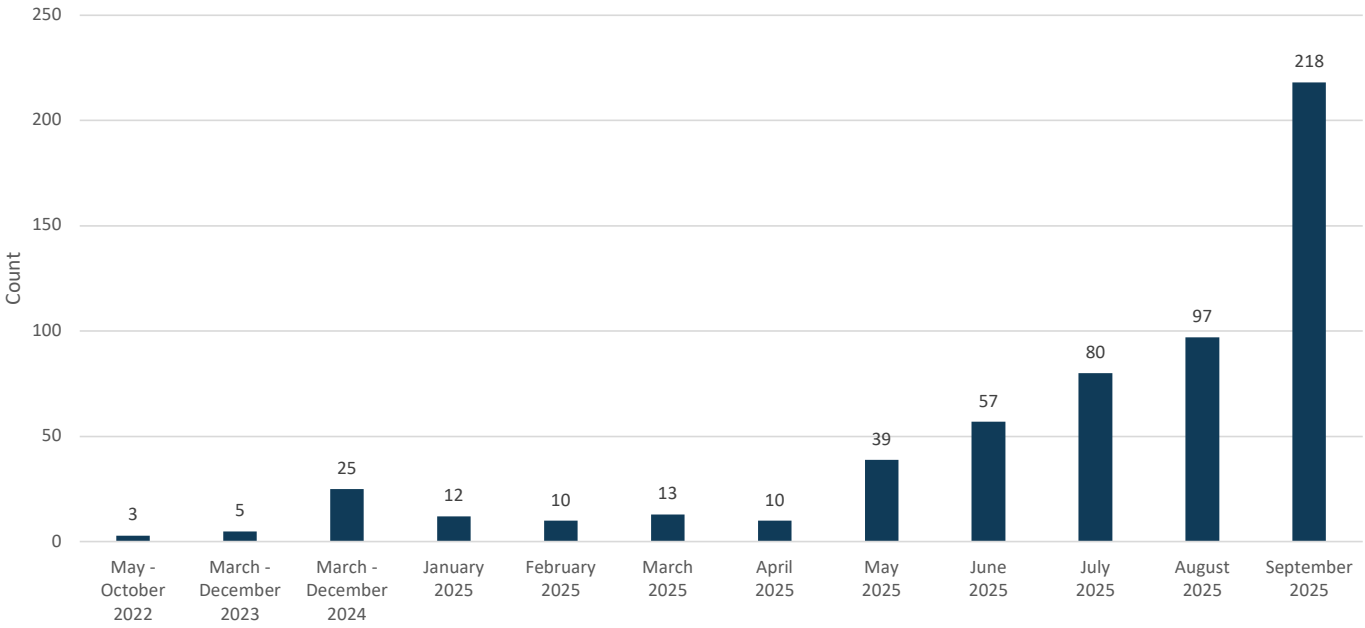
As of September 23, 2025, a day prior to Cal DOJ's visit to Golden State, 569 individuals were detained at Golden State representing 61 different countries. Although the facility reported that all detainees were male, of the 32 we interviewed, one detainee who was interviewed self-identified to Cal DOJ as female. The length of stay for the detainees ranged from one day to 1,237 days. The average length of stay totaled 82.8 days.

Table 12. Snapshot of Detainees Housed at Golden State on September 23, 2025[220]

No. of Countries of Origin:	**61**
No. of Female Detainees:	0
No. of Male Detainees	569
Average Age:	No data provided
Average Length of Detention:	83 Days
Longest Length of Detention:	1,237 Days

The earliest detainee arrival date as of Cal DOJ's 2025 site visit was May 5, 2022. The latest arrival date was September 22, 2025. Based on the detainees who were present as of the 2025 site visit, the number of arrivals per month increased in each month between May and September. The population was at about 81% capacity in September when 218 active detainees arrived.

Figure 14. Arrival Month of Detainees on September 23, 2025 Roster at Golden State



Facility administration reported that the population at Golden State grew from 159 on May 2, 2023 to 569 on September 23, 2025. While the average length of stay for detainees held at Golden State on September 23, 2025 was 82.8 days, ICE reported that for the Federal Fiscal Year (FFY) 2025 (October 1, 2024 - September 30, 2025), the average length of stay for detainees was 111 days, the longest of all reported ICE facilities in the country.[221]

220 Population in tables is based on facility records and do not reflect gender identity not reported to, or recorded by, the facility.

221 ICE, FY 2025 National Detention Statistics, *supra*, at Facilities. The facility with the next highest average length of stay is River Correctional Center in Monroe, Louisiana, at 78 days. *Ibid*.

The top 10 most represented countries were India (160), Mexico (128), El Salvador (37), Vietnam (24), Guatemala (22), China (14), Cuba (12), Russia (11), Colombia (10), and Honduras (10). Of the 32 detainees interviewed, the most represented countries of origin included Mexico, India, and Belize. Only one detainee interviewed reported being born in a country different from the country where they have citizenship.

Detainees who were interviewed varied with respect to their immigration status before detention. However, 13 detainees (41%) reported they had some form of legal immigration authorization—lawful permanent residency, valid work permits, or refugee status—or were in the process of applying for legal status (i.e. through the asylum process) at the time they were detained. One detainee reported that he was a U.S. Navy veteran, who had served for six years.

V. Conditions of Confinement

Conditions of confinement consist of various factors, policies, and practices that impact the experiences of detainees, including the provision of health care and mental health. The conditions reviewed below include: 1) the intake and orientation process; 2) security classification system; 3) food and water access; 4) housing units; 5) detention and safety; and 6) access to recreation, programming, and visitation.

As detailed in this section, Cal DOJ found some deficiencies, including inconsistent intake and orientation processes resulting in gaps in services and programming and recreation issues. Detainees also reported problems with food quality, fears about the potential for transfers, safety concerns, and issues with the grievance process.

A. Intake and Orientation

1. Intake Process

When detainees arrive at Golden State, they are placed in the intake area for processing. Golden State's intake area consists of a bench along a long hallway where detainees sit after arriving at the facility, seven single wet cells–a holding cell with a toilet and a sink–and a portable pay phone. There is a single shower available for use by detainees in intake, which can also be used by detainees housed in the medical unit and those held in restricted housing. Detainees reported lengthy intake experiences, often due to the number of detainees being processed at the same time. For one detainee who reported arriving with over 50 other detainees, intake occurred in the cafeteria space to accommodate the large group, with detainees sleeping on the floor as they waited to be processed.

Figure 15. Intake Hall and Bench at Golden State

Figure 16. Intake Phone at Golden State

PBNDS 2.1 requires detention facilities to implement an orderly process for the intake and reception of newly arrived detainees; this process, which includes recording a detainee's basic personal information, a criminal history check, and a medical, dental, and mental health screening, should take no longer than 12 hours. **Based on reports from 29 detainees, the intake process took between two hours and two days. This variability coincided with multiple issues with intake as described by detainees, including delays in medical screenings**.

During interviews, Cal DOJ asked detainees if they received food in the intake area while waiting to be processed into the facility. Eighteen detainees (56%) reported that they were provided with food, while 11 detainees (34%) reported that no food was provided. One detainee shared that despite remaining in intake for about 24 hours, they were only provided two pieces of bread. Additionally, 21 detainees (66%) reported they had access to water during the intake process, while eight detainees (25%) reported no access to water.

PBNDS mandates that all newly arrived detainees shall be medically screened "to protect the health of the detainee and others in the facility."[222] This screening includes a medical, dental and mental health assessment, and must occur "as soon as possible, but no later than 12 hours after arrival."[223] Facility staff reported that a detainee arriving with a fever or rash would trigger placement in one of two clinic observation rooms. Nineteen of the detainees interviewed (59%) reported that the intake process included a medical, dental, and mental health screening. However, detainees shared varying accounts of what their medical screening entailed. Some detainees described being seen by a healthcare provider, undergoing vital checks, and answering questions about medical history, while others indicated that they received some but not all components of the required screening. One detainee reported that no one conducted any health screening or asked about their medical history, but they did obtain a TB test. Of the detainees that confirmed they underwent a health screening, three reported that there was no dental screening.

2. Orientation

PBNDS 2.1 requires that all detention facilities provide an orientation and handbook to each detainee.[224] GEO Group's facility specific handbook for Golden State was only available in English and Spanish at the time of our site visit. This finding contrasts with those of Cal DOJ's last visit in 2023, when an ICE detainee handbook was reportedly available in 12 languages, though the Cal DOJ team was only provided the English and Spanish versions. During interviews, Cal DOJ asked detainees whether they received orientation materials. Eighteen detainees (56%) reported receiving a handbook, two detainees (6%) reported receiving a handbook and an orientation, three detainees (9%) reported receiving some alternate orientation to the facility, and seven detainees (22%) reported that they did not receive any orientation or orientation handbook upon their arrival. Sixteen of the 23 detainees (70%) who confirmed that they received orientation resources also reported the resources were in a language they could understand.

During an unannounced inspection of Golden State in January 2025, ODO found that the orientation materials did not reference any legal orientation programs[225] available to detainees, which is a requirement under the PBNDS.[226] Additionally, ODO found that the orientation handbook did not include details about the days and hours a detainee may contact the ICE Enforcement and Removal Operations (ERO) San Francisco staff, which is also required under the PBNDS.[227] While Cal DOJ was not provided a copy of the handbook during this visit, the version of the handbook received during

222 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § B, p. 53.
223 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, p. 266.
224 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ F-G, pp. 55-57.
225 ICE, *Golden State Annex Unannounced Compliance Inspection* (Jan. 2025), *supra*, p. 10.
226 ICE, PBNDS 2011, Part 6.1 Detainee Handbook, Part V, § B, p. 412.
227 ICE, *Golden State Annex Unannounced Compliance Inspection* (Jan. 2025), *supra*, p. 10.

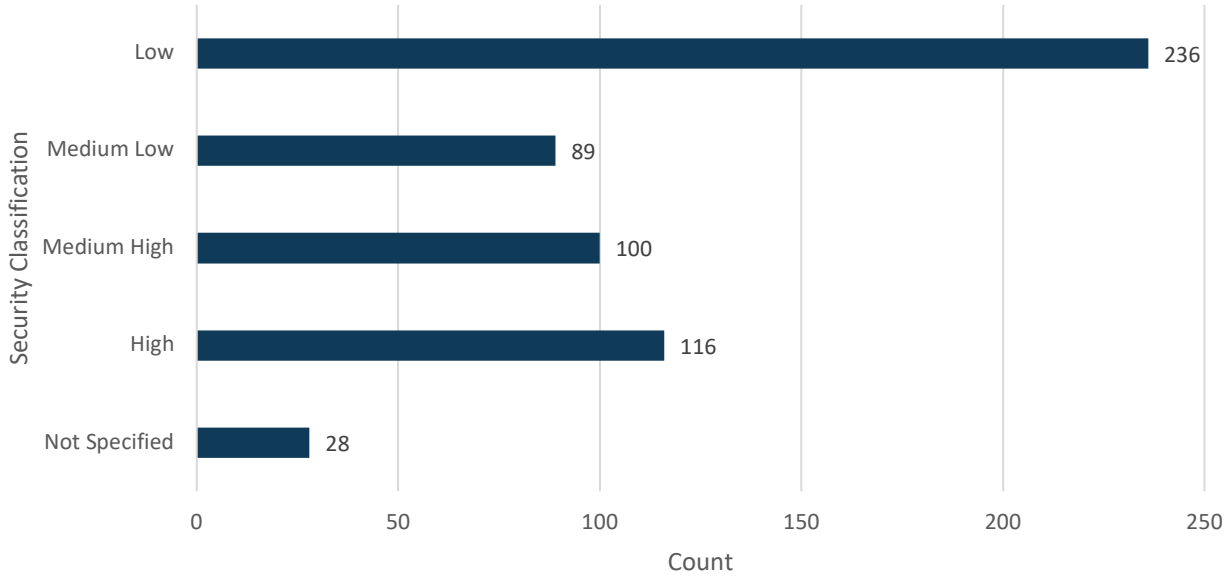
the 2023 review did not include information regarding legal orientation. However, the 2023 handbook referenced resources in a separate list maintained by ICE, as well as the law library schedule and rules.[228]

Detainees appeared to have access to most basic needs upon arrival and within their housing units. Staff reported that upon entering Golden State, all detainees received a set of sweats, three pairs of underwear, three t-shirts, a colored shirt (corresponding to their classification level), socks, slippers, shoes, a beanie, and pants. Detainees also receive a standard hygiene packet with a toothbrush, toothpaste, comb, shampoo, soap, a cup, and a spoon. Detainees were responsible for cleaning their utensils in the housing unit. During detainee interviews, however, Cal DOJ heard from one detainee that the facility was unable to provide the standard clothing issue and they received only one pair of underwear and two sets of t-shirts and pants upon arrival, instead of three. The detainee did report that they were able to submit their clothing to be laundered every night.

3. Security Classification System

The PBNDS require that all detainees be classified upon arrival and before admission into the general population.[229] The classification process categorizes detainees using the ICE Custody Classification worksheet or similar system to produce a score that places a detainee in a Low, Medium-Low, Medium-High, or High classification, through consideration of criminal history, medical information, vulnerability risks, and identified disabilities.[230]

Consistent with the PBNDS, detainees at Golden state are classified as Low, Medium-Low, Medium-High, or High. Facility staff reported that Golden State maintains a dedicated classification team that handles both the initial classification of detainees as well as their re-classification within 30-, 60-, or 90-day increments. As shown in **Figure 17**, over half of the detainees (325; 57%) housed at Golden State as of the day prior to Cal DOJ's visit were classified as Low or Medium-Low security. ICE statistics for FY 2025 show that approximately 89% of the individuals held in Golden State were reported as non-criminal (detainees without any criminal conviction).[231]



228 The GEO Group, Inc., *Supplement to the National Detainee Handbook, Golden State Annex* (2022-2023) <https://lccrsf.org/wp-content/uploads/2024/12/GEO-GSA-Handbook-5.24.22.pdf> (as of Apr. 15, 2026).
229 ICE, PBNDS 2011, Part. 2.2 Custody Classification System, Part V, §§ A-D, pp. 61-63.
230 *Id*. at § C, pp. 62-63.
231 ICE FY25 Detention Statistics (Sept. 2025), *supra* (528 detainees out of Golden State's average daily population, 596, were classified as "No ICE Threat Level," meaning that they had no criminal convictions).

Figure 17. Golden State Detainees by Security Classification as of September 23, 2025

B. Food, Nutrition, Access to Water

Meals

PBNDS 4.1 requires that three meals are served to every detainee per day and that no more than 14 hours elapse between dinner and breakfast.[232] Facility management shared that all meals served at Golden State are hot and prepared on a consistent serving schedule. The kitchen was reportedly equipped to accommodate special diets including kosher and halal meals as well as dietary restrictions based on medical recommendations (low salt, finger foods, vegan, etc.). However, the facility staff reported that if at any time a detainee opted for a standard meal, the religious accommodation would end. During review of general detainee files, this rule was also written in one detainee's file regarding a requested halal diet.

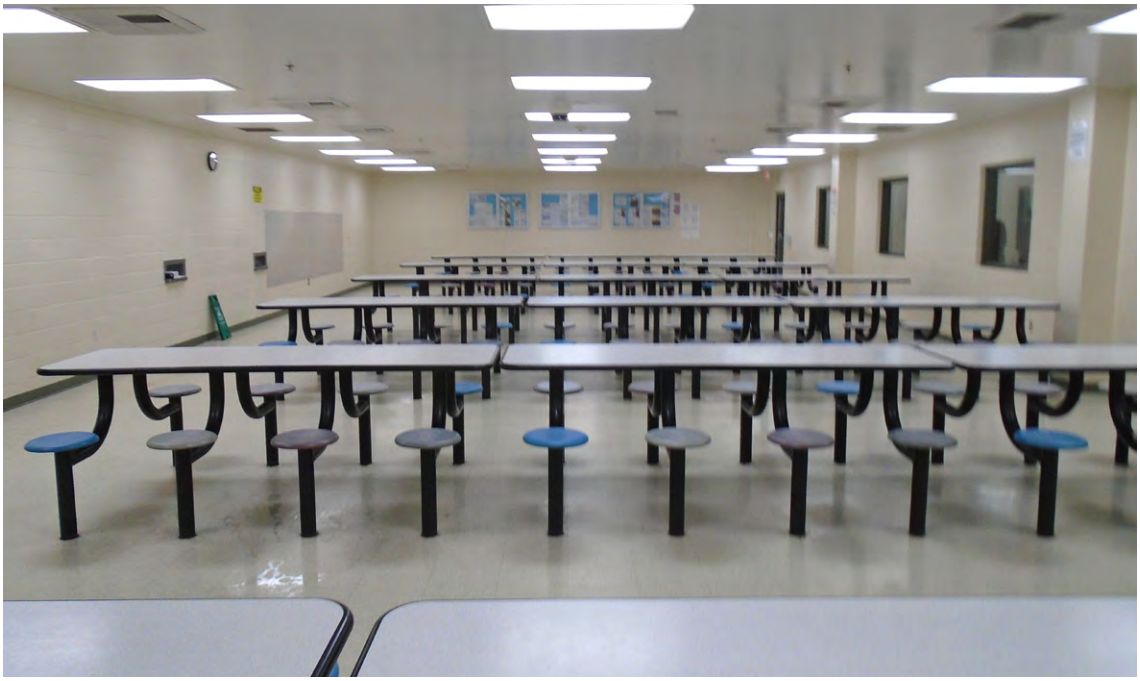


Figure 18. Dining Hall at Golden State

During interviews, Cal DOJ asked a series of questions related to food service and access at Golden State. All detainees interviewed reported that they receive three meals per day. However, 19 of 32 detainees (59%) also reported issues with food, including food portions, food quality, and timing of food service. Eight detainees reported that they supplemented the meals provided by Golden State with items purchased from the commissary. Five of these detainees reported spending approximately $50 per week, with at least one detainee spending $100 during their first week on commissary items such as instant noodles, soups, and tuna to satisfy their hunger.

During interviews, three detainees described various food quality issues, including expired milk, foul-smelling meat, hard rice, and hot food served cold or undercooked. Several detainees also reported that without access to commissary items, they would not have enough food to eat.

232 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232.

Figure 19. Food Supply at Golden State

Figure 20. Kitchen at Golden State

Water

Detainees shared that they access water from large coolers that are placed in the housing unit. Twenty-one detainees (66%) did not report any issues accessing drinking water. However, 11 of the interviewed detainees (34%) reported issues with water quality. Several detainees shared concerns about the taste of drinking water which they described as having a chlorine or bleach flavor.

C. Housing Units

During the site visit, Cal DOJ toured the housing unit wings and walked through a select number of housing units, as permitted by GEO Group. Golden State consists of two separate housing wings (with four separate units in each housing wing), which are large open-air spaces that offer no privacy, with a combination of bunk beds and single beds that accommodate between 86-88 detainees per unit, regardless of classification level (e.g. Low, Medium, Medium-High).

Each housing unit has a toilet and shower area. The housing unit Cal DOJ toured contained five shower stalls, eight toilet stalls, and six sinks. One of the shower and toilet stalls was compliant with the American with Disabilities Act (ADA). Housing units also have enclosed rooms with glass walls for programming or other events, a wall of phone stations for calls, and some tables and chairs.

1. General Condition of Facility and Housing Units

PBNDS provides that facility staff must ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness, which includes daily dusting, mopping, and trash disposal.[233] Detainees are only required to maintain their immediate living areas by making the bed, stacking loose papers, and keeping the floor around their spaces neat.[234]

During interviews, 12 detainees (38%) reported that they had concerns about the conditions in their housing units, including safety concerns and issues with cleanliness. Detainees reported that GEO Group has detainees cleaning common areas (either voluntarily or via the work program), but some detainees disclosed that the facility had previously hired someone else to clean. According to detainees, facility staff has made various cleaning agents available to detainees, such as mops, brooms, and pails, and told them to use those items when detainees thought it was necessary to do so. GEO Group personnel confirmed that detainees are responsible for cleaning their housing units. One detainee shared that they must clean their own unit and are not provided any personal protective equipment to clean. This practice appeared inconsistent with PBNDS standards.

Upon review of general detainee files, Cal DOJ found that several newly arrived detainees had been required to sign a form on the day of their arrival to Golden State, a form available in English or Spanish only, stating that the detainee completed training/received instruction how to use cleaning products as intended. This practice was concerning given many detainees did not speak English or Spanish.

With respect to safety issues, two detainees expressed concerns with how densely populated the housing units were with over 80 detainees. One detainee reported that there are gang members in the unit, and another reported that there was a small group of detainees who are accessing drugs but did not feel they could safely report the issue to staff.

2. Segregation

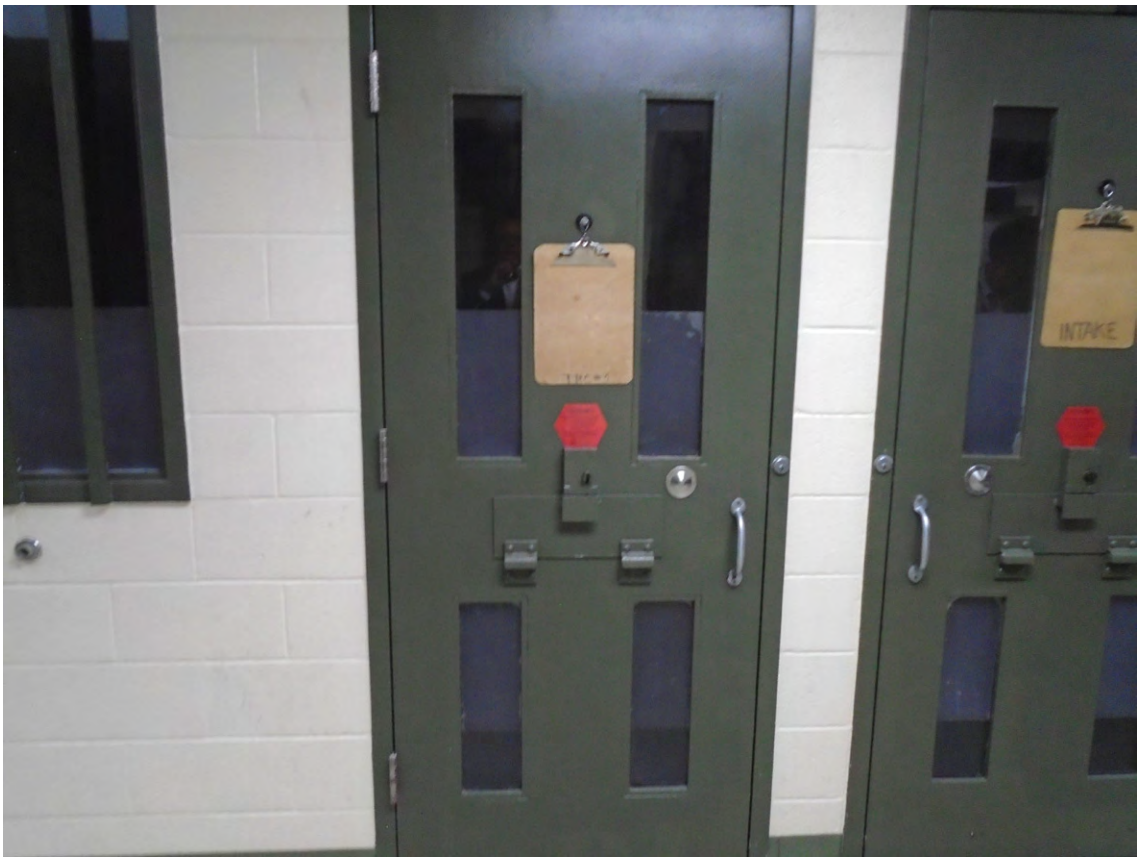
Golden State maintains a restrictive housing unit that houses detainees in pre-disciplinary segregation, protective custody, and disciplinary segregation. Segregation cells in this unit all contained a toilet and

233 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety, Part V, § A, p. 21.
234 ICE, PBNDS 2011, Part 5.8 Voluntary Work Program, Part V, § C, p. 406.

sink. Facility staff reported that detainees placed in the restricted housing unit (RHU) for administrative segregation receive two hours of recreation time, while detainees on disciplinary segregation only receive one hour.

GEO Group provided a log of detainees who were released from RHU in 2025. Admission dates ranged between November 2024 and May 2025. Cal DOJ analyzed this log to assess how long detainees spent in restricted housing during this time.[235] The average length of stay in the RHU as calculated by Cal DOJ was 27 days, which is a substantial length of time to be placed in segregation. Most records (37 of 44, 84%) of detainee stays in the RHU indicate that the detainee spent 30 or fewer days in restricted housing. However, five records (11%) suggest that the detainee spent 100 or more days in restricted housing. Records indicate that one detainee was placed in the RHU for 295 days.

Figure 21. Restrictive Housing Unit Doors at Golden State



D. Detention and Safety

1. Staffing

The PBNDS require staffing levels at each facility that ensure sufficient supervision for those detained.[236] While Cal DOJ requested staffing records for Golden State in advance of the site visit, GEO Group did not produce any records. Facility leaders reported that Golden State's full time employment positions were mostly filled at the time of Cal DOJ's visit, and that retention levels were satisfactory. Facility staff reported that the majority of the workforce at Golden State are GEO Group employees including those that work in food services, health care, and facility maintenance.

235 Length of stay in restricted housing could not be calculated by Cal DOJ for 11 out of 55 records (20%), because of issues with data quality or lack of completeness of the data.

236 ICE, PBNDS 2011, Part 2.4 Facility Security and Control, Part V, § A, p. 82; Part 2.11 Sexual Abuse and Assault Prevention and Intervention, Part IV, § E, p. 151.

The PBNDS require that all new employees shall be provided training before assuming any duties.[237] Facility staff reported that detention and civilian staff undergo a two-week pre-service training and one-week in-service training. Staff also reported that detention staff receive an additional week and two days of pre-service training.

2. Use of Force

The PBNDS establish that facility staff may use force and restraints when necessary and reasonable after all efforts to otherwise resolve a situation have failed.[238] Cal DOJ and its immigration detention expert reviewed all use of force files documenting incidents that occurred since Cal DOJ's last site visit. The review showed that the incidents mostly complied with the PBNDS with some areas requiring improvement including management of detainees with special or mental health needs and use of de-escalation.

Facility leadership had reviewed each of the six use of force incidents files that Cal DOJ reviewed. In one instance, facility leadership determined that a use of force was unnecessary, resulting in a separate assessment for disciplinary action against the involved detention officers. This was consistent with PBNDS requirements.[239] However, Cal DOJ identified one incident in which mental health issues were not assessed, and at least two incidents in which there was no attempt at de-escalation. In one calculated use of force incident, facility staff failed to use appropriate gear.

3. Requests and Grievances

The PBNDS require that every facility maintain a procedure to protect detainee rights and provide a process for informal and formal grievances, which should be explained to detainees in a language or manner they understand.[240] However, at Golden State, file review indicated that facility staff did not always respond to grievances in the detainee's preferred language. Cal DOJ's review of a sampling of files showed that Golden State did not always maintain copies of detainee requests. During a January 2025 inspection, ODO found that Golden State did not track informal grievances or their resolutions, in violation of the PBNDS,[241] which require that all grievances be logged with the date, name of detainee, nature of the grievance, date a decision was provided to the detainee, and the outcome.[242]

Detainees shared challenges in dealing with and understanding the grievance process. One detainee reported that he was still waiting to receive a pair of sweats or shorts, despite having asked over a week before the interview. Another detainee reported that he was never informed how to file a grievance and despite seeing the tablets in the unit, was unsure how to use them to submit a grievance. One detainee reported that the handbook included a section on the grievance process but he remained unclear on the process.

4. Staff and Detainee Relations

PBNDS maintains standards for staff-detainee communications, and encourages informal, direct, and written contact and informal supervisory observation of living and working conditions.[243] Per PBNDS, detainees should have frequent opportunities for informal contact with supervisory and managerial facility staff.[244] During interviews with Cal DOJ, detainees described varied experiences with facility staff. One detainee reported that some staff are "nice," and "treat them with dignity." However, some interviewed detainees also described staff as unresponsive, inconsistent in how they apply the facility

237 ICE, PBNDS 2011, Part 7.3 Staff Training, Part V, § B, pp. 454-455.
238 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part I, p. 200.
239 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, § P, pp. 212-213.
240 ICE, PBNDS 2011, Part 6.2 Grievance System, Parts I-II, p. 414-415, Part V, § B, pp. 414, 415-416.
241 ICE, *Golden State Annex Unannounced Compliance Inspection* (Jan. 2025), *supra*, p. 10.
242 ICE, PBNDS 2011, Part 6.2 Grievance System, Part V, § D, p. 419.
243 ICE, PBNDS 2011, Part 2.13 Staff-Detainee Communication, Part I, p. 188.
244 ICE, PBNDS 2011, Part 2.13 Staff-Detainee Communication, Part II, p. 188, Part V, § A, p. 189.

rules with detainees, disrespectful during sleeping hours, and generally dismissive of any requests for basic items. One detainee further reported that if he filed any grievance or informal report, he felt he would be retaliated against.

Five detainees reported being verbally abused by staff. For example, one detainee described a detention officer who turns on the lights during sleeping hours and yells at the entire housing unit. Another detainee reported that two detention officers were particularly hostile and would call the detainees "animals" and scream that they deserved to be there. None of the detainees interviewed reported being physically hurt by staff at Golden State.

5. Language and Culture

Language access did not appear to meet the needs of the Golden State population or comply with the PBNDS. The PBNDS require that all facilities provide language access to limited English proficient detainees to ensure meaningful access to programs and activities.[245] During a discussion with Cal DOJ's immigration detention expert, facility leadership shared that GEO Group's language line service contract affords access to seven languages. During interviews, facility staff were dismissive of GEO Group's language access shortfall, noting that ICE's handbook is available in 17 languages. Nonetheless, Golden State falls far short of the PBNDS requirement that a facility must provide limited English proficient detainees with language assistance including bilingual staff and professional interpretation or translation services.[246]

Detainees described multiple language access concerns. While tablets in housing units offered some language access, the limited number of tablets and limited understanding of the tablet programs left detainees without many options. Two detainees reported challenges to understanding rules and tablet programs, despite speaking a more resourced language (i.e. Spanish). Two detainees reported that they still did not understand how to use the tablets in their unit, and another detainee reported that the audio was difficult to hear even when using the language line services at the facility. One detainee shared that he was the only person in the facility who spoke a specific language and felt particularly isolated by his inability to communicate with anyone, as orientation handbooks and library materials did not appear to be available in the language he spoke.

Golden State also relied on detainees to interpret on behalf of other detainees, a practice that is inconsistent with PBNDS requirements that bilingual staff or qualified interpretation or translation services are used when communicating with limited English proficient detainees.[247] One detainee reported that they learned rules and processes from other detainees.

6. Prison Rape Elimination Act (PREA)

The Prison Rape Elimination Act (PREA), which applies to detention facilities, was passed in 2003 to reduce sexual abuse in prisons and create a "zero-tolerance standard" for rape in prison.[248] Facility staff reported that Golden State completed a PREA re-certification the week before Cal DOJ's visit. Facility staff also reported that, while there are no set PREA investigators, there is a full-time PREA coordinator and two other management staff who are trained PREA investigators. During the tour of the facility, Cal DOJ found that staff made necessary announcements to notify male detainees of a female individual entering the housing unit, or vice versa, as required by PREA. Toilet and shower areas in the housing units that were toured by Cal DOJ had privacy curtains on all shower stalls, which also is required by PREA. However, one detainee reported that while the shower curtains provided enough privacy, the toilet areas did not afford sufficient privacy.

245 ICE, PBNDS 2011, Part 2.13 Staff-Detainee Communication, Part II, p. 188.
246 ICE, PBNDS 2011, Part 2.13 Staff-Detainee Communication, Part II, p. 188, Part V, § B, p. 189.
247 ICE, PBNDS 2011, Part 2.13 Staff-Detainee Communication, Part V, § B, p. 189.
248 34 U.S.C. § 30302; see also *U.S. v. Mujahid* (9th Cir. 2015) 799 F. 3d 1228, 1233.

E. Access to Social and Programming Opportunities

1. Contact with Family and Legal Representatives

Golden State appeared to offer multiple opportunities for non-legal visitation, phone calls, and written contact. Visitation is available seven days a week and most detainees have access to contact visits with family and friends, unless visitation is restricted to non-contact visits for disciplinary, safety, or other reasons. Golden State provided more opportunities for visitation because visitation is split between the two housing wings.[249] Golden State had a large visitation room with ample seating for contact visits and an area with four booths for non-contact visits. During detainee interviews, five (16%) of the detainees interviewed shared that they had family or loved ones visit them in person while at Golden State. Four detainees (13%) also reported having in-person visits with their attorneys.

During a tour of the facility a phone listed fees for phone access, which included $1.20 to leave a voicemail message, $.07 per minute for a debit call, $.11 per minute for a collect call, $.15 per minute for international landline calls, and $.35 per minute for an international mobile call. These rates are reportedly set by Talton Communications, which is also ICE's contractor for the tablets available to detainees.

All detainees interviewed reported that they had been able to contact family or loved ones since arriving at Golden State. Most contact was conducted via telephone call (30; 94%) and/or video conference (12; 38%), and some in-person visits (5; 16%). However, 11 detainees (34%) reported there were issues contacting loved ones. Some detainees shared that it was too expensive to call family by phone and two who were able to call said it was sometimes difficult to hear due to poor sound quality on the facility phones. Although videochat had better sound, it was more expensive to use. Additionally, Cal DOJ only observed instructions for phone use in English and Spanish, which likely contributed to the issues with detainees contacting family and loved ones. One detainee reported using alternate means to communicate with family abroad, including by calling a friend in the U.S., who then contacts the detainee's family. Additionally, another detainee reported he was not able to contact family or loved ones during the first four days at Golden State because the code they were provided was not working.

2. Programming and Recreation

Cal DOJ found there were limited social and programming opportunities for detainees at Golden State. Cal DOJ observed some evidence of programming and daily recreation options available to detainees, including an outdoor recreation space with a soccer field, a dirt track, and various stationary exercise equipment. Staff reported that there is also a second, smaller, outdoor recreation space with a basketball court. Cal DOJ also toured an indoor recreation room with a foosball table, an air hockey table, table tennis, books, and some weights. Indoor recreation activities were available to detainees based on a schedule with rotating access to each housing unit. A sign posted in the room stated that capacity is limited to eight people. It was unclear how multiple housing units of 86-88 detainees would be rotated through the space.

249 ICE, *Golden State Annex Hours of Visitation* (updated Feb. 24, 2026) <https://ice.gov/detain/detention-facilities/golden-state-annex> (as of March 26, 2026).

Figure 22. Indoor Recreation Space at Golden State

The PBNDS require that in facilities with an outdoor recreation space, detainees should have access to least one hour of outdoor recreation per day, seven days per week.[250] Several detainees reported that they were pleased with the outdoor recreation space which had a soccer field, handball courts, and exercise machinery. However, during interviews detainees reported that access to outdoor recreation was suspended for about two weeks after an attempted escape, and outdoor recreation was only recently restored after a one or two-week suspension. One detainee reported that after first arriving, outdoor recreation was provided for three hours per day, but recently had been reduced to one hour.

Other programming included detainee-initiated programs and religious services offered by third-parties one to two times per week. During the visit, Cal DOJ observed one group of detainees engaged in a class to learn English, which was taught by another detainee.

According to facility staff, each housing unit had 15 tablets for use by 88 detainees, which provided access to courses and self-help programs, and allowed detainees to watch movies for a fee. The ratio of tablets to detainees was a source of frustration, particularly in units where staff do not regulate tablet use. One detainee explained in an interview that when they get access, tablets are not charged or are disconnected (offline). Another detainee reported that in his unit, there were only twelve tablets for 80 people to share, but the internet connection drops, making them even more difficult to use. Cal DOJ observed and facility staff shared that housing units also maintained distraction items for detainees, including televisions, board games, puzzles, books, and an Xbox video game console. Detainees also had access to a facility library.

250 ICE, PBNDS 2011, Part 5.4 Recreation, Part II, p. 370, Part V, § B, p. 371.

3. Voluntary Work Program

The facility has a Voluntary Work Program through which detainees can be paid $1 per day to perform various tasks around the facility. The PBNDS require that detainees be able to volunteer for work assignments but otherwise should not be required to work, except to perform personal housekeeping.[251] The facility reported that at the time of Cal DOJ's visit, there were 20 detainees in the program. Detainees reported being aware of the work program. One detainee reported that the housing unit is clean because detainees clean the facilities themselves. Another detainee shared that those who participated in the program from their respective unit did not do a good job. It was not clear from detainee reports and facility staff interviews how available the Voluntary Work Program was to interested detainees, and whether detainees who cleaned the housing units were receiving compensation.

VI. Due Process

Cal DOJ also evaluated due process rights of detainees held at Golden State. Golden State appeared to maintain some access to legal services, but Cal DOJ found some obstacles to accessing legal resources based on limited language access and limited resources.

A. Access to Legal Services and Representation

Facility staff reported that the California Collaborative for Immigration Justice (CCIJ) continues providing a monthly "Know Your Rights" presentation, which detainees can sign up to attend. As discussed above in the Legal Orientation Programs Section, federal funding for types of legal orientation presentations was terminated in April 2025 and the issue is in litigation. However, these legal presentations were still available to detainees at Golden State as of September 2025.

Thirteen of 32 detainees who were interviewed (41%) reported that they were represented by an attorney or other legal representative. Seventeen detainees (53%) reported that they were unrepresented. Ten of the 13 detainees who were represented (77%) reported that they had been able to communicate with their attorney. These 10 detainees reported they used telephone calls (9; 90%), videoconference calls (6; 60%), and/or in-person visits (4; 40%) to communicate with their representatives. One detainee further reported receiving documents personally during an attorney visit.

Two detainees identified due process concerns at Golden State, including difficulties in being able to use the phone system to communicate with a legal representative. One detainee detailed having to wait two weeks to speak with his attorney. Another detainee reported that the code he entered for phone access was not working.

B. Access to Materials Needed for Immigration Case

Detainees at Golden State can receive contact legal visits seven days a week with the opportunity to pass legal papers. During interviews, three detainees reported they have sent or received documents to or from their attorney. Out of these three, only one reported issues in sending or receiving the documents. For detainees who reported attempting to represent themselves, legal research is available on discs in English only and periodically updated by ICE but available in several terminals in each of their law libraries. The discs available during our site visit were dated July 18, with no year indicated, and staff reported that they are only updated when new materials are received, but staff were unaware of how frequent updates occurred.

251 ICE, PBNDS 2011, Part 5.8 Voluntary Work Program, Part II, p. 405, Part V, §§ A, C, p. 406.

Figure 23. Library at Golden State

There were also limitations for detainees to visit the library and access necessary resources. During a facility tour, Cal DOJ also observed a general information center in the hallway connecting the four units in Housing Wing A. However, there were no postings regarding *Franco-Gonzalez v. Holder*[252] and no posting was observed inside the housing unit Cal DOJ toured. During detainee interviews, one detainee shared that it was difficult to get access to the library as the units each get one hour of access per day, but only eight of the over 80 people in the unit get to visit during that one hour slot. While there was a sign-up sheet and schedule, it is first-come/first-serve. Another detainee reported that he was in the process of applying for a U visa, and the information available at the facility was outdated (from 2020). The detainee further reported that after making a request for updated resources, the facility refused to accommodate him.

VII. Health Care

Golden State operates a medical unit which has separate spaces to allow for privacy during medical exams. Cal DOJ and its medical expert reviewed processes for required examinations, continuity of care and specialty referrals, staffing, and overall medical concerns as part of this report, finding deficiencies with several aspects of Golden State's health care including timely assessments and evaluations, disruptions in continuity of care, and inadequate staffing to serve the detainee population.

A. Intake assessments, evaluations, and diagnoses

The PBNDS require that after intake, the facility's medical staff must conduct a comprehensive health assessment, including a physical examination and mental health screening within 14 days of arrival if no concerns are identified at intake or within two working days when screening indicates a need

252 The permanent injunction under *Franco-Gonzalez v. Holder* provides that detainees diagnosed with certain mental health disorders be appointed an attorney, among other processes, and that facilities post information notifying detainees of the settlement. *Franco-Gonzalez v. Holder* (C.D.Cal. Apr. 23, 2013, No. CV-10-02211-DMG (DTBx)) 2013 WL 8115423; *Franco-Gonzalez v. Holder* (C.D.Cal. Oct. 29, 2014, No. CV-10-02211-DMG (DTBx)) 2014 WL 5475097.

for care.[253] Cal DOJ's medical expert found that comprehensive assessments occurred according to inconsistent patterns. Of 15 charts reviewed, five detainees received assessments outside the mandated time frames, including in some cases where screening had indicated elevated blood pressure or other needs for time-sensitive follow-up. Eight occurred within PBNDS time frames, and two did not need assessments due to detainees been recently held at other facilities.

Detainees reported inconsistencies in the timing of these evaluations. Seventeen of the 32 detainees interviewed (53%) reported receiving a comprehensive health assessment within the 14-day time frame. Seven detainees (22%) reported that they did not undergo a comprehensive assessment within the required time frame, and six detainees (19%) were unsure if or when they received their comprehensive assessment. Two detainees (6%) reported that the medical evaluation occurred approximately two to three weeks after their arrival.

Similarly, Cal DOJ found inconsistent timeliness in responses to detainees who requested medical and mental health services while housed at Golden State. Eighteen detainees (56%) reported that they had submitted specific requests for medical or mental health services. Half of those 18 detainees indicated that they received the requested help, while the other half reported that they did not receive the care requested. One detainee reported that he specifically requested a mental health appointment about three to four weeks prior to the interview and had not heard back. Another detainee reported that he requested mental health services and it took four to five days to get an appointment. Two detainees reported not receiving timely care for skin infections.

File review revealed similar inconsistencies in addressing medical requests (also referred as the sick call process). Sick call requests appeared to increase between Cal DOJ's 2023 visit, from an average of 8-10 requests per night to 20-40 requests per night in 2025. While the increased number of sick calls is expected given that the population increased from 159[254] to 569 between Cal DOJ's 2023 and 2025 site visits, the increase has resulted in some delays to care. Cal DOJ's medical expert reviewed the paper sick call requests that are saved in detainee health records at Golden State. From these, six (75%) received responses within 24 hours. However, some charts indicated missing sick call slips or delays in urological care where prompt and/or same-day responses would have been appropriate. For example, file review revealed that one detainee reported urinary symptoms after an intake exam, but medical staff did not collect a urine sample until nine days after the issue was reported by the detainee. Medical chart review also included instances of timely and appropriate treatment, along with accommodations for language, mobility, diet, and housing needs.

Mental health care access appeared improved from Cal DOJ's 2023 site visits as detailed in Cal DOJ's 2025 report focusing on mental health care.[255] Cal DOJ's medical expert considered mental health during chart review. In one instance a detainee was appropriately referred to mental health after reporting a history of a suicide attempt and abuse. However, there was no note in the medical chart indicating that the visit occurred, which is required under PBNDS.[256] Other charts indicated timely care, and Cal DOJ's medical expert noted one case in which medical providers responded sensitively and collaboratively to the needs of a patient with a personality disorder diagnosis. However, one detainee reported that he had waited over a month for a response to a request for mental health care and had not yet received care at the time of Cal DOJ's site visit.

253 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § M, p. 268.
254 *Immigration Detention in California* (Apr. 2025), *supra*, p. 52.
255 *Id.* pp. 54-66.
256 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, pp. 266-268.

B. Continuity of Care, Sick Call, and Referrals to Outside Care

1. Chronic Care and Continuity of Care

Ongoing care for detainees with chronic conditions also showed inconsistencies. A review of four medical charts of detainees with diabetes and/or hypertension showed that two of the four patients experienced lapses in care. While some lapses were disruptions in prescription medication, other lapses were due to a lack of necessary lab work and a substantial delay for a specialty referral. This delay was raised to medical staff by Cal DOJ's medical expert during the site visit. Charts at times reflected interruptions in care due to transfer into or out of the facility. In one case, a detainee with diabetes showed elevated blood sugar levels at intake screening, but did not receive insulin for over 24 hours after this screening. Another patient reporting use of cholesterol medication during intake had not yet received a prescription one month later, though other medications the same detainee reported during intake had been filled.

Reports from detainees regarding their medication experience at the facility suggest interruptions to existing prescriptions upon arrival, and inconsistent communication with detainees about medication changes. During Cal DOJ's 2025 site visit, only two of eleven detainees (18%) interviewed who had arrived with medication or ongoing medical treatment confirmed they were receiving the same medication or treatment as prior to their arrival at Golden State. Seven detainees reported receiving different medication or treatment than before they had arrived; two of those seven reported that they were not informed of the change to their medication or treatment. Of the seven who received new medication or treatment, four detainees reported that their new medication or treatment was not as effective as what they had been previously prescribed. Some detainees reported receiving medication promptly after intake, while others reported delays or not receiving medication they reported needing at intake. One detainee reported waiting two months to receive a prescription for blood pressure medication that the detainee reported to the intake clinician.

Figure 24. Medicine Supply at Golden State

2. Outside Referrals

Cal DOJ's medical expert also found delays when detainees are referred to outside care. The PBNDS require that every facility shall directly or contractually provide its detainee population with specialty health care.[257] Medical staff did not acknowledge prolonged timelines for outside care, and at least some specialty care was completed appropriately, such as an epilepsy case requiring neurology care,

257 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § A, p. 260.

and a case in which a detainee required oral surgery. However, there were concerns with specific patient experiences. Cal DOJ's medical expert reviewed one medical chart where the facility had appropriately requested a consultation to rule out cancer, which ICE had initially denied but ultimately approved four months later after first requiring an ultrasound. In another case also described above under *Chronic Care and Continuity of Care*, facility staff had failed to make an ophthalmology referral to address a critical vision concern. In both cases patient wait times were not appropriate for the urgency of the conditions.

C. Staffing

Despite a substantive increase in the population in 2025, staff denied making commensurate adjustments to medical staffing to accommodate shifts, though medical staffing levels were higher than they had been at the time of Cal DOJ's 2023 site visits.[258] At the time of the 2025 site visit, facility administration reported that the medical unit was 96% staffed with a doctor, two advanced practitioners (both certified nurse practitioners), seven full-time registered nurses (RNs), five part-time RNs, six full-time licensed vocational nurses (LVNs) and two part-time LVNs. Mental health staff consisted of one psychologist and one psychiatrist, who provided telepsychiatry services. However, the psychiatrist provided one eight-hour shift per week of telepsychiatry, which Cal DOJ's medical expert assessed as being insufficient to cover the expected need of the population.

A dentist and dental assistant provided on-site services two days per week. However, one detainee reported, and file review corroborated, a wide range of wait times for dental care. Some detainees were able to receive timely extractions or other care while others waited for periods of two to three months.

Quality improvement appeared to occur to some degree driven by GEO Group corporate staff, but the facility did not appear to have an established internal process of quality improvement review. Staff reported not having emergency drills and rather relying on the regularity of actual urgent or emergent response situations to keep skills fresh, which is not best practice to ensure staff development.

258 *Immigration Detention in California* (Apr. 2025), *supra*, p. 66 (listing one nurse practitioner, three full time RNs, seven part time RNs, and seven LVNs).

9. Mesa Verde ICE Processing Center

I. Introduction and Summary of Key Findings

Given the rapid increase in detainees held in immigration detention facilities within the state, Cal DOJ conducted a site visit of the Mesa Verde ICE Processing Center (Mesa Verde) on September 25-26, 2025, to ensure that the health and safety of those detained is not compromised under these changing conditions. Following the expiration of a COVID-related injunction in June 2025, as discussed below, coupled with increased immigration enforcement throughout the state during the same period, Cal DOJ found that the detainee population within Mesa Verde substantively increased compared to Cal DOJ's last site visit in 2023. Cal DOJ also observed large movements of detainees into and out of Mesa Verde starting in June 2025 and, as a result, all detainees at the facility during Cal DOJ's visit arrived in June 2025 or after. Thus, the information Cal DOJ could assess from detainee interviews and file review was limited in scope to June 2025 and after.

Based on its review, Cal DOJ made the following key findings:

- Mesa Verde's detainee population increased eightfold (from 41 to 370 detainees) from May 1, 2023, to September 25, 2025.[259] As of September 25, 2025, the detainee with the longest length of stay at Mesa Verde arrived on June 10, 2025.

- The frequency of detainee intakes and departures adversely impacted the processes by overwhelming the staff and space. Detainees described inhumane intake conditions including lack of toileting privacy or any division between toileting, eating, and sleeping areas.

- At the time of Cal DOJ's September 25, 2025 site visit, a majority (234; 63%) of the detainee population was classified as Low custody.

- Mental health and initial female health care intake assessments did not consistently occur within the timelines mandated by the PBNDS for such assessments, including in some cases where health care screenings indicated a need.

- While GEO Group did not provide complete staffing information as requested by Cal DOJ to assess staffing adequacy, Cal DOJ's review of the information that was provided indicated that nursing staff had to work overtime to provide for detainee needs.

- The provision of medical care was compromised and delayed by: (1) delays in approvals of referrals for specialty and outside care; and (2) cancelled or dropped referrals due to transfers of detainees between facilities. The absence of proper quality assurance procedures also contributed to the facility not identifying medical service concerns and taking corrective actions.

- Mesa Verde appeared to have abdicated responsibility for the maintenance of housing units and shifted it onto detainees.

- Detainees consistently reported issues with the quality and quantity of food, as well as access to clean potable water, and that they needed to supplement their diet by purchasing food from the commissary.

259 *Immigration Detention in California* (Apr. 2025), *supra*, p. 80 (41 detainees); Cal Dept. of Justice, Office of the Attorney General, *Immigration Detention in California* (July 2022) <https://oag.ca.gov/system/files/media/immigration-detention-2022.pdf?> p. 12 (as of Apr. 2, 2026) (45 detainees).

II. Facility Background

Mesa Verde, located in Bakersfield, California in Kern County, is operated by GEO Group. ICE began detaining immigrants at Mesa Verde in 2015 through an Intergovernmental Services Agreement (IGSA) with the City of McFarland.[260] The facility's contract was converted from an IGSA to a direct contract with GEO Group in December 2019 after the City of McFarland terminated the contract following changes in state law. Although Golden State is listed as an annex to Mesa Verde in the contract with ICE,[261] Golden State is not physically proximate like Adelanto and Desert View, GEO Group's other two civil immigration detention facilities in California. Instead, GEO Group treats its Mesa Verde and Golden State facilities as distinct and thus this report discusses them separately.[262] Mesa Verde also operates under the PBNDS.

Mesa Verde's maximum capacity is 400 detainees[263] and it houses both female and male adults. The last reported inspection of Mesa Verde was conducted by the Department of Homeland Security's Office of Detention Oversight (ODO) in April 2025.[264]

Table 13. Key Data Points, Mesa Verde ICE Processing Center

Facility:	**Mesa Verde ICE Processing Center**
Operator:	GEO Group
Housing Detainees Since:	2015
Bed Capacity:	400
Type(s) of Detainees Facility Can Hold:	Female and Male Adult Civil Detainees

III. Methodology and Limitations

Cal DOJ staff and experts, including a medical expert and immigration detention expert, visited Mesa Verde on September 25-26, 2025. The site visit was planned in response to reports of the rapid population increase at Mesa Verde and focused on the impact of this increase on conditions of confinement. Cal DOJ and its experts collected data and observed conditions at the facility, interviewed detainees and facility staff, and reviewed relevant documents and detainee files. Cal DOJ and its medical expert also interviewed the Health Services Administrator and Medical Director to complete review of detainee medical and mental health care.

Cal DOJ interviewed 24 individuals detained at the facility, chosen by selecting a sampling of detainees from each housing unit with a range of intake dates and lengths of stay, countries of origin, languages spoken, and custody levels. Cal DOJ also interviewed detainees who signed up to speak with Cal DOJ on notices posted in dormitories preceding the site visit. Cal DOJ interviewed detainees in their preferred language, either by Cal DOJ staff who are proficient in the language or through a telephone interpretation service. The languages used during the interviews included English, Spanish, and Mandarin.

260 DHS, Office of Inspector General, *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, CA* (Nov. 2, 2023) <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> p. 1 (as of Mar. 19, 2026). The City of McFarland is about 26 miles north of the City of Bakersfield, both located in Kern County.

261 While the new Mesa Verde contract expanded the total bed capacity, it did so by incorporating both Central Valley and Golden State as "annexes." Mesa Verde itself, through this contract, remained limited to a capacity and guaranteed minimum of 400 immigration detainees, while the two annexes would each house 700 detainees. DHS, ICE Budget Overview, *Fiscal Year 2022 Congressional Justification, Operations and Support* (2022) <https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf> p. 118 (as of Apr. 2, 2026).

262 Central Valley is not currently being used to house ICE detainees, so that facility will not be discussed in this report despite it being an "annex" to Mesa Verde.

263 ICE FY24 Detention Statistics (Oct. 2024), *supra*.

264 ICE, Office of Detention Oversight, *Mesa Verde ICE Processing Center Inspection* (April 15-17, 2025) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/2025-MesaVerdeIPC-BakersfieldCA-April.pdf> (as of Mar. 19, 2026).

Despite the ability and capacity of the facility to allow contact interviews, facility staff informed Cal DOJ that the ICE field office only allowed non-contact interviews. Thus, interviews were conducted by teams of two Cal DOJ team members through plexiglass dividers and phones, in three side-by-side non-contact booths within the attorney interview room. Due to the size of the interview area and the number of booths, the private and confidential nature of Cal DOJ's interviews may have affected detainee's willingness to share the most genuine and personal details. The use of phone translation services also negatively affected interviews because the interpreter had difficulty hearing the detainees' responses.

Figure 25. Non-Contact Visitation Space at Mesa Verde, 2023

IV. Detained Population

At the time of Cal DOJ's 2025 visit, the facility housed 370 detainees. In previous visits, female detainees had been held at Mesa Verde[265] but there were no female detainees during Cal DOJ's last visit in May 2023.[266] At that time, the facility held only 41 male detainees.[267] However, at the time of Cal DOJ's 2025 visit, the facility housed 259 male and 99 female detainees, and 12 detainees for whom information about sex is unclear.

On Cal DOJ's September 25, 2025 visit, detainees at Mesa Verde represented 44 different countries. The top 10 countries of origin were Mexico (61 detainees); India (51); Ecuador (24); Guatemala (22); El Salvador (21), Peru (20); China (19); Colombia (17); Nicaragua (16); and Vietnam (14). The average age of detainees present on September 25, 2025 was 35.9 years old, with the youngest being 18 years old, and the oldest being 71 years old.

265 Cal Dept. of Justice, Office of the Attorney General, *Immigration Detention in California* (Feb. 2019) <https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2019.pdf> p. 16 (as of Apr. 17, 2026); Hendricks, *'Waste of Federal Funds': ICE Ends Contract With Northern California Jail After Years of Outrage Over Conditions*, KQED (Dec. 9, 2022) <https://www.kqed.org/news/11934879/waste-of-federal-funds-ice-ends-contract-with-norcal-jail-after-years-of-outrage-over-conditions> (as of Mar. 19, 2026).
266 *Immigration Detention in California* (Apr. 2025), *supra*, p. 80.
267 See *Id.* at pp. 79-80.

Table 14. Snapshot of Detainees Housed at Mesa Verde on September 25, 2025

Total Population:	370
No. of Countries of Origin:	44
No. of Female Detainees:	99
No. of Male Detainees:	259
No. of Other/Unclear Detainees:	12
Average Age:	36 years
Average Length of Detention:	29 days
Longest Length of Detention:	107 days

End of Class Settlement Agreement Impacted the Number of Detainees at Mesa Verde.

Mesa Verde's detainee population of 370 represents an over eightfold increase in population since Cal DOJ's last visit in May 2023 when it held 41 male detainees.[268] The detainee population at Mesa Verde was previously limited under an injunction in the case *Zepeda Rivas v. Jennings* (*Zepeda*).[269]

On April 20, 2020, detainees at Mesa Verde filed a class action alleging that conditions at the facility violated their constitutional rights by exposing them to unreasonable risks of infection and death from COVID-19, due to unsanitary and crowded conditions.[270] Plaintiffs secured two injunctions in June and December 2020 related to COVID-19, establishing bail for some detainees and safety protocols inside Mesa Verde.[271]

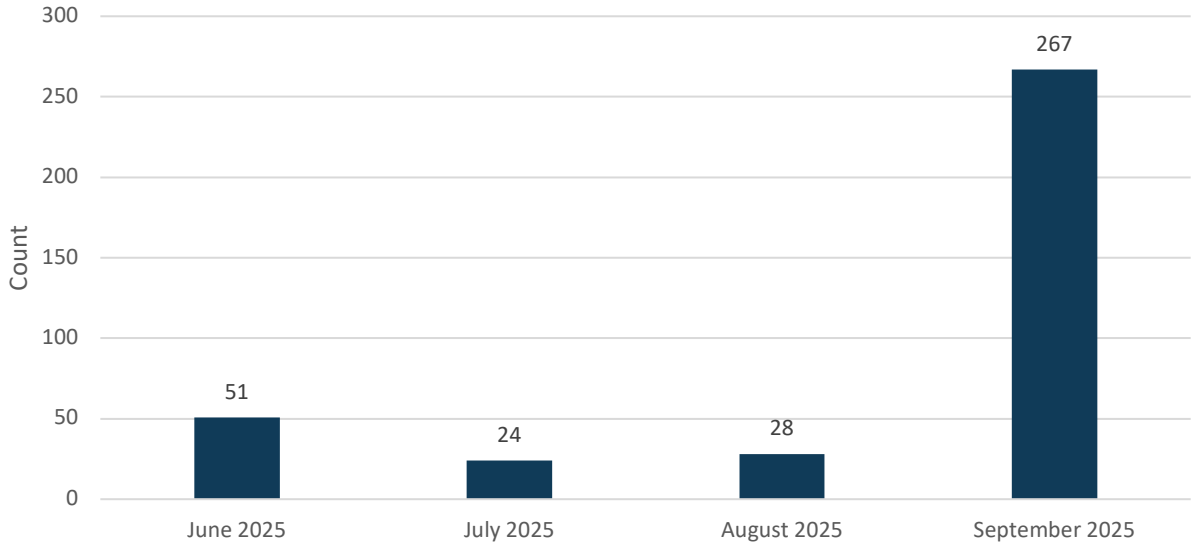
On January 27, 2022, the parties moved to settle the matter.[272] Pursuant to the *Zepeda* settlement, for three years following the effective date of June 9, 2022, Mesa Verde agreed to certain safety measures to protect detainees from COVID-19, and ICE agreed not to "re-detain" any non-detained class members released under the court's previous injunctions, unless they fell into certain exceptions listed in the settlement.[273] Additionally, the *Zepeda* settlement required the facility to refrain from implementing any guidance which may permit the facility's population to rise above those levels permitted by the previous injunctions in the case for 60 days following the effective date.[274] As a result, with the *Zepeda* settlement in place, during Cal DOJ's November 2021 and May 2023 site visits there were only 45 detainees[275] and 41 detainees[276] present at the facility, respectively.

ICE increased its immigration enforcement efforts in Los Angeles and throughout the state, at the same time as the cap on detainees under the *Zepeda* settlement was set to expire on June 9, 2025.[277]

268 *Immigration Detention in California* (Apr. 2025), *supra*, p. 80.
269 *Zepeda Rivas v. Jennings* (N.D.Cal. June 9, 2020, No. 20-cv-02731-VC) ECF No. 357.
270 *Zepeda Rivas v. Jennings* (N.D.Cal. Apr. 20, 2020, No. 3:20-cv-02731-VC) ECF No. 1 (Complaint); *Zepeda Rivas v. Jennings* (N.D.Cal. Jan. 27, 2022, No. 3:20-cv-02731-VC) ECF No. 1205-1 (Settlement Agreement).
271 On June 9, 2020, the court issued a preliminary injunction which initiated a bail process allowing detainees to be temporarily released, and that ordered defendants to provide the plaintiffs with detailed, current information concerning conditions affecting the health and safety of detainees. *Zepeda Rivas v. Jennings* (N.D.Cal. June 9, 2020, No. 3:20-cv-02731-VC) ECF No. 357. On December 3, 2020, the court issued a second preliminary injunction establishing distancing, quarantine, intake and testing protocols for the protection of the detainees and staff at Mesa Verde. *Zepeda Rivas v. Jennings* (N.D.Cal. Dec. 3, 2020, No. 3:20-cv-02731-VC) ECF No. 867.
272 *Zepeda Rivas v. Jennings* (N.D.Cal. Jan. 27, 2022, No. 3:20-cv-02731-VC) ECF No. 1205-1 (Settlement Agreement).
273 *Id*. at pp. 10-14, 20. Although the settlement agreement was filed on January 27, 2022, and signed by the parties between December 14 and December 17, 2022, the effective date was delayed until the agreement was accepted by the court following a fairness hearing. See *Zepeda Rivas v. Jennings* (N.D.Cal. June 9, 2022, No. 3:20-cv-02731-VC) ECF No. 1258 (Order Granting Motion for Final Approval of Settlement).
274 *Zepeda Rivas v. Jennings* (N.D.Cal. Jan. 27, 2022, No. 3:20-cv-02731-VC) ECF No. 1205-1, p. 7 (Settlement Agreement).
275 *Immigration Detention in California* (July 2022), *supra*, p. 12.
276 *Immigration Detention in California* (Apr. 2025), *supra*, p. 80.
277 *Zepeda Rivas v. Jennings* (N.D.Cal. Jan. 27, 2022, No. 3:20-cv-02731-VC) ECF No. 1205-1, p. 23 (Settlement Agreement)

The roster provided to Cal DOJ shows the first arrival date for individuals detained at Mesa Verde as of September 25, 2025, was June 10, 2025. Facility staff reported that before the expiration of the *Zepeda* settlement, the facility only held 53 detainees but that by the end of June 2025 it held 387 detainees. Thus, the population of the facility increased about 630% between May and June 2025, according to facility administration. As shown in **Figure 26**, a review of arrival dates for detainees held at the facility on September 25, 2025 indicates that Mesa Verde experienced a second surge of new arrivals in September 2025, with over 70% of its population as of Cal DOJ's site visit arriving in September 2025. As of Cal DOJ's September 25, 2025 site visit, detainees' length of detention ranged from zero (i.e. the detainee arrived the day the roster was created) to 107 days, with an average of 29.2 days.

Figure 26. Arrival Month of Detainees on September 25, 2025 Roster at Mesa Verde



These numbers are not a complete account of the detainees held at the facility in 2025. Rather, they only reflect the population at the time of Cal DOJ's site visit.

Effect of Conditions of Confinement on the Detained Population.

Detainees who spoke to Cal DOJ expressed that the conditions they have experienced have negatively affected their mental health. **Detainees expressed to Cal DOJ a sense of confusion and betrayal, leading to feelings of depression and despair because they cannot understand why they are being held in detention, or why they are experiencing these conditions of confinement.** One detainee expressed to Cal DOJ that they felt tricked because they have no criminal record, paid taxes, yet they are now separated from their family and experiencing inhumane treatment. Detainees also expressed struggling with the fact that after spending years paying taxes, working and living above-board, and starting families, they were now in detention and purportedly considered a danger to their own communities. Detainees expressed worry and stress about the uncertainty their detention has brought to their families, some of whom are United States citizens.

Detainees interviewed by Cal DOJ reported having Lawful Permanent Resident status (4; 17%) or otherwise being in the process of gaining that status, including being asylum applicants or recipients (4; 17%); having statuses that accorded them work permits (3; 13%); and being DACA recipients (1; 4%). And yet they remain detained.

(by its own terms, settlement was set to terminate three years from its effective date); see also *Zepeda Rivas v. Jennings* (N.D.Cal. June 9, 2022, No. 3:20-cv-02731-VC) ECF No. 1258 (order granting motion for settlement with effective date of June 9, 2022).

Further, detainees also complained about being treated poorly over the course of detention. One detainee described sleep deprivation due to noise and crowding in housing units. Another described being fearful to speak to Cal DOJ and report conditions because of the fear instilled in them while in detention. Multiple detainees also reported that repeatedly being moved between facilities and across the United States erodes their mental health; prevents their families from knowing where they are and contacting them; and further instills a sense of fear, confusion, separation, and isolation.

V. Conditions of Confinement

Conditions of confinement consist of various factors, policies, and protocols that affect the experiences of detainees, including the provision of health care and mental health. The conditions reviewed below include: 1) intake process; 2) food, nutrition, and access to water; 3) housing units; 4) detention and safety; and 5) access to social and programming opportunities.

As explained in this section, Cal DOJ found several deficiencies, including but not limited to an unpredictable intake environment, resulting in a lengthy and overcrowded intake process. Detainees also reported deficiencies related to food and access to clean and potable water; reported issues with unsanitary bathrooms and showers; an apparent abdication of the responsibility to maintain the housing units, leaving this burden to detainees; and strained relations between detainees and staff.

A. Intake Process, Security Classification, and Departures

1. Intake Process

Within 12 hours of arriving at the facility and before placement in a housing unit, the PBNDS require detainees to receive an initial medical, dental, and mental health screening, be assigned a security classification, receive clothing and personal hygiene items, and then be assigned to a housing unit.[278] During this time, detainees in the intake process are to be kept separated from the detainee population that has already been assigned a permanent housing unit; ICE's stated reason for the initial segregation is to protect the "safety, security and good order of the facility."[279]

The intake space at Mesa Verde contains four cells, with the total capacity of holding seven people. Three of the cells are used for holding detainees, with one cell capable of holding one individual and the other two capable of holding up to three individuals each. The fourth cell is an ADA cell that has a shower. According to facility staff, the ADA cell is left unoccupied and offered to incoming detainees to shower.

278 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ A-B, pp. 50-51; Part 2.2 Custody Classification System, Part V, § D, p. 63; Part 4.3 Medical Care, Part V, § J, p. 266.
279 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § A, p. 50.

Figure 27. Intake Cell at Mesa Verde

The increase in detainees at Mesa Verde starting in June 2025 appears to have created a chaotic, unpredictable intake environment, resulting in a lengthy and overcrowded intake process. During the *Zepeda* settlement, the facility had set intake days. According to facility staff, after the expiration of the *Zepeda* settlement, Mesa Verde cannot predict when intakes may arrive and when it may handle a larger number of detainees. Staff reported that intake could see just two or three people at a time or as many as 20 to 30 persons either incoming or departing. As seen by Cal DOJ during its tour of the intake area, because the intake area has a capacity of holding just seven individuals, it cannot accommodate the larger groups. During large intakes, facility staff explained that detainees may be placed in chairs outside of intake in the hallway, as well as in an available room in the medical area. During these large intakes, facility staff sometimes use the dining hall for staging and/or processing intakes–often resulting in already-housed detainees having to eat their meals in their housing units. At the time of Cal DOJ's visit, the use of the dining hall for a large intake had recently occurred.

Figure 28. Dining Hall at Mesa Verde

Cal DOJ spoke to multiple detainees who reported being part of large intake groups. These detainees described intakes that involved over 85 people and being processed in the dining hall. Several other detainees stated they were placed in the same small cell within the intake area (meant to hold up to three people), in groups of 10 or 11 to 20-25 people.

Mesa Verde staff explained that when intake consists of 20 to 30 people, the 12-hour PBNDS requirement cannot be met. While 12 of the 24 detainees (50%) who spoke to Cal DOJ reported that their intake was completed in under 12 hours, six (25%) reported that intake took between 12 and 19 hours, two (8%) reported their intakes took one day to a day and a half, and two others (8%) reported they were in intake for three days. These staff and detainee reports align with Cal DOJ's review of the facility's roster. Cal DOJ's analysis, based on detainees at Mesa Verde as of September 25, 2025, showed that from September 1, 2025 to September 25, 2025, Mesa Verde received 267 arrivals and that, for example, on September 11, 2025, there were 84 detainees admitted into the facility.

While other detainees experienced intake in smaller groups, they nevertheless reported experiencing crowded conditions and a lack of privacy during intake. Both female and male detainees described having to sleep on the floor due to lack of space and being forced to relieve themselves in front of each other within intake groups of 10 to 15 people, during intake processes that lasted up to 18 hours. A female detainee who reported sharing a cell with 10 people, said that she had to eat and relieve herself in the same room with other members of her group for over 24 hours. A male detainee reported being in a cell with 11 people for over 18 hours, and described detainees having to take turns lying down, sitting, and standing due to lack of space. Another detainee reported sharing space with about 16 people, forcing some detainees to sleep on the toilet due to the lack of space. Additionally, two detainees reported being held in shackles, one during their over 8-hour intake process and the other as they waited in a van outside the facility waiting for intake to begin. Of the detainees who recalled spending three days in intake, one reported sharing the same cell with about six or seven individuals.

Despite the influx at intake and staff's depiction of intake as a "high-paced environment," according to facility staff there was only a "slight adjustment" to intake staffing to accommodate the increased population.

2. Orientation

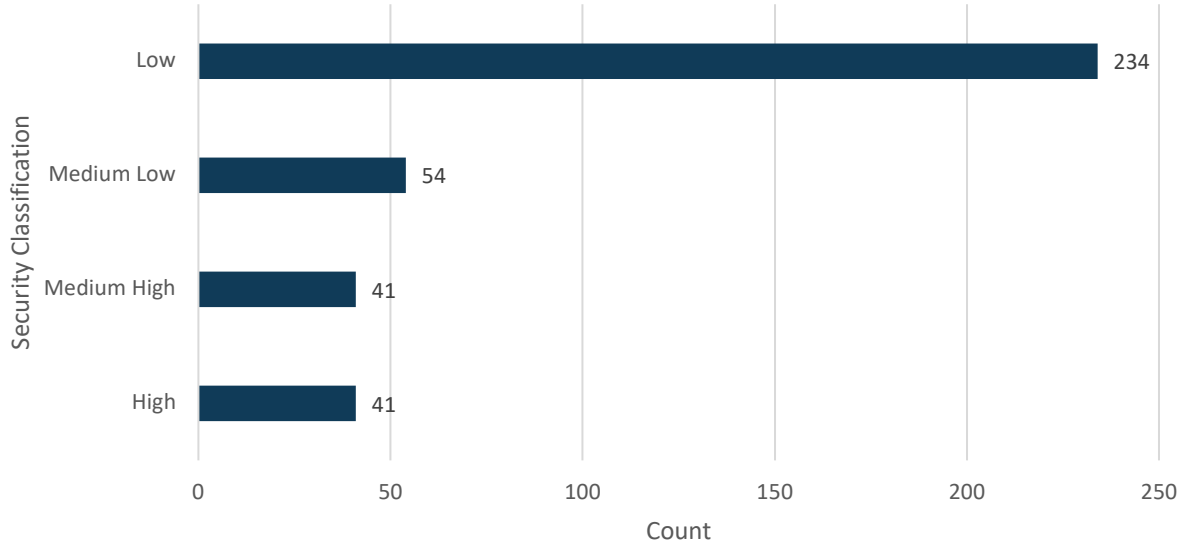
PBNDS 2.1 requires that all facilities provide an orientation and handbook to each detainee.[280] Thirteen detainees who spoke with Cal DOJ (54%) reported receiving a handbook and three detainees (13%) reported viewing an orientation video. Further, the facility's detainee handbook appeared only to be available in English and Spanish. Seven detainees (29%) who spoke with Cal DOJ reported not receiving a copy of a handbook or an orientation.

3. Security Classification System

Facilities are required to implement a formal security classification process for "managing and separating detainees based on verifiable and documented data."[281] The security classification level determines, among other things, a detainee's housing assignment. It is also intended to protect detainees from harm by assigning detainees to housing with persons of similar backgrounds and criminal histories.[282]

As shown in **Figure 29**, during Cal DOJ's 2025 visit 234 detainees (63%) were classified as "Low custody." These results echo the information provided by facility staff, who stated that the majority of its current detainees fall under the "low-risk," "no-threat" classification.

Figure 29. Mesa Verde Detainees by Security Classifications by Percentage of Detainees as of September 25, 2025



4. Departures

Both intakes and departures are processed through the same intake area. Given the limited intake space (discussed in the *Intake Process* section), movement of both incoming and outgoing detainees may cause congestion in the intake area, especially since incoming and departing detainees must be kept separate. Since only three cells are meant to hold detainees, with a total capacity of seven detainees at one time, just one departure means there are only two cells left available for incoming detainees.

Based on a roster dated September 3, 2025, provided to Cal DOJ by the facility, Mesa Verde held 229 detainees on that date, with one of the four dorms unoccupied. According to facility staff, the empty dormitory was cleared out after those detainees were moved from Mesa Verde to Cal City.

280 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ F-G, pp. 55- 56.
281 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part I, p. 60.
282 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part II, p. 60, Part V, §§ D-G, pp. 63-65.

However, by Cal DOJ's visit on September 25, 2025, all dorms were occupied, and the population was 370. This means there was one sizeable departure of detainees from Mesa Verde in early September 2025, followed by a rapid increase in intakes through the end of the month. These large intakes and departures impacted intake conditions such as space and the ability of staff to properly manage detainees.

Some detainees expressed that departures and movements to other facilities are being used as retaliation, or threatened to be used as retaliation, for detainees that complain of the conditions of their confinement. These reports are consistent with information reported by detainees at other facilities (as discussed in the *Introduction and Summary of Key Findings* section in the *Golden State Annex* chapter; and in the *Detained Populations* section in the *California City Detention Facility* chapter).

B. Food, Nutrition, Access to Water

Meals

PBNDS 4.1 requires that three meals are served to every detainee per day, of which at least two are hot, and that no more than 14 hours elapse between dinner and breakfast.[283] Facility staff reported that breakfast is served starting at 6:30 a.m., lunch starting at noon, and dinner is served starting at 6 p.m.

Facility staff provided Cal DOJ with a copy of their facility menu for the week of February 13, 2025. Despite the menu showing a variety of offerings including vegetables and fruit, over half of detainees (16; 67%) interviewed by Cal DOJ complained about the quality or quantity of the food. Detainees described the food provided using words such as "dog food" and "horrible." Detainees also described the food as late, tasting bad, having small portions, and being comprised mainly of beans and bread. Other detainees expressed that food can be cold on the inside or even frozen. Several detainees also said the food had upset their stomachs and caused diarrhea.

As a result, some detainees reported that they refrain from eating the food and must resort to purchasing food from the commissary. One detainee explained that without the commissary, detainees would starve. Of those detainees that reported their average commissary spending to Cal DOJ, the amounts ranged from about $40-$50 to $150 a week.

As for special diets, one detainee reported that their kosher diet meals were cold or still frozen, forcing them to change to another diet. The halal diet was described as just the regular meal with the meat or protein removed, and the religious or vegetarian meal was reported by detainees as consisting of two pieces of bread and salad, leaving detainees hungry and needing to supplement with the commissary. One detainee reported that despite making the facility aware of a peanut allergy, Mesa Verde continued to provide peanuts in their meals.

Water

PBNDS 4.1 requires that clean, potable drinking water be available to detainees at all times.[284] In each housing unit, up to 100 detainees access drinking water from sinks and a faucet. Of the detainees who spoke to Cal DOJ, 18 (75%) stated they had issues regarding access to clean potable drinking water. Detainees reported that the drinking water tastes "bad" or "weird," smells bad, and comes with a chemical, iron or metallic taste. One detainee reported getting diarrhea from drinking the water.

283 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232.
284 *Ibid*.

Detainees also reported issues regarding not consistently getting access to cold or hot water. For example, during Cal DOJ's visit, team members observed that the hot water machine in the dorm for female detainees was out of order. This issue appeared to depend on the housing unit detainees found themselves in, with some complaining of broken water filters and lack of hot water, and others stating they only have access to hot water for drinking.

C. Housing Units

Mesa Verde has four dorms, each housing up to 100 detainees in 50 bunks. During our visit, one housing unit was used for female detainees, two for Low/Medium-Low security male detainees, and one for Medium-High/High security male detainees. The housing units are "u" shaped, with showers and bathrooms located in the middle, surrounded by the bunks. Each dorm appeared to have at least 10 tablets, although Cal DOJ could not confirm if they were all operable. At the entrance of each dorm were two privacy phone booths, the tablets, laminated legal info, mailboxes for grievances and requests, and a podium for a detention officer to oversee the unit.

1. General Condition of Facility and Housing Units

The PBNDS provide that the facility must ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness, which includes daily dusting, mopping and trash disposal,[285] but detainees are only required to maintain their immediate living areas by making the bed, stacking loose papers and keeping the floor around their spaces neat.[286] Cal DOJ's visit was announced and occurred over a month after Cal DOJ initially requested access. Based on detainee reports, the conditions Cal DOJ observed may have been better than what detainees typically experienced in the weeks prior to our visit. Of the detainees who spoke to Cal DOJ, 21 (88%) reported they had concerns about the conditions in their housing units, particularly that the housing units are dirty and unsanitary.

During file review Cal DOJ identified a form entitled "Detainee Training – Use of Chemical Cleaners" that all detainees at Mesa Verde are required to complete at intake acknowledging training for how to use certain cleaning products. Multiple detainees complained that staff do not clean the housing units as required and that only detainees clean. Detainees were observed cleaning their housing units during Cal DOJ's tour. Most are paid $1 a day to do so, and some do it out of necessity.

Detainees also reported that living in such close proximity to up to 99 other people makes living uncomfortable, causing noises to echo and making it hard to sleep at night. Other detainees reported that some units are too hot, while others are too cold–affecting living conditions and the ability to sleep.

2. Access to Basic Needs

Detention facilities have an obligation to provide basic necessities to the detainees they hold. PBNDS 4.5 requires that detainees must be "issued clean, laundered, indoor/outdoor temperature-appropriate, size appropriate, presentable clothing during intake."[287] PBNDS 4.5 also requires that each detainee be issued clean bedding and linens, which include one mattress, one blanket, one pillow, two sheets, and one pillowcase.[288]

In interviews with Cal DOJ, some detainees expressed concern over mattresses and pillows that smell of urine. During its tour of the facility, Cal DOJ observed only three washing machines and three dryers–an insufficient number for a detainee population on that date of 370. Several detainees

285 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety, Part V, § A, p. 21.
286 ICE, PBNDS 2011, Part 5.8 Voluntary Work Program, Part V, § C, p. 406.
287 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part V, § B, p. 328.
288 *Id*. at § G, p. 330.

reported issues with laundry, both based on wait times and sanitation issues. Some detainees reported receiving clothes that appeared used and dirty, even after they came back from laundry service. Several other detainees complained of delays in laundry, leaving them without adequate clothes for the cold conditions within their housing units and the weather outside. Another detainee worried about the sanitary conditions of the laundry and believed laundry caused their rash.

Figure 30. Laundry Facility at Mesa Verde

The PBNDS also require "operable showers," in order "to ensure safety and promote hygienic practices."[289] However, detainees explained to Cal DOJ that they need to use lotion bottles and/or the labels of those bottles, and place them on showerheads to make sure the water streams down; that they do not feel clean after showering; and that showers are not sanitary. One detainee described mold and the facility's remediation methods that left detainees with sore and scratchy throats.

289 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part V, § E, p. 329.

Figure 31. Shower at Mesa Verde

Figure 32. Lotion Bottle at Showerhead at Mesa Verde

Further, despite PBNDS 4.5 requiring that "detainees shall be provided with a reasonably private environment in accordance with safety and security needs,"[290] both male and female detainees told Cal DOJ that the shower curtains are too small to provide privacy and that they believe the curtains are see-through. Detainees also stated that toilets and showers are dirty and unsanitary and that the area is hard to keep clean. They reported that because bathroom doors do not fully close, detainees feel exposed. Some are afraid of getting sick because of these conditions.

D. Detention and Safety

1. Staffing

The PBNDS require staffing levels at each facility that ensure sufficient supervision for those detained.[291] Given the over eightfold population increase, Cal DOJ was particularly interested in whether Mesa Verde is sufficiently staffed to ensure the health and safety of its detainees. In preparation for our site visit, Cal DOJ requested relevant documents from Mesa Verde. As of this report, the facility failed to produce all the information requested. This impedes Cal DOJ's ability to assess whether staffing levels and practices are sufficient for the population's needs. Nevertheless, Cal DOJ was able to gain an understanding of staffing through interviews with both facility staff and detainees.

While the facility reported low staff turnover rates and some issues with staff calling out, information collected from detainee interviews indicated other issues. Detainees reported that the increase in population resulted in newer, untrained staff that oftennmade mistakes and appeared to need further training. Other detainees who arrived during the active September 2025 period reported that the facility's systems were down upon arrival and that Mesa Verde appeared short-staffed at the time.

2. Use of Force

Facility staff produced a Use of Force log for 2025, showing 10 separate entries of use of force from April 7, 2025 to September 5, 2025. In the facility's log, all incidents were listed as "immediate." Cal DOJ's immigration detention expert reviewed three of these files and found that the facility applied

290 *Id*.
291 ICE, PBNDS 2011, Part 2.4 Facility Security and Control, Part V, § A, p. 82; Part 2.11 Sexual Abuse and Assault Prevention and Intervention, Part IV, § E, p. 151.

either a 2-point restraint or handcuffs in all three cases. File review showed Cal DOJ could only confirm that video was available for one of the three incidents.

3. Requests and Grievances

The facility could not recall grievances dealing with security and staff but stated it was not seeing too many grievances. Based on interviews with facility staff, facility leadership assumed that lower ranked grievances were being resolved below, and were being timely resolved and responded to by staff. However, facility leadership not knowing the number or the nature of grievances is concerning and a possible sign of disengagement by administrators. The only performance indicator that administrators appeared to monitor is how many grievances were designated "level 3," the point at which issues are referred up to them for resolution. This approach disregards the nature and number of complaints that detainees lodge, and the adequacy or inadequacy of the responses that subordinate supervisors provide, especially as to those complaints that are reoccurring.

4. Staff and Detainee Relations

Mesa Verde reported that staff were working well with detainees, and that they could not recall any complaints related to staff and detainee relations. Overall, detainees expressed mixed experiences with staff, with some detainees depicting detention officers as calm and approachable, and others describing detention officers as bad. Detainees who categorized staff as "bad" explained that staff was disrespectful, would discriminate against them, and would instigate and provoke or not bother to break up fights with and between detainees. One detainee described staff's behavior toward detainees as being treated "like a dog." Detainees also cited the need for more training, especially for newer staff, and explained that some staff have their own arbitrary rules and often yell at detainees.

Of the 24 detainees who spoke to Cal DOJ, eight detainees (33%) indicated they had been insulted or yelled at by facility staff. For example, detainees recounted staff members who yell at detainees on a daily basis, shine flashlights in detainees' faces, and yell at detainees while they are engaged in prayer. Another detention officer was described as taunting detainees, aggressive, laughing in detainees' faces, and as making comments about liking to shoot detainees and telling detainees "they should deport you."

Lastly, some detainees also reported language isolation caused by staff's preference for those who speak English or Spanish. Detainees reported witnessing Chinese detainees not being offered interpretation services within the housing units, and thus being ignored and becoming isolated.

E. Access to Social and Programming Opportunities

1. Non-legal Visitation, Phone Calls

According to Mesa Verde staff all non-legal visits are contact visits, and non-contact visits are only used for disciplinary reasons. Detainees reported that phone calls and video calls to family and friends are too expensive for them. Other detainees reported that technical difficulties, lack of privacy and ability to hear calls, and a lack of access to tablets also limit their ability to contact family and friends.

2. Programming and Recreation

Detainees must also have access to outdoor recreation at a reasonable time of day.[292] Most detainees reported receiving two hours of outdoor recreation time in the morning, and another one in the afternoon. However, detainees explained that their morning recreation time, which starts as early as five or six in the morning, is too early especially given how hard it is to fall asleep and that lights

292 ICE, PBNDS 2011, Part 5.4 Recreation, Part V, § B, p. 371.

are turned off for the night at around 12:30 a.m. Others complained that their afternoon outdoor recreation time conflicts with meal times, forcing detainees to choose between food and outdoor time.

Figure 33. Yard at Mesa Verde, 2021

3. Voluntary Work Program

During Cal DOJ's 2023 visit, Mesa Verde's voluntary work program was of grave concern due to the treatment of its workers, which led to a calculated use of force incident meant to quell a hunger strike that the facility failed to properly document and report.[293] During our September 2025 site visit, Mesa Verde continued their voluntary work program. Mesa Verde refused to answer how much detainees are currently being paid;[294] however, detainees reported that workers receive $1 a day. Facility staff was unwilling to answer any questions that elucidated any details of their current voluntary work program. However, as discussed above, Cal DOJ's review showed that detainees were required to sign a form at intake stating they completed training and received instruction on how to use cleaning products—a form usually reserved for detainee workers.

As addressed above, based on detainee interviews, maintenance of the facility's housing units appears to have been turned over almost exclusively to detainee workers. It is concerning that the facility refused to discuss with Cal DOJ a program that it appears to heavily rely upon and that has been associated with concerns during past reviews.

VI. Due Process

Cal DOJ considered how conditions of confinement affect due process rights of detainees held at Mesa Verde. Facilities must give detainees access to legal materials, legal calls, and mail; provide the ability to access legal services and representation; and facilitate detainees' court attendance.[295] The library has legal information regarding cases like *Zepeda* and *Franco*, saying that information is available upon request.[296] However, this information is not presented in an obvious or clear way to detainees. Cal DOJ

293 *Immigration Detention in California* (Apr. 2025), *supra*, pp. 98-99.
294 See *Immigration Detention in California* (Apr. 2025), *supra*, p. 101 (detainees were being paid $1 a day).
295 ICE, PBNDS 2011, Part 6.3 Law Libraries and Legal Material, Part V, §§ A-N, pp. 422-428.
296 The permanent injunction under *Franco-Gonzalez v. Holder* provides that detainees diagnosed with certain mental health disorders be appointed an attorney, among other processes, and that facilities post information notifying

also noticed a *Franco* notice posted inside the library; however, the notice was one among eight on a small corkboard and focused on a motion for attorneys' fees under *Franco*.

Mesa Verde stated they maintain a process by which attorney calls are not monitored. However, two detainees expressed issues with the process of getting their attorneys approved and securing access to them. They complained it delayed their ability to speak to counsel and communicate sensitive issues, and affected their ability to prepare for court. Additionally, detainees complained that making attorney phone calls in the dorms is difficult because there is no privacy; due to the noise inside the units, it is also hard to hear.

VII. Health Care

Cal DOJ also reviewed Mesa Verde's provision of health care including: 1) medical staffing; 2) intake assessments, evaluations, and diagnoses; 3) referrals to outside care and upon transfers; and 4) quality assurance and grievance reviews.

Cal DOJ found several deficiencies, including but not limited to initial intake assessments and related follow-ups regarding mental health and female health were not occurring within the timelines prescribed by the PBNDS; delayed referrals due to approval times and detainee transfers; and a quality assurance program which was lacking and caused lapses in care to go unreviewed. This section also discusses follow-up concerns related to Cal DOJ's 2023 report.

A. Staffing

As discussed above, Cal DOJ was particularly interested in staffing to ensure the health and safety of detainees given the rapid eightfold expansion of Mesa Verde's detainee population. However, GEO Group did not produce staffing information to Cal DOJ, presenting an obstacle to Cal DOJ's ability to assess whether staffing is sufficient for the needs of the population. Nevertheless, Cal DOJ was able to gain an understanding of medical staffing through interviews with both facility staff and detainees.

GEO Group informed Cal DOJ that all of Mesa Verde's health care funded positions were filled at the time of Cal DOJ's visit. Facility staff explained that the facility's Medical Director supervises two advanced practitioners: a certified Physician Assistant, and a registered Nurse Practitioner. Although Mesa Verde's population had increased substantially since 2023, Cal DOJ's medical expert concluded that the staffing remained at a reasonable proportion of detainees per licensed provider. At Mesa Verde, female health care is only provided by the medical director, calling into question whether the facility can meet standards under the PBNDS with just one trained and qualified provider on staff who can provide female health care. For example, as explained in the following section, the fact that there is only one clinician who can provide pelvic and breast exams at Mesa Verde results in the facility not meeting PBNDS timeline standards for completing reproductive health assessments, at least with those presenting with gynecologic complaints at intake in the cases reviewed by Cal DOJ.

Facility staff stated that the nursing positions were all filled, which were slightly up from Cal DOJ's last visit. However, according to Cal DOJ's medical expert, some registered nurses must regularly work overtime to cover 28 shifts per week.

Facility staff stated that their new psychologist will be on duty full time, and on site for four 10-hour shifts per week. Likewise, Cal DOJ was informed that a new psychiatrist funded up to a full-time employee had recently started, and that only the psychiatrist was using telehealth to see patients. Dental staffing included a dental assistant, but not a dental hygienist, and a dentist who works two days at Mesa Verde and two days at Golden State each week. According to facility staff, dental care workload

detainees of the settlement. *Franco-Gonzalez v. Holder* (C.D.Cal. Apr. 23, 2013, No. CV-10-02211-DMG (DTB)) 2013 WL 8115423; *Franco-Gonzalez v. Holder* (C.D.Cal. Oct. 29, 2014, No. CV-10-02211-DMG (DTB)) 2014 WL 5475097.

can reportedly be managed on site, with some complex cases and full mouth and jaw x-rays completed off site if needed. In interviews with Cal DOJ, at least two detainees complained about both the lack of response for dental requests and the lack of assistance once seen by dental staff.

Figure 34. Dental Exam Room at Mesa Verde

B. Intake Assessments, Evaluations, and Diagnoses

Initial Medical Care (Intake Screening and Comprehensive Health Assessment)

PBNDS 4.3 requires that detention facility health care staff conduct an initial medical, dental, and mental health screening of new detainees as soon as possible, but no later than 12 hours after a detainee's arrival to the facility.[297] The facility must also conduct a comprehensive health assessment of each detainee within 14 days of the detainee's arrival.[298] Thirteen (54%) of the detainees interviewed by Cal DOJ reported not receiving all three necessary aspects (medical, mental health, and dental) of the initial screening within 12 hours. Seven detainees (29%) stated they did not receive a dental assessment. Detainees who reported experiencing delays in receiving their initial medical screenings waited from around 18 to 19 hours, to three to five days. Additionally, 18 (75%) of detainees interviewed by Cal DOJ reported not receiving a comprehensive health assessment within 14 days of their arrival. At the time of Cal DOJ's visit, a few detainees reported they were still waiting despite the 14 days having come and gone.

Cal DOJ found that mental health intake assessments did not consistently occur within PBNDS time-frames. PBNDS 4.3 specifies that a referral for mental health services from intake must be linked to an evaluation by qualified staff within 72 hours or sooner if necessary, and that if the initial reviewing practitioner is not a mental health provider, then the detainee is to be evaluated by a mental health provider within the next business day.[299] Cal DOJ's file review showed several examples of individuals who either arrived with a history of mental health treatment or tested positive for needing such treatment, but who nevertheless had to wait for five to 22 days to see mental health staff. Of the detainees who stated that they requested mental health services, one was still waiting after one week, and two others felt the visit was not helpful.

297 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, p. 266.
298 *Id*. at § M, p. 268.
299 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, pp. 269-270.

Cal DOJ also found that female health care intake assessments and needed follow-ups did not occur within the timelines required under the PBNDS. The PBNDS require an initial medical screening "within 12 hours of arrival," that is "conducted by a trained and qualified health provider," that provides information related to health services for female detainees, and that "when a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment."[300] As previewed above, the facility cannot meet the PBNDS with regard to female health care with just one trained and qualified provider on staff. This is especially concerning for females who screened positive for gynecologic concerns at intake, or where the initial intake health evaluations were completed by practitioners who are not prepared to or do not provide gynecologic care. For example, one detainee who reported a gynecologic concern at intake waited three-and-a-half weeks to be seen. Another detainee had to wait about two months for an intake gynecologic exam and PAP smear. These prolonged care timelines for medically necessary and time sensitive gynecologic evaluations go beyond the usual wait times needed for approvals and scheduling, and do not meet the PBNDS timeline requirements.

Requesting Medical Care and Medical Records

Although emergency encounters appeared to be managed appropriately by nursing staff, in at least one file reviewed by Cal DOJ, a detainee who had recent abdominal surgery was not seen the same day despite a surgical site concern and difficulty breathing. According to Cal DOJ's medical expert, these symptoms should have been triaged as a same-day priority. Relatedly, one detainee reported to Cal DOJ that detainees need to submit medical requests several times to be seen, and that the tablets support only English and Spanish, with no other language support available to assist detainees who speak other languages. Another detainee stated they waited three months to see a doctor after submitting their request.

C. Delays and Obstacles to Referrals to Outside and Specialty Care

All specialty care referrals from a facility must be pre-approved by ICE Health Services Corps (IHSC). Cal DOJ's file review revealed that while some specialty care referrals proceeded in appropriate timelines, other specialty care referrals stalled at the IHSC approval step (especially for female detainees), or were interrupted by detainee transfers between facilities. Delays based on IHSC approvals caused one detainee to wait 70 days for an ophthalmologist referral and caused another to continue to wait (this patient had already waited for over a month after a referral by the time of Cal DOJ's visit and still had no approval as of the date of Cal DOJ's visit), for a medically-necessary colposcopy (a gynecologic procedure), despite this type of procedure not normally needing much IHSC deliberation. Colposcopies are normally ordered to evaluate pre-cancerous conditions, which this detainee presented at intake. These types of referrals should have been immediately approved by IHSC based on clear clinical need and scheduled promptly (as soon as possible) with a gynecologist.

Importantly, PBNDS 4.3 also prohibits the disruption of medical care due to a detainee moving between facilities.[301] Instead, facilities are required to consider medical needs prior to any move and to consider the disruption that such a move would cause to a detainee's medical care, while also considering alternatives to transfer.[302] However, there were several examples of transfers affecting referrals and medical care. File review of both departing and arriving detainees revealed that, despite some pending consultations being printed on transfer summaries, the summaries lacked detail as to a reason or importance for the referral, and that these consults appeared to be canceled as a matter of practice once a detainee was moved to another facility.

300 ICE, PBNDS 2011, Part 4.4 Medical Care (Women), Part V, § B, pp. 323-324.
301 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § Z, p. 276.
302 *Id*.

For example, one detainee who was referred out for an evaluation of tongue lesions had appointments with oro-maxillofacial surgery and otolaryngology specialists approved and scheduled approximately eight and 11 weeks, respectively, after the referrals were submitted. However, the detainee was then moved to another facility three days prior to the first appointment and, based on the facility's apparent practice of cancelling consultations upon transfer, likely had the wait times restarted at the new facility. According to Cal DOJ's medical expert, the cancelling of such consults upon removal to a new facility is a system-induced prolongation of wait time for what could be presumed is a potentially cancerous lesion until proven otherwise by biopsy. Cal DOJ's file review identified another detainee who had two referrals cancelled due to transfers between facilities. One referral was for a medically-necessary gynecology evaluation for postmenopausal bleeding that was generated at the previous immigration facility. This detainee's medical file showed that the appointment was cancelled when the detainee was transferred to Mesa Verde. The same referral was never re-submitted when she arrived at Mesa Verde and thus the diagnostic evaluation fell through the cracks.

Further, PBNDS 4.3 requires that "upon transfer to another facility, the medical provider shall prepare and provide a Medical Transfer Summary."[303] While it appears that registered nurses prepared release summaries for detainees, these summaries did not appear to include information that would prompt expedited re-referrals at the new facility. Thus, they did not sufficiently address the problem of prolonged timelines, or the potential for care drops when referrals must be re-initiated at destination facilities after arrival at a new facility. According to Cal DOJ's medical expert, this is one area of documentation where changes could potentially reduce the risk of care lapses at destination facilities. Cal DOJ saw several examples of this, including one detainee's medical file that showed they were taken to Mesa Verde from another facility, then removed to Cal City, and who had a physical therapy referral generated at Mesa Verde discontinued upon their transfer out to Cal City.

D. Quality Assurance and Grievance Review

Facility staff informed Cal DOJ that some quality assurance meetings are held monthly. Facility staff described that the Health Services Administrator personally reviewed task queues to ensure completion of work and that, additionally, nurses review pending tasks to assist with follow-through. Facility staff reported to Cal DOJ that the Medical Director reviewed all hospital send outs and continued to review all detainee medical history and physical records. However, facility staff could not detail any corrective actions or efforts to identify care gaps and continuously improve care quality other than the Medical Director's own documentation reviews. This issue is particularly important given the change from providing care to a male-only population at 10% facility capacity to the current census increase of around 800% of the previous population and which now includes female detainees. When Cal DOJ pressed the facility about any areas for improvement, facility staff called this "a loaded question" and declined to answer or disclose any lapses which had been remediated. Instead, facility staff stated that health services were "operating very well."

However, several issues emerged during Cal DOJ's review. For example, file review showed that one female detainee who was seen twice in July 2025 had a noted history of post-menopausal bleeding, a condition which was also reported at intake in June 2025. This condition should have been further evaluated to rule out gynecologic cancer. However, while file review showed a plan for a referral to diagnostic services, no referral was recorded as of September 25, 2025. Another detainee had a referral for diagnostic care of a potentially pre-cancerous condition, but that referral had not been approved or declined a month later. According to Cal DOJ's medical expert, these lapses in care would have ideally been reported and reviewed within the quality improvement program to examine potential fixes to prevent recurrences, since they were not caught by the various chart review activities.

303 ICE, PBNDS 2011, 4.3 Medical Care, Part V, § Z, p. 276, § BB, pp. 277-278.

E. Follow-up on Mental Health Concerns from Prior Reviews

Cal DOJ's 2025 report focused on the provision and quality of mental health care.[304] In this report, Cal DOJ continues to be concerned about the effects of the facility's mental health treatment and conditions of confinement, and its effect on detainees' mental health. As explained above (*Detained Population* section), detainees expressed to Cal DOJ that the conditions of confinement are negatively affecting their mental health.

Cal DOJ is also concerned about Mesa Verde's medical wellness checks for those on suicide watch. In a 2023 Office of the Immigration Detention Ombudsman (OIDO) report, OIDO reported that as of September 1, 2022, Mesa Verde was conducting welfare checks every twelve hours, failing to meet the PBNDS requirement of wellness checks every eight hours.[305] As a result, on January 11, 2023, the Acting Assistant Field Office Director issued a corrective action memorandum for the facility.[306] This memorandum stated that the HSA provided remedial training on December 20, 2022, for all nurses to conduct welfare checks every eight hours for detainees on suicide watch.[307] OIDO found that this corrective action was "sufficient to address the compliance deficiency."[308] However, based on Cal DOJ's September 2025 review, nurses were still conducting welfare checks every 12 hours, or once every nursing shift, rather than the requisite check every eight hours. Thus, Cal DOJ is concerned that medical wellness checks may not have been brought into compliance since the 2023 OIDO report.

304 *Immigration Detention in California* (Apr. 2025), *supra*, p. 11.
305 DHS, *OIDO Inspection, Mesa Verde ICE Processing Center* (June 16, 2023) <https://www.dhs.gov/sites/default/files/2023-06/OIDO%20Final%20Inspection%20Report%20-%20Mesa%20Verde%20ICE%20Processing%20Center.pdf> p. 10 (as of Mar. 19, 2026).
306 *Id.*
307 *Id.*
308 *Id.*

10. Imperial Regional Detention Facility

I. Introduction and Summary of Key Findings

Cal DOJ conducted a two-day site visit of the Imperial Regional Detention Facility (Imperial) on October 7-8, 2025. The site visit and interviews at Imperial illustrate a facility less burdened by surging detainee populations and generally prepared and staffed to provide basic necessities. For the most part, detainees interviewed by Cal DOJ at Imperial reported that the food quality was better than at other facilities. The detainee population at Imperial has shifted from mostly people who appear at the border to people who have been living in the United States as internal immigration enforcement continues to surge. Imperial has also seen an increase in demand for care for chronic health conditions, such as diabetes, alongside an increase in detention of older immigrants. There were also two deaths of detainees held at Imperial between September 2025 and January 2026.

Cal DOJ made the following key findings:

- The detainee population at Imperial changed from Cal DOJ's June 2023 site visit to its October 2025 site visit as follows: 1) Imperial only housed male detainees in 2023, but as of the 2025 visit it also housed female detainees; 2) the detainee count increased from 492 in June 2023 to 627 in October 2025, an approximately 27% increase, including 62 female detainees; and 3) the average length of stay more than doubled from 62 days to 133.7 days during this period.

- Most detainees (481 detainees; 76.7%) held at Imperial as of the production of its October 2, 2025 roster, were classified as Low security.

- Detainees access drinking water through water fountains or sinks in the housing unit, but several detainees reported the water caused skin rashes and some reported resorting to boiling the water in microwaves before drinking it.

- Detainees who have been at other facilities reported in their interviews with Cal DOJ staff that the conditions of confinement at Imperial were an improvement as compared to the other facilities. Imperial offered the most recreation time and programming to detainees compared to other facilities visited. It also appears that increased kitchen staffing has had a notable impact on food quality and detainee experience.

- Detainee reported inconsistent use of language interpretation services, including during the intake process and during regular interactions between detention staff and detainees.

- Imperial has installed 36 video/phone booths (15 dedicated for court hearings) for detainees to attend virtual court hearings and attorney visitation. This appears to improve the conditions for access to due process.

- Based on Cal DOJ's file review and staff interviews, it appears that Imperial is more staffed in health care positions as compared to Cal DOJ's site visit in 2023 and notably has expanded its mental health care staff during this period.

- Cal DOJ's file review indicated that Imperial has a high sick call volume but draws on stable and experienced senior nursing staff, and that an increased number of as-needed nursing staff is available. At the time of the site visit, the staff seemed able to respond promptly to requests. However, detainee reports and medical chart review revealed delays or problems obtaining referrals for specialists and getting care for chronic conditions such as diabetes and liver conditions.

- Cal DOJ's file review identified concerns regarding the facility's management of detainees with severe mental health issues, including two detainees who experienced extended stays in restrictive housing of over 200 days. Concerns were also identified in this area in Cal DOJ's 2023 report.

II. Facility Background

Imperial, located in Calexico, California in Imperial County, is operated by the Management and Training Corporation (MTC). Imperial opened in 2014, and ICE entered into a direct contract with MTC in 2019 for three five-year terms, totaling 15 years. The PBNDS apply to this facility.

Imperial has an official capacity of 704 beds. ICE pays MTC a guaranteed minimum of 640 beds at Imperial.[309] At the time of Cal DOJ's visit, 565 male detainees and 62 female detainees were held at Imperial.

The last reported inspection of Imperial was conducted by the Department of Homeland Security Office of Detention Oversight in January 2025.[310]

Table 15. Key Data Points, Imperial Regional Detention Facility

Facility:	**Imperial Regional Detention Facility**
Operator:	Management and Training Corporation
Housing Detainees Since:	2014
Bed Capacity:	704
Type(s) of Detainees Facility Can Hold:	Female and Male Adult Civil Detainees

Figure 35. Imperial Facility Building

309 ICE FY25 Detention Statistics (Jul. 2025), *supra*.
310 ICE, Office of Detention Oversight, *Imperial Regional Detention Facility Inspection* (Jan. 14-16, 2024) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/imperialRegDetFac_CalexicoCA_Jan14-16_2025.pdf> (as of Mar. 19, 2026).

III. Methodology and Limitations

Cal DOJ staff and experts, including a medical expert and an immigration detention expert, visited Imperial on October 7-8, 2025. The site visit was planned in response to an increase in ICE enforcement and the detained population in California. Cal DOJ collected data and observed conditions at the facility, interviewed detainees and facility staff, and reviewed relevant documents. Cal DOJ and its medical expert also interviewed the Health Services Administrator, Director of Nursing, and a Medical Physician.

Cal DOJ also interviewed 27 individuals detained at the facility, chosen by selecting a sampling of detainees from each housing unit with a range of intake dates and countries of origin. Cal DOJ also interviewed detainees who signed up to speak with Cal DOJ on notices posted in dormitories preceding the site visit. These interviews took place in a private setting with two Cal DOJ team members. Cal DOJ interviewed detainees in their preferred language, either by Cal DOJ staff who were proficient in the language or through a telephone interpretation service. The languages used during the interviews included Arabic, Armenian, English, French, Garre, Persian, Russian, Spanish, Turkish, Urdu, and Vietnamese.

IV. Detained Population

The detainee population at Imperial saw a number of changes including more detainees, the addition of female detainees, and a longer length of stay. Imperial's detainee population of 627 as of October 2, 2025 represents an increase of 135 detainees since Cal DOJ's site visit in June 2023. Although the facility did not house female detainees in June 2023, the facility held 62 female detainees as of October 2, 2025. **The average length of stay more than doubled from 62 days as of Cal DOJ's 2023 site visit to 133.7 days as of the 2025 site visit**; the median length of detention as of the 2025 site visit was 82 days; and the longest length of stay was 688 days.

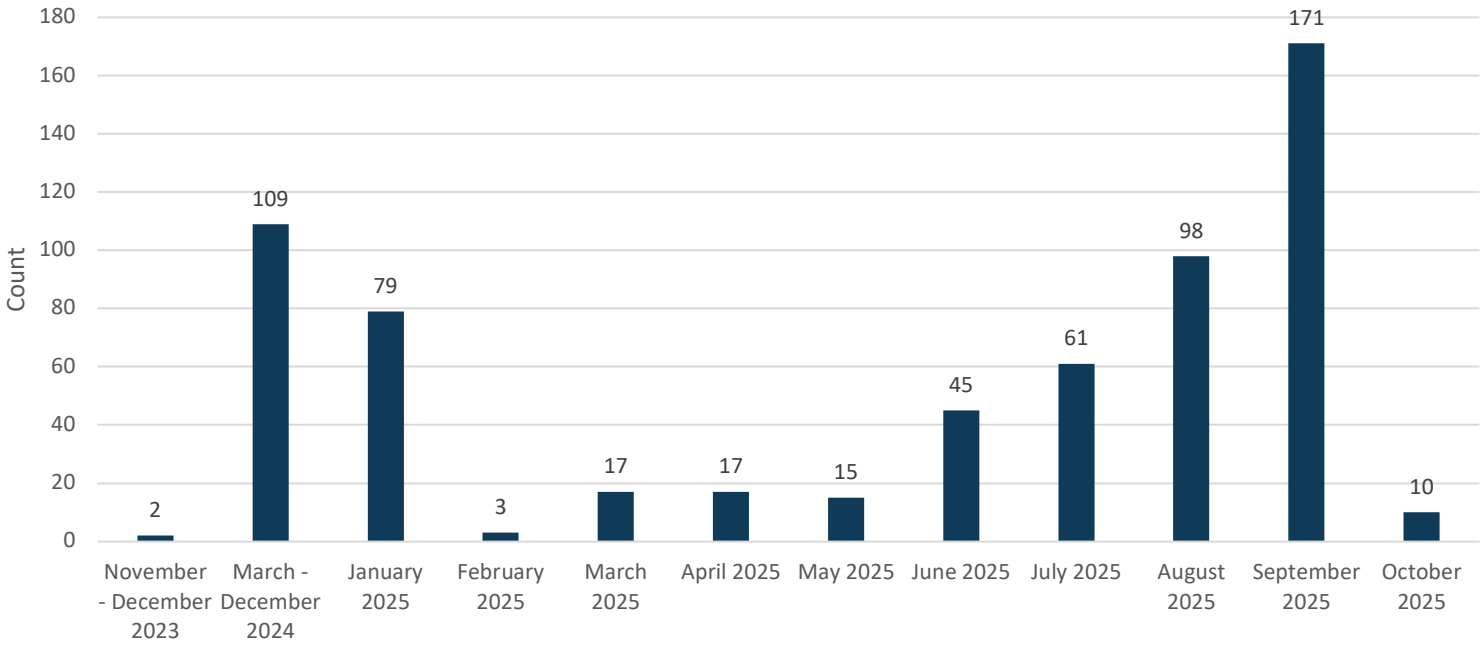
Table 16: Snapshot of Detainees Housed at Imperial Regional Center on October 2, 2025

Total Population:	**627**
No. of Countries of Origin[311]:	71
No. of Female Detainees:	62
No. of Male Detainees:	565
Average Age:	36
Average Length of Detention[312]:	134 Days
Longest Length of Detention:	688 Days

Figure 36 shows the arrival dates, by month, of detainees present at Imperial as of October 2, 2025. Notably, the largest concentration of new arrivals at Imperial included 171 detainees who arrived at the facility in September 2025 and who were still present on October 2, 2025. Eighty of the 171 detainees arrived over the course of five days in September 2025, between September 17 to September 21.

311 This figure is from MTC's roster of detainees provided to Cal DOJ on October 2, 2025.
312 ICE FY25 Detention Statistics (Sept. 2025), *supra*.

Figure 36. Arrival Month of Detainees on October 2, 2025 Roster at Imperial



The arrivals described above only include those individuals who were held at the facility as of October 2, 2025, not all detainees who were held at the facility during this period. **Figure 36** is not representative of all detainees who were held at Imperial on or before October 2, 2025, and who were released, deported, or transferred prior to this date.

At the time of Cal DOJ's 2025 visit, the detainees at Imperial represented 71 different countries. The top 10 countries of origin were Mexico (112 detainees), China (48), Russia (47), India (33), Guatemala (30), El Salvador (24), Cameroon (21), Cuba (20), Colombia (19), and Ethiopia (19).

Immigration status before entering immigration detention varied among detainees interviewed. Approximately half of the detainees interviewed (13; 48%) reported that they had an undocumented status before entering immigration detention. Eight participants (30%) indicated they had some legal immigration status, such as asylum status or a tourist visa, or were in the process of applying for legal status (i.e. through the asylum process).

V. Conditions of Confinement

Cal DOJ's review also looked at conditions of confinement at Imperial generally and assessed the extent to which the intake process and access to food and water have changed, including the following: intake and orientation; food, nutrition, and access to water; conditions of housing units; detention safety and staff-detainee relations; and non-legal visitation and programming/recreation.

A. Intake and Orientation

1. Intake process

Upon arrival at Imperial, detainees undergo an intake process that includes a mental health screening, a medical intake, and a brief suicide screening. A detainee may be referred for a comprehensive mental health evaluation or sent to the hospital from intake before they are accepted at the facility, or a psychiatrist may be called for acute needs. At least one detainee reported that he received two free three-minute calls at intake.

PBNDS 2.2 requires a medical, dental, and mental health screening within 12 hours of arriving to the facility and before placement into a housing unit.[313] Detainees reported that the intake process generally occurred within 12 hours upon arrival. Some detainees Cal DOJ interviewed reported they were processed within three to four hours and others reported being processed within 10 to 12 hours. Other detainees reported that they were in intake for one day, two days and four days.

During a compliance inspection by ICE's ODO on January 14-15, 2025, ODO reported concerns regarding the lack of interpretation services for eight detainees and delays in intake processing.[314] During these delays, the individuals were held in administrative segregation for an unknown period of time due to lack of medical clearance.[315] These individuals spoke Haryanvi, Kotokoli, and Dogri, which were not languages available through Imperial's language service provider. Thus, the detainees could not be screened within 12 hours and staff could not obtain consent for medical examinations.[316] As discussed below, Cal DOJ shares these language access concerns after interviews with facility staff.

Figure 37. Intake Holding Room at Imperial with Partial-Privacy Bathroom

2. Orientation

PBNDS 2.1 requires that all detention facilities provide an orientation and handbook to each detainee.[317] It also requires a facility to provide a translator or access to interpreter services if a detainee does not understand English or Spanish.[318] A detainee reported that Imperial plays orientation videos in English and Spanish. Facility staff stated that the facility handbook is only available in English and Spanish while the ICE handbook is available in eight to nine languages. The facility handbook includes facility rules and procedures about topics such as the disciplinary system and requests, while

313 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § D, p. 63; Part 4.3 Medical Care, Part V, § J, pp. 266-268.
314 ICE, Office of Detention Oversight, *Imperial Regional Detention Facility Inspection* (Jan. 14-16, 2025) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/imperialRegDetFac_CalexicoCA_Jan14-16_2025.pdf> p. 8 (as of Apr. 2, 2026).
315 *Id*.
316 *Id*.
317 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ F-G, pp. 55-56.
318 *Id*.

the ICE handbook generally discusses topics such as classification levels and general health and safety information.[319] During interviews, three detainees (12%) who reported receiving orientation materials reported that these materials were not in a language they could understand.

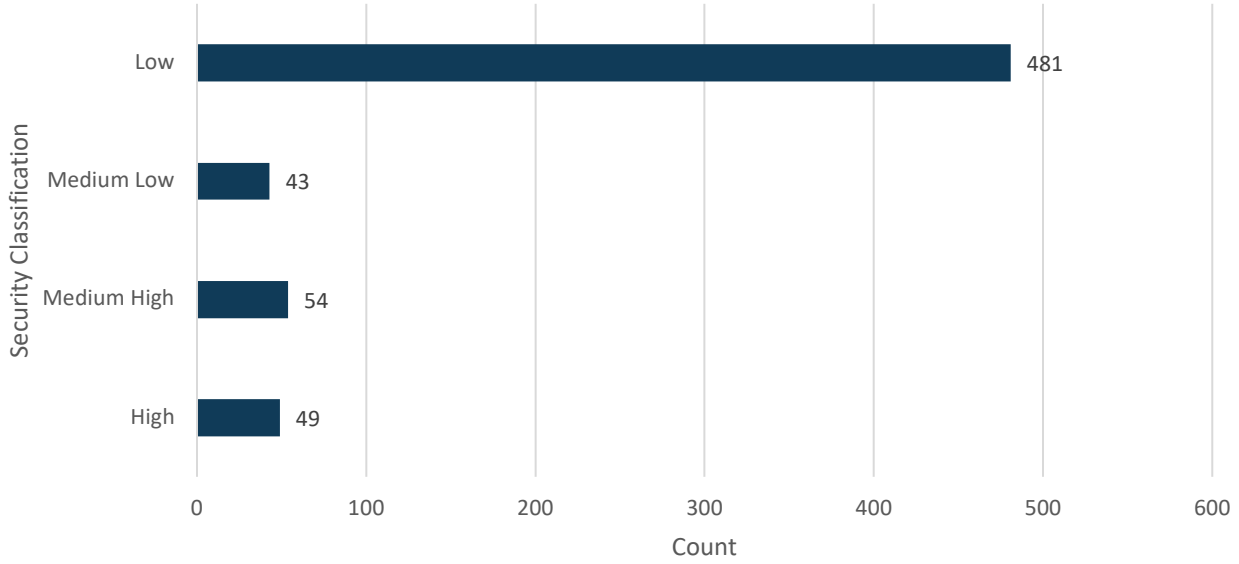
The lack of facility-specific information provided in a detainee's primary language makes it difficult for detainees to comply with facility rules and regulations of which they may not be aware. For example, one detainee who spoke Farsi reported that Imperial provided a handbook in English and he did not understand the handbook at all; subsequently, he was disciplined for three rule violations that he did not understand and was moved to a different housing unit.

3. Security Classification System

PBNDS 2.2 requires a facility to implement a formal classification process for "managing and separating detainees based on verifiable and documented data."[320] Security classification levels generally determine a detainee's housing assignment and are intended to protect detainees from harm by assigning detainees with similar backgrounds and criminal histories in the same housing unit.[321]

As shown in **Figure 38**, at the time of Cal DOJ's 2025 site visit, Imperial held 627 detainees in custody of which 49 detainees (7.8%) were assigned the High classification level, 54 assigned Medium-High (8.6%), 43 assigned Medium-Low (6.9%), and 481 assigned Low (76.7%).

Figure 38. Imperial Detainees by Security Classification as of October 2, 2025



ICE Detention Statistics from September 25, 2025, also indicate a large majority (90.7%) of detainees did not have a criminal history.[322]

Cal DOJ's 2025 report identified concerns with Imperial's security classification system. However, the limited file review during this visit did not allow Cal DOJ to determine if and how the process may have changed regarding security classifications at Imperial.

319 ICE, *National Detainee Handbook* (Mar. 23, 2026) <https://www.ice.gov/detain/detention-management/national-detainee-handbook> (as of Apr. 10, 2026).
320 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part I, p. 60.
321 *Id*. at Part II, p. 60-61, Part V, §§ D-G, pp. 63-65.
322 ICE FY25 Detention Statistics (Sept. 2025), *supra*.

B. Food, Nutrition, Access to Water

Meals

PBNDS 4.1 requires that detainees receive three meals per day, and that no more than 14 hours elapse between dinner and breakfast.[323] Facility staff reported that they serve three meals per day and that female detainees eat their meals in their housing unit. All 27 detainees interviewed corroborated that they received three meals per day.

Most detainees reported that the food served at Imperial was generally acceptable and edible and that they receive fruit daily, such as a banana and apple. One detainee interviewed by Cal DOJ reported that they receive meals with chicken two to three times per week, as compared to other detention facilities they were held at where they only received chicken once every few months. During the site visit, Cal DOJ observed kitchen workers baking fresh bread and opening boxes of oranges for the next meal. The *Voluntary Work Program* section below details the program, including detainee kitchen workers.

Figure 39. Cold Storage Room of Kitchen at Imperial

Most detainees (20; 47%) Cal DOJ interviewed did not report experiencing issues with food. However, at least one detainee reported concerns about sanitation and food handling by volunteer detainee workers. One detainee reported that kitchen workers often do not follow sanitation rules and some supervisors are not strict about enforcing the rules; for example, a detainee reported that some workers grab food without gloves when filling food trays and another detainee reported that they do not use beard hair nets. The detainee also reported that when washing plates, some detainees only rinse trays with water and do not use dish soap. Detainees also reported to Cal DOJ that detainee workers in the kitchen sometimes do not measure out portion sizes, so some trays have too much food and others have an inadequate portion. One detainee reported observing another detainee experience retaliation for complaining about their small food portion, in the form of a false write-up.

323 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232.

Some detainees with special diets reported that they were receiving their requested diets, including a halal diet. Other detainees who require special medical diets reported that they had not received their diets; and one detainee reported that they received a medical diet or if they received the wrong diet, it was corrected right away.

Water

PBNDS 4.1 requires that clean, potable drinking water is available to detainees at all times.[324] Detainees reported availability of water in the housing units and that clean drinking water is provided during mealtimes in large water jugs, but reported that detainees must purchase their own cups from the commissary to drink or save this water for later.

Eleven detainees (41%) of those Cal DOJ interviewed reported they had concerns about water quality, including the drinking water tasting "bad," "awful," or having a "chemical" or "chlorine" taste. Two detainees reported that they boil their water in the microwave before drinking it due to concerns with the water quality; another detainee avoids the tap water and buys bottled water from the commissary. One detainee reported that he experienced skin rashes and the doctor told him that the drinking water in the housing units was causing these skin issues; the doctor recommended boiling his water to purify it before drinking. This detainee reported that he now boils the water for six minutes every day before drinking.

C. Housing Units

Imperial has 11 housing units each housing up to 64 detainees. During the 2025 visit, one housing unit was used for female detainees, eight units for Low/Medium-Low security male detainees, and two units for Medium-High/High security male detainees. The housing units each have a common area surrounded by two floors of bunks with showers and bathrooms located in the interior end and access to a small outdoor recreation space on the other end. Each dorm has a small multipurpose room at the front of the housing unit with windows, including space to pray with prayer rugs available for use. The detention officer's desk sat next to the door to the outdoor space. Each housing unit appeared to have at least two microwaves and seven telephones, although Cal DOJ could not confirm if they were operable. Facility staff reported that each housing unit has nine tablets available, although Cal DOJ could not confirm if they were operable.

1. General Condition of Facility and Housing Units

The PBNDS provide that facility staff must ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness, which includes daily dusting, mopping and trash disposal,[325] but detainees are only required to maintain their immediate living areas by making the bed, stacking loose papers, and keeping the floor around their spaces neat.[326] Housing units at Imperial are primarily cleaned by porters who are part of the facility's voluntary work program. These detainees are assigned to clean the common areas in housing units and were said to clean twice per day and as needed. Facility staff reported that pressure washing in the shower areas was completed once per week.

Many of the male detainees generally reported that their housing units were clean. Three female detainees reported that their housing unit was clean or had no issues, and that detainees take turns cleaning the housing unit three times a day; one reported that the showers were often dirty, and the facility did not regularly clean the showers.

324 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232.
325 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety, Part V, § A, p. 21.
326 ICE, PBNDS 2011, Part 5.8 Voluntary Work Program, Part V, § C, p. 406.

2. Access to Basic Needs

PBNDS 4.5 requires a facility to issue at least two sets of uniforms, including two pairs of socks, two pairs of underwear, and one pair of shoes.[327] Worn out or damaged shoes must be replaced by the facility at no cost to the detainee.[328] Socks and underwear may be changed daily, and uniforms may be exchanged at least twice per week, with a maximum of 72 hours between changes.[329] Facility staff reported that detainees are issued three sets of clothes and one sweater. Socks were kept in a separate room and facility staff reported underwear were available with no shortages.

Fewer detainees reported issues about clothing or blankets as compared to other facilities visited by Cal DOJ. However, detainees reported that the conditions are too cold in the housing unit and in the intake rooms, and that they were only provided with "thin" or "paper" blankets.

Detainees also reported concerns that while the upstairs showers in the housing unit had curtains (three of the eight showers), the downstairs showers did not have any privacy. One detainee reported that usually only two of the three showers with privacy are operational and detainees had to wait two hours to shower.

D. Detention and Safety

1. Staffing

The PBNDS require staffing levels at each facility that ensure sufficient supervision for those detained.[330] Based on Cal DOJ's review of staffing information produced by MTC, there appeared to be relatively few vacancies for staff positions. Facility staff reported that there has been a consistent flow of job applicants, that Imperial has not experienced recent problems with staffing, and that the detention staff has been fully staffed. File review conducted by Cal DOJ showed that almost all detention positions were filled and use of overtime among facility staff was limited. Detention staff work in three eight-hour shifts, and staff reported that there is a policy that if the first shift is heavier with longer shift hours, the third shift will be lightened with a shift of fewer hours.

2. Requests and Grievances

Detainees submit requests through tablets provided by ICE through a contract with Talton. Paper requests have been discontinued and are only used temporarily when the tablets stop working. Facility staff reported that Imperial provides nine tablets per housing unit, which house up to 64 people. Tablets allow detainees to request medical care and file grievances; have video calls with family members; email their attorneys; read resources and research caselaw; schedule family and legal visits; and watch movies with pay-for-entertainment options added. Given that tablets serve as the only way for detainees to submit requests, the ratio of working, charged tablets to detainees may not be enough, particularly as tablet usage for various facility functions and online tools increase.

Some detainees reported that there are not enough tablets in the housing units. One detainee reported how "very few tablets" were available for translation assistance and that as a result, they have trouble communicating with detention staff. Two detainees reported issues of detainees checking out tablets for most of the day and not returning them after they use it.

327 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part V, § B, p. 328.
328 *Id*.
329 *Id*. at § H, p. 330.
330 ICE, PBNDS 2011, Part 2.4 Facility Security and Control, Part V, § A, p. 82; Part 2.11 Sexual Abuse and Assault Prevention and Intervention, Part IV, § E, p. 151.

Other requests made by detainees include work orders to fix equipment in the housing units. One detainee in restricted housing reported that the TV needed to be fixed for two weeks; he filed a grievance and was told that the facility ordered a new TV.

3. Staff and Detainee Relations

During interviews Cal DOJ asked detainees about their experiences with staff. Detainees reported a mix of positive and negative experiences when describing dynamics between detention officers and detainees. Twenty-six detainees were asked whether they had been insulted or yelled at by facility staff. Ten of these detainees (38%) reported that they had, and 16 (62%) reported that they did not have this experience.

Detainees reported that some detention officers were "good people" and others were "not good" or treated detainees "badly." Eight detainees reported that they witnessed or experienced some staff who used offensive language and yelled at detainees. Other detainees reported that some detention officers did not care to help detainees with issues or requests, and behaved in a way that "assert[ed] their authority" over detainees. Two detainees also reported that they have seen detention staff treat English-speaking or Spanish-speaking detainees "better" or more favorably than non-English or non-Spanish speaking detainees. However, other detainees reported that most or some of the detention officers treated detainees well or were "really nice" and helpful in assisting detainees with issues or requests. Seven detainees reported that they had positive views of or no issues with detention staff or officers at Imperial as compared to other facilities if they were previously transferred.

4. Language and Culture

The facility has policies and tools to provide language access, and these appear to be provided in most cases. Facility staff reported that tablets can be used in 60 different languages with a drop-down menu that translates the page into the selected language. Facility staff also reported that most staff speak English and Spanish and carry pocket translators or use interpreter services by phone to explain matters to detainees during intake.

During its 2023 visit, Cal DOJ identified issues with language access, including inconsistent use of interpretation services and issues with language and technological interfaces.[331] These issues appeared to persist during the 2025 visit. Some detainees reported that interpreter services were available during the intake process for health screenings, but other detainees reported that they did not use an interpreter. Cal DOJ also observed some detention staff who used the pocket translators and other staff who communicated with detainees in English even though the detainee did not appear to understand English. Other detainees reported they had problems communicating with detention officers and staff, including one Vietnamese-speaking detainee who communicated to detention officers and staff by writing what they wanted to say on a tablet from Vietnamese to Spanish and having a Spanish-speaking detainee interpret on their behalf. The PBNDS prohibits this practice.[332] Using detainees as translators is problematic because a detainee may not have the requisite language skills for this task, and the interpretation process may impact or be impacted by relationship dynamics among detainees.

331 *Immigration Detention in California* (Apr. 2025), *supra*, pp. 121-122.
332 ICE, PBNDS 2011, Part 2.13 Staff-Detainee Communication, Part V, § B, p. 189.

E. Access to Social and Programming Opportunities

1. Non-legal Visitation, Phone Calls

Non-legal Visitation

Facility staff reported that family and friends may visit between Tuesday to Sunday, and Mondays and Tuesdays are dedicated for legal visitation. Detainees have access to visitation time of one hour to one and a half hours, and the maximum capacity of the visitation room is 100 people. There is a rotating schedule of visitation hours by classification level and housing units to provide visitors with early or late afternoon visitation slots.

Staff also reported that there is a two-person limit on visitation but that detainees may request to extend visitation time or add another visitor. Other facility staff reported that they try to accommodate the number of people, including large families. Staff also reported that they offer non-contact spaces if the contact visitation space exceeds capacity, but the facility had not reached maximum capacity for visitation yet.

Detainees reported that they use the tablets to make video conference calls but those are expensive, including one detainee who reported that he spent five dollars for 22 minutes on a video call.

Telephones

PBNDS 5.1 requires that indigent detainees receive a specified postage allowance to maintain community ties and necessary postage for privileged correspondence.[333] PBNDS 5.6 also requires that indigent detainees shall be permitted free calls on an as-needed basis to family or other individuals providing legal assistance.[334] Facility staff reported that if detainees are indigent or have less than $14.99 in their account for 10 days, they are eligible for three free phone calls a week to family. The facility also provides indigent detainees with free postage. However, detainees reported that the cost of phone calls is too high, including international phone calls, and prevent many from calling their loved ones.[335]

Tablets

As discussed above, facility staff reported that there are nine tablets provided in each housing unit. Besides making electronic requests, video calls, or other features of the tablet, detainees may also watch movies or play games with pay-for-entertainment options. One detainee reported that movies and games are available on tablets for purchase; the detainee reported that he had spent at least $100 watching movies on tablets in the span of two months since arriving at Imperial.

2. Programming and Recreation

Cal DOJ observed that detainees' access to programming and recreation positively impacted conditions of confinement. Based on Cal DOJ's review of programming information produced by MTC, Imperial offers classes in "Basic General Education," English as a Second Language (ESL), and INEA (Instituto Nacional para la Educación de los Adultos),[336] or life skill courses. Imperial also offers life skill courses such as "Basic Hair Fundamentals," parenting courses for mothers and fathers, "Detainee Instructor" courses, driver's education, health and wellness, anger management, and the volunteer work program. Recreation activities included crochet, guitar, meditation, and Zumba.

333 ICE, PBNDS 2011, Part 5.1 Correspondence and Other Mail, Part IV, § B, p. 358.
334 ICE, PBNDS 2011, Part 5.6 Telephone Access, Part II, p. 385.
335 The telephone rates are set by Talton Communications, Inc. Cal DOJ observed on its 2025 site visit that telephone calls cost 7 cents per minute with debit, 11 cents per minute for domestic collect calls, 15 cents per minute for international calls, 35 cents per minute for international mobile calls, and $1.20 per voicemail.
336 INEA is a GED-like course and credits earned can be transferred to Mexico.

Detainees reported that they received access to programming and recreation including the voluntary work program, ESL classes, basketball, soccer, volleyball, baseball, and indoor and outdoor recreation. Detainees reported that Imperial offers English courses, cooking class, and soccer competitions between housing units. Facility staff also reported that at Imperial detainees may take GED preparation programs, anger management classes, and ESL classes.

General Population

PBNDS 5.4 requires that the facility must provide detainees with access to time outside their housing unit for at least one hour a day, seven days a week, at a reasonable time of day, and outdoors when practicable.[337] For detainees in the general population, the facility is required to provide four hours of outdoor recreation time per day, weather and scheduling permitted.[338] It also requires that recreation schedules be provided to detainees.[339]

It appears that Imperial exceeds the outdoor requirement under PBNDS for general population. Detainees have access to outdoor recreation every day. Detainees in general population reported that they have access to a small outdoor recreation space connected to their housing unit from 6:00 a.m. to 8:00 p.m. except for count time. Facility staff reported that count is conducted twice a day at 6:00 a.m. and 2:00 p.m.

The housing units' outdoor recreation space includes one basketball hoop. Detainees in general population also reported that they have access to a large recreation yard for two hours per day. Cal DOJ observed that the large recreation yard included two soccer fields, a dirt track surrounding the yard, two shaded canopies with two sets of benches under each canopy, four gym exercise machines, and a handball court. The big yard also included two large jugs of water and outdoor bathrooms with two toilets, sinks, soap, and privacy walls. At least one detainee reported that there are other resources and activities available.

Figure 40. Outdoor Recreation Yard at Imperial, 2023

337 ICE, PBNDS 2011, Part 5.4 Recreation, Part V, § B, p. 371.
338 *Id*.
339 *Id*.

There is also an indoor recreation space and activities for detainees in general population. One detainee in general population reported that they can check-out musical instruments such as a guitar and board games, including Sorry, Connect Four, Chess, and Jenga. This detainee also reported that there used to be puzzles, but the facility discontinued this activity. Additionally, they reported that there used to be Xbox video games available, but that activity caused conflicts among detainees and the facility discontinued the activity.

Cal DOJ also observed a separate indoor recreation space on the second floor of the facility that included more than 10 tables with two to four chairs at each table and two TVs. Staff reported that Imperial offers arts and crafts and other programs in this space. The back of the room included a separate game room, including a foosball table and basketball hoop game. At least one detainee interviewed reported that they were not aware of a separate indoor recreation space that existed at Imperial.

Restricted Housing Population

PBNDS 5.4 also requires that detainees in restricted housing units must be offered at least one hour a day, seven times a week of recreation or exercise opportunity outside their cells if under administrative custody, and at least one hour a day, five times per week if under disciplinary custody.[340] One detainee in restricted housing reported that they received three hours outside their cell a day. The detainee also reported that the TV in the housing unit is the only indoor recreation activity available but had been broken for the past two weeks.

3. Access to Engage in Religion/Religious Services

Cal DOJ observed that housing units for Low and Medium custody levels have a separate multipurpose room enclosed within the housing unit that some detainees had access to throughout the day. Cal DOJ also observed multiple prayer rugs and detainees who used the space to pray together several times a day. Facility staff reported that the chaplain used the second-floor indoor recreation space to host religious services. Other staff reported that the chaplain oftentimes visits detainees in their housing units to conduct prayers together. At the time of our visit, there was a large Muslim population at Imperial, according to facility administration, who further described that the chaplain typically brought in volunteers for counseling services for different denominations. Cal DOJ also observed that the library had a large section of religion and books of faith, including 3-4 shelves with books in multiple languages and multiple faiths.

Two detainees who identified as Muslim reported that they had access to prayer in the housing units' multipurpose room and prayed together with other detainees five times a day for 10-20 minutes each time. On Fridays, they used a separate, larger room where all the Muslim detainees get together and pray for one hour. One Muslim detainee reported one issue of morning prayer conflicting with tablet access and detainees having to choose whether to attend prayer or line up for tablet access.

Staff also reported that for a "holy day," there are accommodations that can be made so that detainees can receive a special meal. Detainees can submit a request to the chaplain; if the chaplain approves the request, he notifies food services and then the detainee can receive the special meal on that day.

4. Voluntary work program

Imperial has a voluntary work program. Staff reported that the program includes positions in the laundry, the kitchen, dormitory sanitation, recreation assistance, and as porters in administrative offices. Based on Cal DOJ's review of programming information produced by MTC, the voluntary work program at Imperial includes positions as a barber, porter, kitchen worker, laundry worker, library

340 ICE, PBNDS 2011, Part 5.4 Recreation, Part V, § E, pp. 372-373.

assistant, recreation assistant, and yard squad. Imperial reported that it pays detainees $1.00 per day, except for kitchen workers who are paid $2.00 per day, which was recently increased from $1.50 per day. There were roughly 60 detainees working in the voluntary work program; about 30-35 detainees worked in the kitchen and 16 detainees in laundry.

For cleaning and sanitation, detainees are responsible for their own living area and porters clean common areas. Detainees reported that there were detainees working as porters who cleaned the housing units, although Cal DOJ could not confirm if all the porters were getting paid. Facility leaders reported that workers are trained by intake staff and transportation officers on how to use cleaning solutions, and detainees must be certified in how to use chemical agents. At least one detainee reported that he worked as a porter and cleaned one to two hours every day; the facility paid him $1.00 per day. The detainee reported that he typically cleaned toilets and administrative offices and mopped the floors in the hallways and exit areas.

Facility staff also reported that detainees who work in the kitchen work a maximum of five days a week for three-to-four-hour shifts; morning shifts are between 6:00 a.m. to 2:00 p.m. and afternoon shifts are between 10:00 a.m. and 6:00 p.m. There was a brief hunger strike in mid-September and a short work stoppage at the end of September. During the facility tour, Cal DOJ observed approximately 10 detainees working during a kitchen shift. One detainee, who worked as a library assistant for $1.00 per day for two-hour shifts, reported that most jobs are two-hour shifts for $1.00 per day, but kitchen jobs are six-hour shifts for $2.00 per day.

VI. Due Process

Cal DOJ evaluated due process rights of detainees held at Imperial, including access to legal services and representation, access to materials for immigration cases, and access to courts. Also unique to this facility is the availability of over two dozen private phone booths, which appear to positively impact detainees' access to virtual legal visitation and court hearings.

A. Access to Legal Services and Representation

Imperial offers in-person and virtual legal visitation. According to ICE's website, in-person legal visitation is available seven days a week, including holidays.[341] As discussed above, staff reported that Mondays and Tuesdays are days dedicated to legal visitation.

During the facility tour, Cal DOJ also observed private video/phone booths located in hallways. Staff reported that there are 36 booths, which were installed two years prior, and they are used for virtual legal visitation, including virtual calls with attorneys, court hearings, and calls with DHS officers. Each booth includes a telephone and tablet for video calls and electronically signing documents. Staff also reported that the booths are used on average 160-180 times per month for virtual attorney visitation alone. Legal phone calls between detainees and attorneys providing free legal services are free.

341 ICE, *Imperial Regional Detention Facility, Hours of Visitation* (Feb. 24, 2026) <https://www.ice.gov/detain/detention-facilities/imperial-regional-detention-facility> (as of Mar. 24, 2026).

Figure 41. Phone Booths for Virtual Legal Visitation at Imperial

Figure 42. Interior of Phone Booth at Imperial

Of the 27 detainees Cal DOJ interviewed, 17 detainees (63%) reported that they had legal representation. Ten detainees (37%) reported that they were not represented.

Additionally, of the 17 detainees who reported representation, 14 detainees (82%) reported no difficulties communicating with their attorney. One detainee reported that she believed her calls with her attorney were confidential and Imperial responded within a few days to her attorney's request to speak with her. However, one detainee reported issues with the phone connection and poor audio quality. Another detainee reported that they received documents from their attorney, but their attorney had not received documents they had sent; the detainee did not know why this happened. One detainee reported that her attorney requested video visitation, but Imperial did not provide this option. Another detainee reported that for virtual attorney visitation, they can access a private visitation room and use the tablet to send messages or make calls from 6:00 a.m. to 10:00 p.m.

Staff also reported that detainees can call Al Otro Lado, which is a nonprofit organization that hosts Know Your Rights presentations at Imperial every other week. However, at least one detainee reported that the presentations had stopped. As discussed above in the *Legal Orientation Programs (LOPs)* section in the *Standards Applicable to Civil Immigration Detention Facilities and Recent Policy Changes* chapter, federal funding for types of legal presentations terminated in April 2025 but these legal presentations were still available to detainees at Imperial as of October 2025.

B. Access to Materials Needed for Immigration Case

Facility staff reported that detainees can research laws and statutes on tablets and computers and read legal resources digitally. Cal DOJ did not readily see legal books in the library for detainees to access.

At least one detainee who was representing himself reported that the librarian gave him outdated asylum application forms, which caused his court hearing to be rescheduled for two months later. The detainee filed a grievance about the librarian, but reported that no action was taken by Imperial in response to the issue. The detainee also experienced issues with processing payments for immigration filing fees. He reported that the money was withdrawn from his account but he was not provided with a copy of the check or receipt to demonstrate proof of payment at his court hearing, which caused delays in his immigration case.

C. Access to Court

Imperial appears to have improved access to courts since Cal DOJ's last site visits in 2023. Since that time the facility has added a series of private booths which can be used for court hearings by video or phone and staff reported that 15 of the 36 booths are dedicated for court hearings and asylum interviews. Staff reported that through these booths, detainees have access to judges across the country.

It appears that this increase in access to private spaces for court hearings has allowed more detainees to access immigration courts at Imperial. Of the 27 detainees interviewed by Cal DOJ, 25 (93%) reported that that they had attended an immigration court hearing since arriving at Imperial and two (7%) reported that they had not. Two detainees reported using the phone booths for virtual court hearings, which included video conferencing. These responses may be impacted by the total number of detainees at Imperial who did not have hearings yet and/or do not have an attorney. One detainee reported issues with court interpreters and believed the interpreters do not understand immigration proceedings well, which can affect the quality of the interpretation.

VII. Health Care

Cal DOJ reviewed Imperial's provision of health care, including: 1) medical staffing; 2) intake assessments, evaluations, and diagnoses; 3) referrals to outside care and upon transfers; and 4) treatment for chronic care treatment and serious mental health conditions. The last part in this section discussed the recent deaths of detainees.

Based on its review, Cal DOJ found several deficiencies, including but not limited to staffing concerns regarding nursing positions that remained unfilled and the medical director working a full-time job outside of Imperial; insufficient record keeping for offsite specialty care referrals and lack of hospital records after offsite care; and seriously mentally ill patients staying in restricted housing for lengthy periods of time.

A. Intake assessments, evaluations, and diagnoses

Initial Medical Care (Intake Screening and Comprehensive Health Assessment)

PBNDS 2.2 requires a medical, dental, and mental health screening within 12 hours of a detainee's arrival at the facility and before the detainee's placement into a housing unit.[342] Cal DOJ found that intake screenings reported and conducted by medical staff at Imperial were generally completed within 12 hours. Also, newly-arrived detainees had timely access to mental health evaluations based on medical charts reviewed by Cal DOJ. However, Imperial provided detainees with access to dental care only after a detainee had been at the facility for six months. Detainees reported that initial medical and mental health assessments at Imperial were mostly conducted within 12 hours of arrival, but that dental screenings were not conducted at all.

Cal DOJ's medical expert also found that two detainees who had positive findings in their intake screening did not receive subsequent comprehensive assessments by appropriately qualified staff within two working days of the initial screening. PBNDS 4.3 requires that detainees "shall receive a health assessment no later than two working days from the initial screening" if there is a "clinically significant finding" from the screening.[343] Based on review of medical files, Imperial failed to meet this standard, resulting in potentially life-threatening deterioration for at least one detainee. This detainee had a very high risk of alcohol withdrawal and had some symptoms but was sent to general population. The detainee was later taken to the emergency department once his health began to deteriorate. Detainees experiencing severe or life-threatening intoxication or withdrawal must be transferred immediately to an emergency department under PBNDS 4.3,[344] but the detainee was not immediately transferred.

PBNDS 4.3 requires comprehensive health assessments of detainees within 14 days of arrival.[345] Cal DOJ found that comprehensive health assessments conducted by nursing staff may have been substituting review by advance practice providers that should have been prioritized to detect clinically significant findings. Based on review of medical files, comprehensive health assessments were only completed as a formality; sometimes the same nurse who conducted the intake screening completed a different form for the comprehensive assessment at the same time. Of the 27 detainees Cal DOJ interviewed, 20 (74%) reported that they did not receive all components of the comprehensive health assessment within 14 days, four (15%) reported that they received this assessment within 14 days, and two (7%) reported that they were unsure.

342 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § D, p. 63; Part 4.3 Medical Care, Part V, § J, pp. 266-268.
343 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, p. 267.
344 *Id*. at § K, p. 268.
345 *Id*. at § M, p. 268.

Requesting Medical Care and Medical Records

Facility staff reported that although there was a high volume of daily sick call requests, these requests were monitored with the electronic tablet system and were generally tracked and triaged promptly. Staff also reported that detainees were seen in-person for sick call requests within one day. Cal DOJ expressed concern over the increasing detainee population and regularly heavy sick call load of between 50 and 90 requests per day for night shift nurses to triage. Cal DOJ's medical expert found that the nursing sick call burden could be high for Imperial's medical staff depending on the nature of the requests received. At least one detainee interviewed reported that Imperial typically takes two to three days and up to one week to respond to medical requests, including for migraine medication, cream to treat skin problems, and anti-depression medication.

At least one detainee who reported submitting requests for mental health and dizziness due to changing blood sugar reported delays in seeing the medical unit and spending three days waiting to be seen. Another detainee reported that he requested an inhaler for asthma for four to five months before receiving this medication. He reported that as of early October 2025, he had one inhaler that he kept with him and inhaler medication that the nurse provided every night.

B. Referrals to outside care

Facility staff reported that referrals for outside specialists require approval from ICE Health Services Corps (IHSC). This process starts with the medical provider at Imperial who makes a specialty referral for a detainee and the medical records department which initiates contact with the applicable clinic to request an appointment and review the referral information; this initial step takes three to five days on average.

Staff reported that at the same time, facility staff submits the referral information to IHSC for approval for non-emergent care and/or testing, which can vary from one day up to two weeks on average. Specialty appointments can be scheduled in as early as one month or up to six months depending on the specialty. Staff reported that the specialty appointment is booked before ICE approval is requested so that the detainee can be seen as soon as possible. If ICE does not approve the referral, then facility staff will cancel the appointment.

Cal DOJ's medical file review of detainee medical files revealed some concerns about the lack of oversight for Imperial's referral process for outside specialty care. For example, referrals for offsite specialty care are not tracked in Imperial's electronic health record system. In interviews, staff also expressed concerns about scheduling issues and delays with outside clinics. Based on file review, many of the detainees who received outpatient care and returned to Imperial only had a patient summary in their records instead of hospital notes for adequate record of care and transition.

One detainee Cal DOJ interviewed reported that he had made over 100 medical requests and grievances to see a specialist for white spots all over his body and had not received a specialty appointment yet. He was told by ICE to make a request with medical staff at Imperial, but when he did, the medical staff told him that he had to make a request with ICE first. Another detainee reported that he was seen by an external doctor who told him that he needed surgery for the constant pain and infection on his buttocks, but had not received a follow-up appointment for the surgery. According to the detainee, medical staff only provided the detainee with special underwear for his condition.

Two detainees also reported issues with treatment for fungus growing on nails and difficulty receiving treatment. One detainee reported that he had fungus growing on his fingernails, which were thick and overgrown, for the past nine months but did not have a follow-up appointment and was told by medical staff that the facility does not provide treatment for this fungus. Another detainee who had been

held at Imperial for over a year reported that he had an ingrown nail twice on his toenail while held at Imperial; the first time, his toenail was partially removed so it grew back and turned a greenish purple color. The detainee reported making daily medical requests for two months to see an outside provider for the infected toenail and was told that the appointment was scheduled, but ICE later canceled the contract with that provider so his appointment was canceled and he did not receive a follow-up treatment plan. Recently, when the detainee was seeing a physician at Imperial for another health issue, the physician noticed the infected nail and removed the whole nail.

C. Staffing

In its 2021 and 2025 reports, Cal DOJ reported concerns with health care staffing shortages at Imperial, but this appears to have improved for mental health staffing.[346] In June 2023, there was only one psychiatrist providing mental health services; this has increased to one psychiatrist and two licensed marriage and family therapists at the time of Cal DOJ's 2025 site visit.

Facility staff reported that the medical staffing plan at Imperial is based on the maximum capacity of 704 detainees and the current detainee population was more than 150 below this maximum. Staffing vacancies for registered nurses appeared to be mostly filled with a larger list of as-needed nurse resources; however, there has been a staffing vacancy for a full-time Medical Director position at Imperial since 2022. Cal DOJ has concerns that the nursing sick call burden reported could be high for the medical unit depending on the nature of the requests, especially given the increased detainee population since 2023 and the upwards of 50 sick call requests daily that could make the workload more challenging. As of Cal DOJ's 2025 visit, there is only one part-time physician at Imperial who primarily conducts telehealth appointments twice a week for detainees and has another full-time position at a hospital.

The Director of Nursing appeared to be competent and engaged in providing detainees with medical services at Imperial. Other staff, including a senior nurse with long tenure, appeared to help with gaps in leadership of the medical unit. However, Cal DOJ had some concerns that the Health Services Administrator lacks a clinical background, which may impact their ability to provide health care services to detainees.

D. Treatment for Chronic Care and Serious Mental Health Illnesses

Cal DOJ identified several medical concerns during its 2025 site visit at Imperial, including concerns with chronic care treatment and housing placement of detainees with severe mental illnesses.

Concerns with Chronic Care Treatment

Cal DOJ found that all medical practitioners provided chronic care and that Imperial's only physician, who also worked full-time at a local hospital, provided chronic care for a higher level of need. Facility staff reported that there is a need to provide chronic care given the demographic shift in the detainee population to an aging population with more chronic needs. Based on Cal DOJ's review of medical files, one detainee had a lapse in his immunosuppressive medication regimen that he was prescribed to avoid rejection of his transplanted kidney. Imperial medical staff administered his first dose of medication three days after his arrival. There appeared to be a lack of evidence of planning to coordinate the transfer of care from prison to ICE custody. Cal DOJ also found that Imperial did not keep a common blood pressure medication in stock on site so that dosing could start immediately. File review indicated that one detainee waited two days between the order and first dose.

346 *Immigration Detention in California* (Jan. 2021), *supra*, p. 96; *Immigration Detention in California* (Apr. 2025), *supra*, p. 110.

Detainees also reported issues of treatment for chronic care, including for diabetes and liver conditions. One detainee reported that he had diabetes but had not been able to receive his medication to treat it in a timely manner. At the time of his interview with Cal DOJ, this detainee's daily diabetes medication had not been provided in the past three days; he had been feeling dizzy due to his high blood sugar and fell out of his top bunk bed. The detainee reported that, before his detention, he would check his blood sugar daily but the medical staff at Imperial only checked his blood sugar twice a week at 5:00 a.m. He reported that the physician at Imperial ordered a special diabetic diet for him, but that he still received the same food as other detainees. Another detainee with diabetes reported that she had a special medical diet but medical staff did not check her blood sugar on a regular basis, checking it only when she requested it.

Another detainee interviewed by Cal DOJ reported that he had notified Imperial staff at intake about his fatty liver condition and the medication he had been taking for this condition. He said that he had been experiencing pain on the left side of his abdomen but had been unable to receive the medication he needed nor a special medical diet for his liver condition.

Concerns with Housing Placement of Detainees with Mental Illnesses

During its 2023 site visit, Cal DOJ identified issues with how detainees with severe mental illnesses were classified and placed in restricted housing and the capacity of Imperial to serve these populations. These issues appeared to persist during the 2025 visit. Facility staff reported to Cal DOJ that the facility tries to get ICE to transfer detainees with severe mental illnesses to other facilities that can provide better care, but they are not the decisionmakers.

File review revealed that detainees with serious mental illnesses spent variable lengths of time in restricted housing. At the time of the 2025 site visit, some detainees were in restricted housing for nine days and 35 days, and others for 253 days and 320 days. The only forms of housing in the facility are dorms or cells in restrictive housing. In some cases, medical housing may have been more appropriate than isolation in restricted housing for individuals experiencing serious mental illnesses. One detainee exhibiting serious mental health symptoms spent 282 days in restricted housing and was repeatedly hospitalized before being transferred out of Imperial for long-term inpatient psychiatric care. Another detainee spent 242 days in restricted housing, including 140 consecutive days for protective custody; medical files noted that at one point that he was "restless, agitated, sick" with a cough, and the detainee said he "felt like a captive animal."

Cal DOJ's file review indicated that detainees with severe mental illnesses cycled between restricted housing and external inpatient services. Based on Cal DOJ's review of detention files, at least one detainee was not classified as someone with special vulnerabilities at intake, and was disciplined multiple times within the first two months of arrival at Imperial, when it was clear from the files and his actions that the individual had mental health disabilities. Staff reported to Cal DOJ that the facility tries to accommodate and account for the detainees' mental health conditions during the disciplinary process and avoids disciplinary segregation to the greatest extent possible when the detainee has a diagnosed mental health condition.

E. Detainee Deaths

There were two deaths of detainees held at Imperial between September 2025 and January 2026. Huabing Xie died in ICE custody on September 29, 2025, after being transported to the hospital from Imperial earlier that day.[347] ICE reported that Xie had been detained at Imperial for just over two weeks

347 ICE, *Detainee Death Notifications* (Oct. 5, 2025) <https://www.ice.gov/news/releases/illegal-alien-china-passes-away-regional-medical-center-near-san-diego> (as of Mar. 24, 2026); Bravo, *Chinese Migrant Dies in ICE Custody in Imperial County*, NBC San Diego (Oct. 7, 2025) <https://www.nbcsandiego.com/news/local/chinese-migrant-death-ice-custody-imperial-county/3911838/> (as of Mar. 24, 2026).

when he had a seizure and became unresponsive. According to the ICE report, medical staff at Imperial responded by administering CPR and emergency response actions to Xie before he was transferred to the hospital.[348] Facility staff reported that this was the first detainee death since Imperial opened in 2014.

A second detainee, Luis Beltrán Yanez-Cruz, died in ICE custody on January 6, 2026, after being transported to the hospital from Imperial two days prior.[349] According to the ICE report, Yanez-Cruz had been detained in mid-November 2025 in New Jersey and then transferred to Imperial, where he experienced heart-related issues.[350] ICE reported that medical staff at Imperial responded by evaluating his chest pain, then transporting him to a local hospital, and later transferring him by helicopter to a hospital in Indio, California for further care.[351]

348 *Id*.
349 ICE, *Detainee Death Notifications* (Jan. 9, 2026) <https://www.ice.gov/news/releases/illegal-alien-ice-custody-passes-away-california-hospital> (as of Mar. 24, 2026); Rendon, *68-year-old Man Dies of Medical Issue at Indio Hospital Under ICE Custody*, NBC Los Angeles (Jan. 10, 2026) <https://www.nbclosangeles.com/news/local/68-year-old-man-dies-of-medical-issue-at-indio-hospital-while-under-ice-custody/3829787/> (as of Mar. 24, 2026).
350 *Id*.
351 *Id*.

11. Otay Mesa Detention Center

I. Introduction and Summary of Key Findings

Cal DOJ conducted a two-day site visit of the Otay Mesa Detention Center (Otay Mesa) on October 8-9, 2025. Among the seven immigration detention facilities located in California that Cal DOJ visited in 2025, Otay Mesa had the second highest population of ICE detainees (1,433),[352] and the second longest average length of detention (126.5 days).[353] Similar to facilities across the state, Otay Mesa saw a population increase in the last two years, with marked increases in arrivals during the summer and early fall of 2025. Overcrowding is a big concern at the facility, where overflow detainees sleep on "boats" placed on the floor due to the unavailability of beds. As of October 6, 2025, the number of active detainees at the facility was about 21% greater than the population during Cal DOJ's prior visit to Otay Mesa in September 2023.[354]

Based on Cal DOJ's review of documents produced by Otay Mesa, interviews of detainees and staff, and observations made during the site visit, Cal DOJ made the following findings:

- At the time of Cal DOJ's visit, most people (1,182; 82.5%) detained at Otay Mesa were classified at the lowest classification (ICE threat level 1).

- Otay Mesa has experienced surges in population. Arrivals of the detainees present on facility rosters at the time of Cal DOJ's site visit to Otay Mesa peaked in July 2025, followed by September 2025, and August 2025. Detainees reported prolonged intake process times during which they experienced unsanitary conditions and inadequate food and water provisions.

- Overcrowding at the facility impacts cleanliness of the housing units and puts a strain on the resources available for all detainees. For example, in at least some of the housing units, the number of available toilets per detainee was insufficient for the high number of detainees and did not comply with PBNDS standards.

- Otay Mesa is the only facility in California with a policy and practice to strip search detainees after each non-legal contact visit. Detainees reported that this practice has an overwhelming negative impact on the mental health and dignity of detainees.

- While the reported number of use of force incidents at Otay Mesa is low given the size of the facility, Cal DOJ identified some deficiencies. For example, according to Otay Mesa's own incident review records, in one case the use of restraints was utilized when not necessary, and a detainee was not given the opportunity to voluntarily submit to restraints.

- Detainees reported that the quantity and quality of food is inadequate at Otay Mesa, and that it is necessary to supplement meals with food purchased from the commissary.

- Since Cal DOJ's 2023 site visits, Otay Mesa has improved its levels of health care staffing and its processes of reviewing health care service quality and instituting corrective actions.

352 Detainee count was 1,570 for Adelanto on July 7, 2025 and 1,433 for Otay Mesa on October 6, 2025. *See* **Table 2**. Count of Detainees by Facility and Date Span of Data Provided by Facilities (as discussed in the *Detained Populations* chapter).

353 Otay Mesa was second only to Imperial, which had an average length of detention of 133.7 days. *See* **Table 5**. Detainees' Length of Detention in Days for Each Facility (as discussed in the *Detained Populations* chapter).

354 At the time of Cal DOJ's 2023 visit, the total population of persons detained at Otay Mesa was 1,187. *Immigration Detention in California* (Apr. 2025), *supra*, p. 132.

- Otay Mesa's medical recordkeeping practices limit the facility's ability to provide quality, consistent medical care. The system utilized by Otay Mesa makes it difficult to track the status of referrals and ensure that appointments are scheduled. Poor record keeping impacts the facility's ability to monitor referrals for specialty medical care and proper discharge care after detainees return from hospital visits, where a lapse in care could have dangerous consequences.

- Detainees requiring higher levels of medical care or accommodations that Otay Mesa could not provide remained in the facility's medical housing unit for months.

- Cal DOJ's medical expert found a case of tuberculosis with lapses in coordination and care planning with local public health authorities, increasing risk to the patient and to others at the facility.

II. Facility Background

Otay Mesa is located in San Diego, California, and is operated by CoreCivic, Inc. (CoreCivic), a publicly held corporation.[355] CoreCivic has contracts with both ICE and the U.S. Marshals Service (USMS) to house persons in each of those agencies' custody at Otay Mesa. While persons held for ICE in general population are not housed with persons detained under the authority of the USMS, both populations are co-located in the special management/restricted housing units.

Otay Mesa opened in 2015 and was expanded in 2021. Facility staff reported that the facility has a maximum capacity of 1,970 beds (excluding medical and restricted housing beds), and ICE statistics state that 1,142 beds[356] are allocated for persons detained by ICE. ICE's contract with CoreCivic contains a guaranteed minimum provision, therefore CoreCivic is paid in full for 750 beds, whether these are occupied or not.[357]

Otay Mesa is subject to the PBNDS. The last inspection of Otay Mesa by the Department of Homeland Security Office of Detention Oversight (ODO) took place in February 2026.[358]

Table 17. Key Data Points, Otay Mesa Detention Center

Facility:	**Otay Mesa Detention Center**
Operator:	CoreCivic
Housing Detainees Since:	2015
ICE Bed Capacity:	1,142
Type(s) of Detainees Facility Can Hold:	Female and Male Adult Civil Detainees

III. Methodology and Limitations

Cal DOJ staff and experts, including a medical expert and an immigration detention expert, visited Otay Mesa on October 8-9, 2025. The site visit was planned in response to reports of the rapid population increase at Otay Mesa and focused on the impacts of this increase on conditions of confinement. Cal DOJ and its experts collected data and observed conditions at the facility, interviewed detainees and

355 *Immigration Detention in California* (Jan. 2021), *supra*, p. 97.
356 DHS, *U.S. Immigration and Customs Enforcement Budget Overview* (Fiscal Year 2022) <https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf> p. 144 (as of Apr. 3, 2026).
357 ICE, Detention Management, Fiscal Year 2026 National Detention Statistics (Jan. 20, 2026) (as of Mar. 26, 2026) ("ICE FY26 Detention Statistics (Jan. 2026)").
358 ICE, Office of Detention Oversight, *Otay Mesa Detention Center Inspection* (Feb. 24-26, 2026) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/OtayMesaDetCntr_San%20DiegoCA_Feb24-26_2026.pdff> (as of April 6, 2026).

facility staff, and reviewed relevant documents and detainee files. Cal DOJ and its medical expert also interviewed the Health Services Administrator and Medical Director.

Cal DOJ interviewed 29 detainees at the facility, chosen by selecting a sampling of detainees from each housing unit with a range of intake dates and countries of origin. Cal DOJ also interviewed detainees who signed up to speak with Cal DOJ on notices posted in dormitories during the week preceding the site visit. These interviews took place in a private setting with two Cal DOJ team members per interview. Cal DOJ interviewed detainees in their preferred language. The languages used during the interviews included Armenian, English, Mandarin, Pashto, Persian, Russian, Sign Language, Spanish, and Turkish.

IV. Detained Population

Otay Mesa has seen a considerable increase in the number of ICE detainees since Cal DOJ's last site visit in 2023, with population surges in summer and early fall of 2025. According to ICE data released for each federal fiscal year (FFY),[359] the average daily population of detainees at Otay Mesa in the 2023 FFY was 982.[360] This number increased to 1,247 in FFY 2024 and 1,389 in FFY 2025.[361] Cal DOJ previously visited Otay Mesa on September 19-21, 2023, when it held 1,018 male detainees and 169 female detainees.[362]

A review of the roster produced to Cal DOJ and dated October 6, 2025, yielded the following key data points for the detained population at Otay Mesa as of October 6, 2025.

Table 18. Snapshot of Detainees Housed at Otay Mesa on October 6, 2025

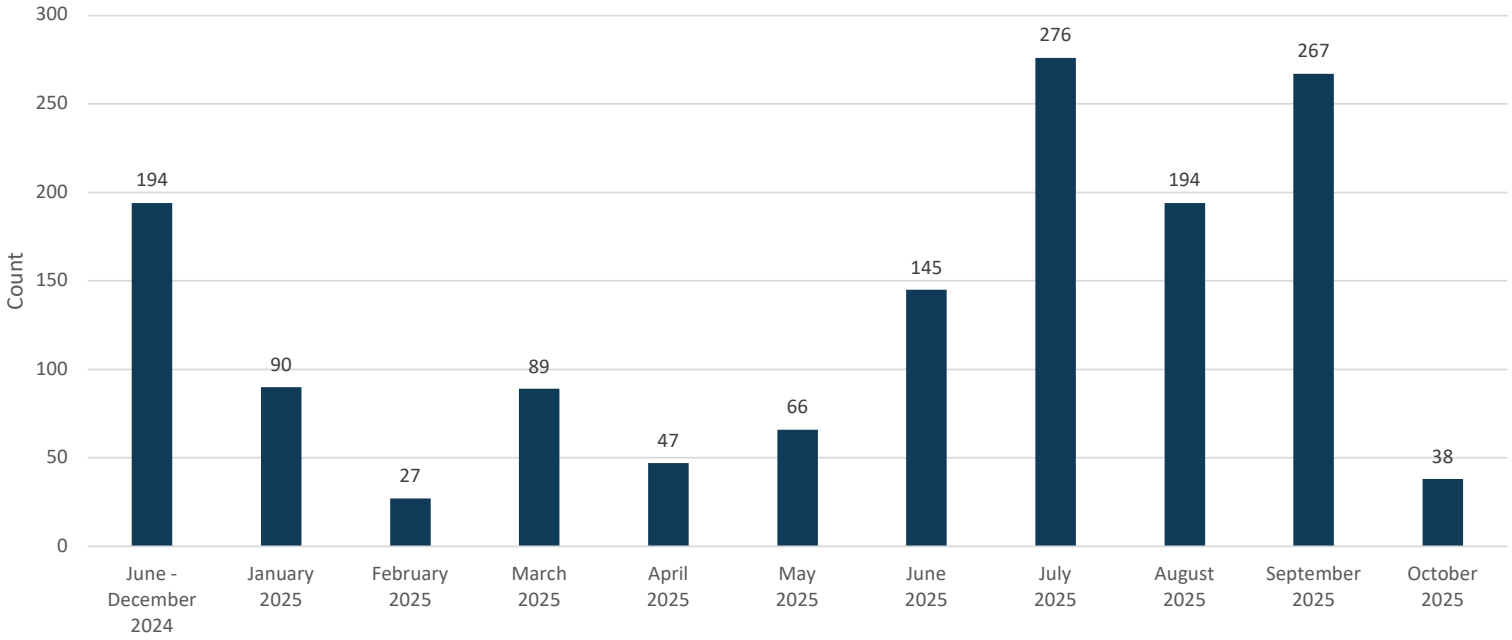
Total Population on October 6, 2025:	**1,433**
No. of Countries of Origin:	86
No. of Female Detainees:	270
No. of Male Detainees:	1,163
Average Age:	37 years
Average Length of Detention:	127 days
Longest Length of Detention:	481 days

The detained ICE population at Otay Mesa as of October 6, 2025 consisted of 1,433 detainees. Of these, 1,163 were male and 270 were female. The average length of stay in the facility was 126.5 days. Eighty-six countries of citizenship were represented in this population, with the most frequently reported countries being Mexico (234) and China (112) followed by Russia (104) and Guatemala (87). The average age of all detainees was 36.8 years and the median age was 35 years.

Cal DOJ reviewed the arrival dates of individuals detained at Otay Mesa on October 6, 2025. As shown in **Figure 43**, the month when the largest number of detainees still present in early October arrived was July 2025, when 276 (19.3%) of these detainees arrived. Other months with many arrivals were September 2025 with 267 detainees (18.6%) and August 2025 with 194 detainees (13.5%). The data shown in **Figure 43** represent the arrivals of the detainees who were present as of October 6, 2025; it is not representative of all individuals detained at Otay Mesa in 2025 and does not include individuals who were released, deported, or transferred prior to Cal DOJ's site visit.

359 The federal government's fiscal year runs from October 1 of one calendar year through September 30 of the next.
360 ICE FY23 Detention Statistics (Oct. 2023), *supra*.
361 *Id.*; ICE FY24 Detention Statistics (Oct. 2024), *supra*; ICE FY25 Detention Statistics (Sept. 2025), *supra*.
362 *Immigration Detention in California* (Apr. 2025), *supra*, p. 132.

Figure 43. Arrival Month of Detainees on October 6, 2025 Roster at Otay Mesa



Facility staff reported changes in detainees' locations prior to arriving at the facility. One staff member reported that the facility is seeing more detainees arrive from within the United States, as opposed to from the border. Another staff member confirmed that border traffic is down. Nonetheless, the facility has experienced surge capacity events (the addition of beds) to accommodate the large influxes of detainees. Facility staff stated that a surge event occurred roughly a few weeks prior to Cal DOJ's site visit. One detainee reported experiencing surge events in July and August 2025. A detainee described the surge he experienced as lasting for two to three weeks. Another detainee who had been housed at Otay Mesa for an extended period reported seeing four surge events at the facility since the current federal administration took over.

V. Conditions of Confinement

Conditions of confinement consist of various policies and practices that shape detainees' experience at Otay Mesa. The conditions reviewed below include: (1) the process by which detainees are processed upon admission at the facility; (2) detainees' access to food, nutrition, and water; (3) conditions of the housing units and detainees' access to basic necessities; (4) staff and detainee relations and use of force incidents; as well as (5) detainees' access to social and programming opportunities.

As explained in this section, Cal DOJ found, and detainees reported, several deficiencies in Otay Mesa's conditions of confinement. For example, detainees reported a prolonged intake process that exceeded the 12-hour PBNDS limit; insufficient food portions and poor food and water quality; overcrowding and limited resources in the housing units, including an insufficient ratio of toilets per detainee in at least one housing unit; instances where use of force practices did not meet PBNDS standards; detainee reports of yelling or insults from some staff; and detainees' inability to communicate with staff despite the availability of interpretation services. Additionally, Otay Mesa's practice of strip-searching detainees after all non-legal contact visits has a severe impact on the morale and personal dignity of detainees.

A. Intake and Orientation

1. Intake Process

When detainees arrive at Otay Mesa, they are initially triaged by nurses outside the building before entering the intake area. Once inside, detainees are placed in holding cells, separated by sex and contract (USMS detainees are separated from ICE detainees). As part of the intake process, detainees must receive an initial medical, dental, and mental health screening, be assigned a security classification, receive clothing and personal hygiene items, and be assigned to a housing unit. This process must take place within 12 hours from the time of arrival.[363]

Figure 44. Intake Holding Cell at Otay Mesa

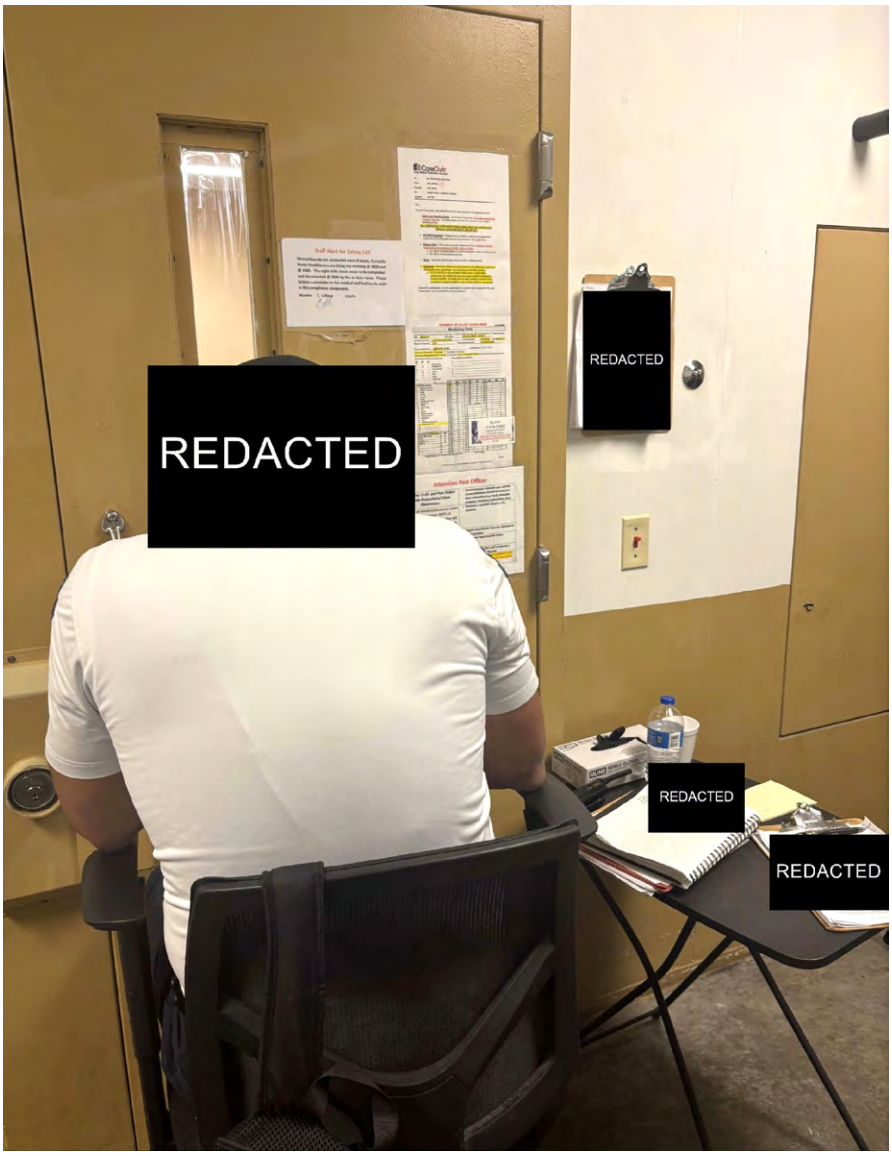
363 ICE, PBNDS 2011, Part 4.3 Medical Care, § J, pp. 266-268; Part 2.2 Custody Classification System, Part V, § D, p. 63.

Figure 45. Intake Holding Cell Toilet with Sink at Otay Mesa

When visiting Otay Mesa's intake area, Cal DOJ observed bags ready for distribution to detainees. These contained clothes and bedding items. The intake area displayed signs instructing that detainees were also to be provided a hygiene kit, a medical wristband, an identification card, and a proper-colored uniform. Cal DOJ observed distribution of sack lunches to persons held in the intake area. Each holding cell has a toilet and a curtain for privacy. One holding cell has a capacity of 22, with two toilets, including one which is disability accessible. The intake area also has three medical examination rooms and one x-ray room. There are two suicide watch cells in the intake area and one in the health unit.[364] During Cal DOJ's site visit, an ICE detainee was held in one of the intake suicide watch cells on a one-on-one watch.

364 *Immigration Detention in California* (Apr. 2025), *supra*, p. 146.

Figure 46. Suicide Precaution Observation at Otay Mesa



During Cal DOJ's site visit, detainees identified several deficiencies with the intake process. First, eight detainees reported not receiving all components of the screening for mental health or dental needs, despite the PBNDS requirement that detainees be screened for medical, dental, and mental health within 12 hours of arrival. Additionally, while health care intake screenings are performed in one of the intake exam rooms with a phone for interpretive service, two detainees who are deaf or hard of hearing also reported that Otay Mesa does not consistently provide sign language interpretation, which can make it difficult or even impossible for deaf detainees to adequately communicate their medical needs.

Eleven of the 29 detainees (38%) Cal DOJ interviewed stated that the intake process had taken over 12 hours, in violation of PBNDS standards, with some reporting they had been in intake for 2-3 days. The extended time in the intake area was made more difficult due to the conditions of the holding cells. Some detainees reported unsanitary conditions in the holding cells, describing the area as "filthy with dirt and hair." Cal DOJ personnel observed a dirty toilet and flies in an empty holding cell. Detainees also stated that the holding cells were very cold, and they were not provided blankets. At least one detainee reported having to sleep on the floor while waiting to be processed. Cal DOJ also met detained individuals who reported arriving with a group so large they had to be processed in the facility's gym instead of the intake area, and remain there for approximately one and a half days.

Detainees also reported problems with access to food and water during intake. Many stated they had received portions of food that were too small, or only received one meal in a span of 10 hours or more, leaving them hungry. Others reported not receiving food at all. According to one detainee, the meal provided during intake was so bad that none of the persons waiting to be processed ate it. During intake, detainees' access to water is limited to tap water from a sink attached to the toilet that everyone in the holding cell (up to 22 persons) uses. Some detainees found this to be unsanitary and did not drink water, concerned they could get sick. Others reported the water had a bad taste and smell.

2. Orientation

ICE detention standards require Otay Mesa to provide an orientation and handbook to each detainee.[365] These resources are important because they allow detainees to learn their rights at the facility as well as the rules and procedures of the facility, including how to request medical care, requirements for phone use and visitation, as well as the facility's discipline system. None of the detainees Cal DOJ interviewed recalled receiving a formal orientation about Otay Mesa; one detainee reported receiving only a description of the facility through an interpreter.

Conversely, 25 (86%) of the detainees interviewed reported receiving a handbook. Otay Mesa provided the handbook to Cal DOJ in 19 languages. Detainees, however, reported that the handbook was only made available to them in English and Spanish. Seven detainees (28%) who reported receiving a handbook also stated that the handbook was not in a language that they could understand. That is, the 11 detainees (38%) who either did not receive a handbook or did not receive a handbook they could understand had limited access to information about their rights while detained at Otay Mesa and how to navigate the facility during their detention.

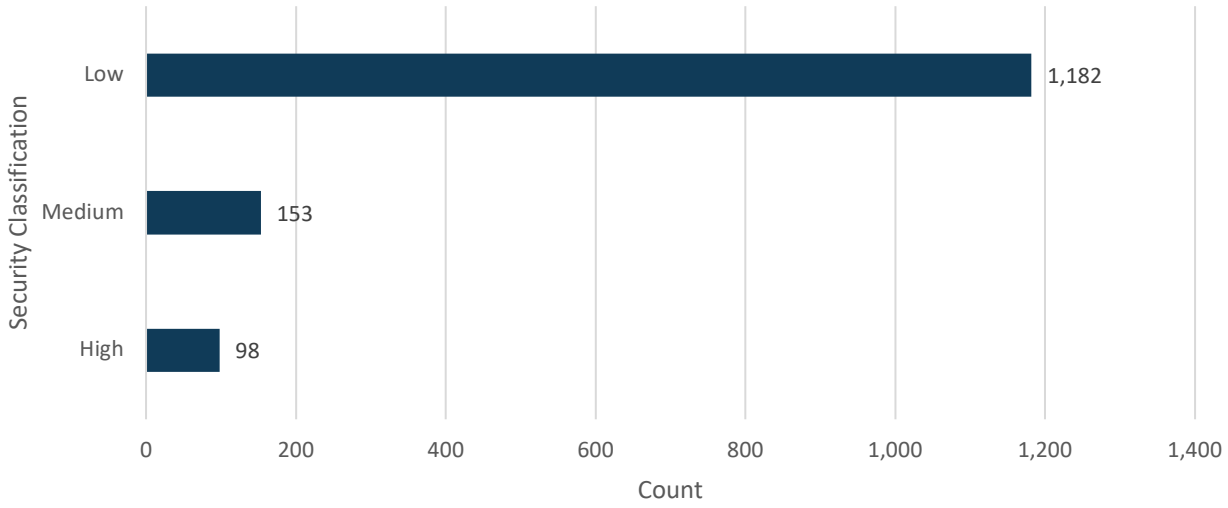
3. Security Classification System

Before admitting detainees into the general population, immigration detention facilities are required to assign a security classification to each person "and physically separate them in accordance with those classification levels."[366] Among other things, classification level determines each person's housing assignment, available recreation, and ability to join the facility's voluntary work program.[367] The classification system is intended to protect detainees from harm by assigning detainees to housing with persons of similar backgrounds and criminal histories.[368] Reclassification must occur 60 to 90 days after the date of initial classification and every 90 to 120 days thereafter.[369]

Otay Mesa classifies the population's custody levels into four categories: Low, Medium-Low, Medium-High, and High. Otay Mesa then assigns detainees into two separate groups for housing assignments—Low and Medium-Low custody detainees can be housed together and separately, Medium-High and High custody detainees can be housed jointly as a second group. CoreCivic produced ICE threat level data to Cal DOJ. As demonstrated in the figure below, the majority of detainees (1,182; 82.5%) were classified at the lowest classification level.[370]

365 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, §§ F-G, pp. 55-57.
366 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part I, p. 60, Part V, § D, p. 63.
367 *Id.* at Part V, § A, pp. 61-62, § F, pp. 64-65.
368 *Id*. at Part II, p. 60.
369 *Id*. at Part V, § H, pp. 65-66.
370 Data produced by CoreCivic reported the admission types for detainees in terms of ICE Levels 1, 2, and 3. We present these categories as Low, Medium, and High in this figure.

Figure 47. Otay Mesa Detainees by Security Classification as of October 6, 2025



A review of detainee files showed some improvements in Otay Mesa's classification system since Cal DOJ's site visit in 2023. Detainee files contained a sheet documenting that detainees who were due for a 60-to-90-day reclassification were provided notice that their classification would be reviewed. Security reclassifications of the files reviewed were completed within the required time frames and staff appeared to be taking special vulnerabilities into account, such as a detainee's mental health, age, weight, and medical needs. Detention files also had forms signed by detainees informing them when they were due for a reclassification.

As noted in prior reports,[371] Otay Mesa appears to continue to house transgender individuals according to their sex assigned at birth regardless of the detainee's best interest. This is consistent with President Trump's Executive Order No. 14168, which instructs DHS to transfer transgender people in detention from placements that reflect their gender identity to new placements that align with sex assigned at birth.[372]

B. Food, Nutrition, Access to Water

Detained individuals at Otay Mesa reported important concerns regarding access to food and water at the facility.

Meals

Many detainees reported issues with the amount, quality, and nutritional value of the food provided. PBNDS standards require that detainees receive three meals per day, and that no more than 14 hours elapse between dinner and breakfast.[373] Although detainees who were asked reported that they generally receive three meals a day, detainees reported two instances where two different detainees were denied a meal as a disciplinary measure, despite the PBNDS prohibition against using the deprivation of food as a form of discipline.[374] Additionally, several detainees stated that the food

371 *Immigration Detention in California* (Jan. 2021), *supra*, p. 101.
372 Exec. Order No. 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615, 8616-8617 (Jan. 20, 2025) <https://www.whitehouse.gov/presidential-actions/2025/01/defending-women-from-gender-ideology-extremism-and-restoring-biological-truth-to-the-federal-government/> (as of Mar. 24, 2026); The American Presidency Project, *Executive Order 14168-Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, UC Santa Barbara (Jan. 20, 2025) <https://www.presidency.ucsb.edu/documents/executive-order-14168-defending-women-from-gender-ideology-extremism-and-restoring> (as of Mar. 24, 2026).
373 ICE, PBNDS 2011, Part 4.1 Food Service, Part V, § D, p. 232.
374 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, § A, p. 216.

portions were too small, one describing the portions as "just enough to survive," but leaving them constantly hungry. Detainees also reported problems with the quality and freshness of the food. Many reported that food that is supposed to be hot is often cold, not thoroughly cooked or expired; describing bad-smelling or half cooked chicken, raw meat, undercooked pasta, and expired milk and tuna. One person also recalled finding pebbles in their food. Some stated that the food made them sick and led to stomach problems. To make up for the small portions or bad quality of the food provided by Otay Mesa, detainees with resources purchase food from the commissary. However, commissary food is expensive and limited. Some detainees interviewed by Cal DOJ reported spending between $30 and $80 per week on food items.

In addition to the portion size and quality of the meals at Otay Mesa, detainees complained about the nutritional value and repetition of the food. During the site visit, Cal DOJ observed fresh apples in the kitchen; however, several detainees lamented they had not seen a fresh piece of fruit since their arrival at Otay Mesa, and only sometimes received canned fruit. The limited availability of fruit was supported by Cal DOJ's review of Otay Mesa's menus: out of 105 meals provided over a 5-week period, only 6 meals included a serving of fruit: three were half cup servings of "fruit espuma" (fruit foam) and three were half cup servings of "fruit." Additionally, detainees complained of not receiving sufficient protein, and reported growing tired of the repetition of porridge at breakfast, and rice and beans for other meals.

Detainees with special diets also reported issues with their meals at Otay Mesa, including repetition and cold meals. Detainees described difficulty in obtaining their requested diet or the facility not always honoring the diet, even once approved. Cal DOJ's immigration detention expert reviewed menus for special diets and found that, as reported by detainees, religious and medical diets are not comparable to the regular menu. Special diets have more repetition in offerings, limited access to protein, and more cold than hot meals.

Finally, nine of the detainees interviewed (31%) stated that the use of microwaves in the housing units often led to conflict in the units. Detainees must wait in long lines for approximately one hour to heat up food or boil water. This wait is exacerbated when one of the microwaves breaks down. The long lines to use the microwaves cause increased tension and sometimes lead to fights between detainees.

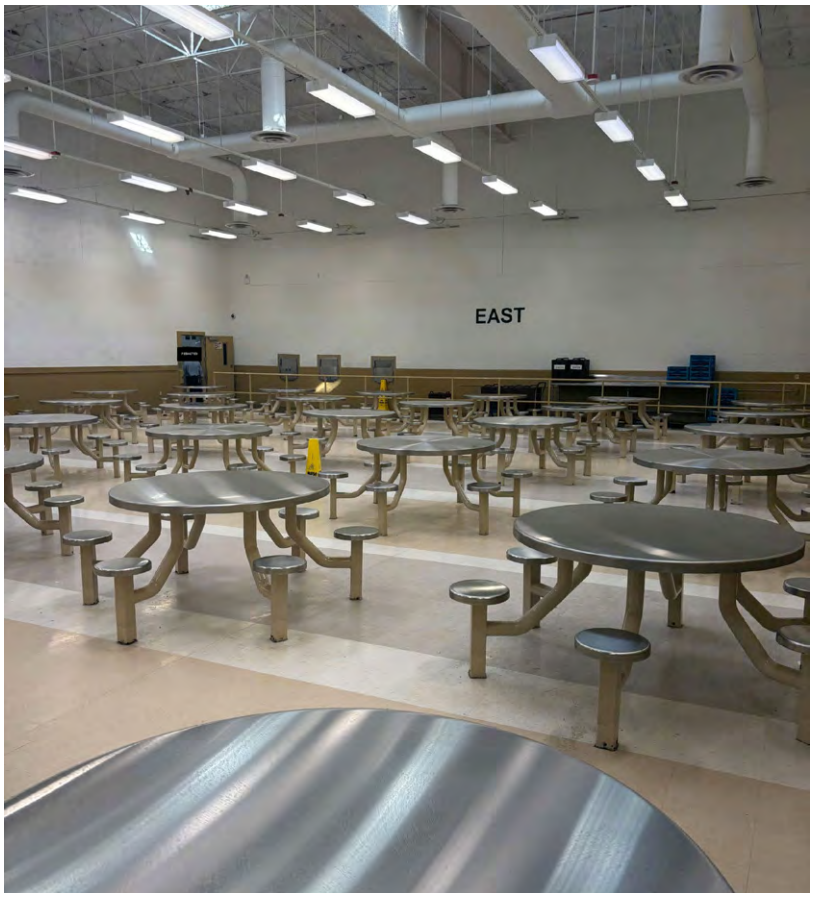
Water

Fifteen detained persons interviewed (52%) also reported issues with access to water. According to detainees, drinking water in the Otay Mesa housing units is tap water, and some described observing bugs coming from the sink, as well as mildew or mold on the faucet. Many detained persons reported that the water had a bad taste, and some also stated it had a foul smell. One person reported he had developed an infection and skin rash and medical staff recommended that they boil the water in the microwave until it bubbles.

Dining and Kitchen Facilities

Otay Mesa has two dining halls (East and West), each with approximately 252 seats. According to facility staff, all meals are served in the dining halls, except for meals served to detainees in the RHU, or when there is an outbreak or incident, in which case meals are taken to the housing units.

Figure 48. Dining Hall at Otay Mesa



Trinity Food Services is the contractor in charge of the food service operations. During the tour, Cal DOJ had the opportunity to visit the kitchen facilities and did not observe deficiencies. The kitchen area was spacious and lit with skylights. Food storage areas were in order and organized, with dates marked on food supplies and temperature control in cold storage areas. The cold storage space included bagels and vegetables marked with September dates. Room temperature storage included dry goods marked with receipt dates and bread, marked September 29, 2025 (eight days had passed since delivery date). Fresh carrots, celery, cabbage, apples, and bell peppers were visible. According to kitchen staff, allergy diets are prepared in a separate area and served through a different window than regular diets, which is important to avoid cross-contamination. The kitchen facility at Otay Mesa is also inspected annually by the San Diego Health Department and its most recent certificate of inspection, at the time of Cal DOJ's visit, was dated June 4, 2025.

Figure 49. Food Storage Area at Otay Mesa

C. Housing Units

As described above, Otay Mesa has experienced an increase in population in the last two years, with many active detainee arrivals in summer and early fall 2025. This increase in population has led to overcrowded conditions and puts a strain on resources available to detainees in their housing units.

1. General Condition of Facility and Housing Units

During Cal DOJ's visit, detainees at Otay Mesa expressed two primary concerns regarding the condition of their housing units: overcrowding and uncleanliness.

Otay Mesa has been identified as one of the top 20 detention facilities in the United States with detainee populations that exceed their contractual capacity.[375] According to the roster of active detainees provided by the facility on October 6, the population of ICE detainees was 1,433. This count exceeded the number of beds allocated to ICE detainees (1,142) by 291, or an excess of about twenty five percent (25%). Similarly, based on data provided by CoreCivic regarding its September 19, 2025 active ICE detainee roster at Otay Mesa, the total number of detainees that day was 1,590. This number exceeds the contractual bed capacity (1,142) by 448 people, or about 39%.

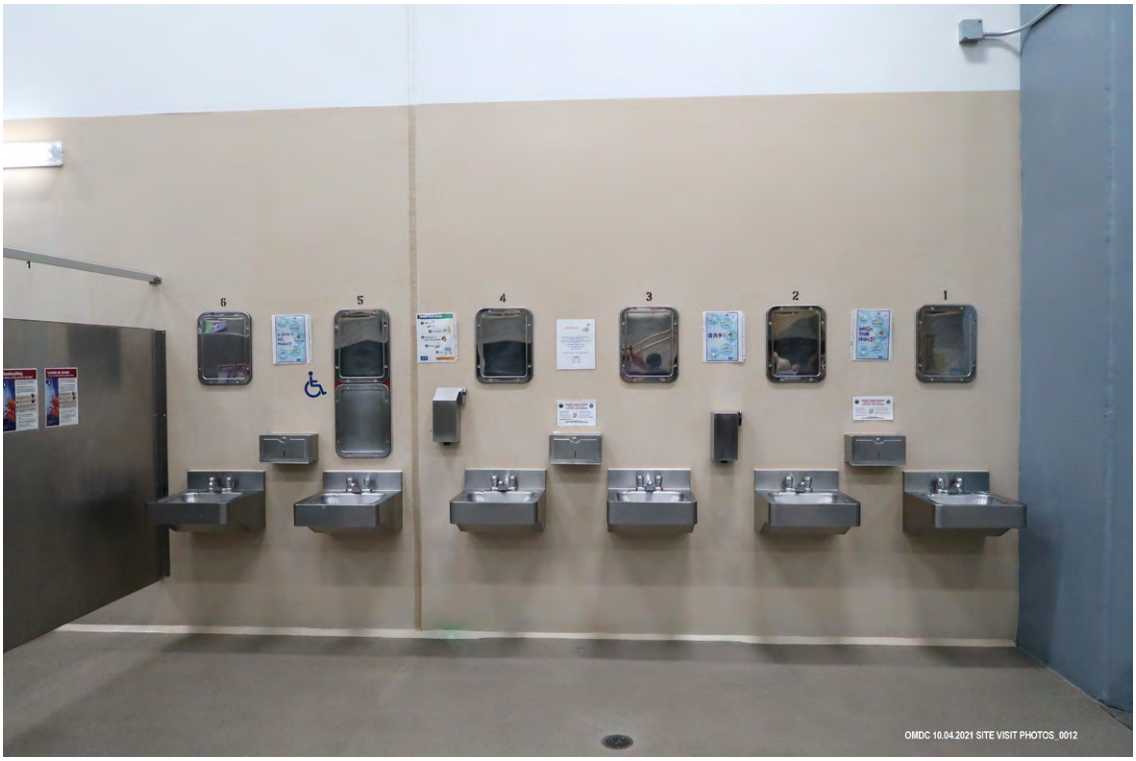
These findings align with reports from detainees, who stated that their housing units often had 20-30 people over capacity. Facility staff confirmed that, during population surges, housing units with open bay housing can add 32 beds and units with cells can add 12 beds. Housing units where detainees sleep in bays usually accommodate eight persons in four bunkbeds; however, during the periods of overcrowding, two additional persons were assigned to each bay and given "boats" or cots to sleep on the floor. According to some detainees, these extra boats were removed before visits from agencies

375 Out of the 181 detention facilities in the U.S., 84 exceeded their contractual capacity on at least one day between October 2021 and mid-April 2025. Otay Mesa was ranked 15th highest in the number of persons detained above the facility's contractual capacity. TRAC Immigration, *ICE Contractual Capacity and Number Detained: Overcapacity vs. Overcrowding* (July 8, 2025) <https://tracreports.org/reports/762/> (as of Mar. 24, 2026).

such as Cal DOJ but would then return. **One person reported that an 89-year-old detainee had been assigned to sleep in a "boat" on the floor and other detainees had to help the detainee get in and out of bed.** Overcrowding causes additional problems for detainees, including increased tension over the sharing of limited resources, and more issues with cleanliness of restrooms and common areas.

A common theme among detainees was the lack of cleanliness of bathrooms and showers. PBNDS provide that facility staff must ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness, which includes daily dusting, mopping and trash disposal,[376] but detainees are only required to maintain their immediate living areas by making the bed, stacking loose papers and keeping the floor around their spaces neat.[377] Otay Mesa does not provide staff to clean the housing units. Instead, detainees in the volunteer work program clean the housing units three times a day, five days a week. Nonetheless, due to the high number of persons sharing the facilities, these quickly become dirty again. One person in the voluntary work program stated that staff often deny them bleach or other cleaning products to be able to clean thoroughly. Many detainees reported seeing mold or fungus and insects and larvae in the shower, and consistent mold on the shower curtains. Some also stated that the bathrooms smell like urine and that feces could be found in the shower stalls. These conditions worsened when the housing units were over capacity, with one detainee stating that during surges "there was trash everywhere."

Figure 50. Sinks in Housing Unit at Otay Mesa



Some detainees also reported hazardous conditions in the housing units, caused by wet floors and slippery shoes, that have caused several people to slip and fall. According to detainees, the facility has not addressed the problem. One detainee stated that when they complained about a slipping hazard due to a ceiling leak that was causing water to collect on the floor, a staff person responded: "if you fall, you fall."

376 ICE, PBNDS 2011, Part 1.2 Environmental Health and Safety, Part V, § A, p. 21.
377 ICE, PBNDS 2011, Part 5.8 Voluntary Work Program, Part V, § C, p. 406.

2. Access to Basic Necessities

Denial of access to basic hygiene items is contrary to ICE detention standards, which require that each detainee be able to maintain "acceptable personal hygiene practices through the provision of adequate bathing facilities and the issuance and exchange of clean clothing, bedding, linens, towels and personal hygiene items."[378] Nonetheless, detainees at Otay Mesa reported problems accessing basic necessities, such as toilet paper and toiletries, as well as toilets frequently going out of order. Several detainees reported that toilet paper often runs out and days can go by before the supplies are replenished. Similarly, toiletry supply carts in the units frequently run out. And although detention standards prohibit utilizing the distribution of hygiene items as reward or punishment,[379] at least one person reported that some staff withhold access to hygiene items and cleaning supplies as a means to assert their authority over the detainee population.

In some housing units, the number of available toilets per detainee did not comply with ICE standards. Detention facilities are required to provide "an adequate number of toilets, 24 hours per day."[380] For female detainees, the minimum ratio is one toilet for every 8 detainees. For male detainees, the ratio is one toilet for every 12 detainees.[381] According to the roster provided by Otay Mesa on September 19, 2025, the total number of female detainees in Housing Unit A was 145. If all 16 toilets were functional, there would have been one toilet for every 9 detainees, exceeding the minimum ratio of 8:1. According to detainee accounts, however, four to five toilets are often out of order in Housing Unit A, and during Cal DOJ's tour of Housing Unit A, only 14 of the 16 toilets were functional, therefore making it more likely that the ratio is even greater than the already deficient 9:1. Detainees in other housing units also reported lacking a sufficient number of working toilets.

Figure 51. Doors to Toilet in Housing Unit at Otay Mesa

378 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part I, p. 327.
379 *Id*. at Part V, § D, p. 328.
380 ICE, PBNDS 2011, Part 4.5 Personal Hygiene, Part V, § E, p. 329.
381 *Id.*

3. Segregation

Otay Mesa has one male and one female restricted housing unit, which house both ICE and USMS detainees in disciplinary or administrative segregation.[382] An issue of concern is that female ICE detainees and female USMS detainees are co-located in an administrative/disciplinary segregation unit for those who are pending investigation or serving their penalty in disciplinary segregation. The standard practice in detention facilities, including local jails, is to separate criminal and civil detainees. Here, the comingling of USMS and ICE detainees can be problematic because not only are they under separate contracts or memoranda of understanding, but persons detained by USMS are criminal detainees, whereas persons detained by ICE are civil detainees.

Moreover, PBNDS detention standards require administrative segregation cells to be "adequately lit" and, generally, persons detained in administrative segregation must "receive the same privileges available to detainees in the general population."[383] However, the cells in the administrative/disciplinary segregation unit for female detainees are in an interior, windowless cellblock. The cells are dark, the ceiling is noticeably low, the opportunity for exercise of any kind within the cell is severely limited, and persons detained in this unit lack any of the amenities available to those in general population, notably, a day room or dining area.

Figure 52. Door to Administrative Segregation Cell at Otay Mesa

382 *Immigration Detention in California* (Jan. 2021), *supra*, p. 104.
383 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, §§ J, L, p. 181.

D. Detention and Safety

1. Staffing

The PBNDS require staffing levels at each facility that ensure sufficient supervision for those detained.[384] One of Otay Mesa's strengths relates to its staffing levels. The facility has more full-time equivalent (FTE) staff than its contract with ICE requires. CoreCivic, unlike other facility operators with ICE contracts, assigns a civilian case manager to each housing unit, whose responsibilities encompass monitoring receipt and response to detainees' grievances, participation in disciplinary hearings in which detainees in that housing unit may be involved, and detainees' reclassification reviews. Additionally, the starting salary for detention officers at Otay Mesa—$38.49 per hour—exceeds comparable positions in the region except for ICE's facility in California City, which is also operated by CoreCivic.

2. Use of Force

Otay Mesa reported 12 use of force incidents with dates between March 8, 2025, and September 6, 2025, a low number for the size of the facility. According to the facility's records, pepper spray was used on four of those occasions and a minor injury was sustained by one detainee.

Review of use of force files demonstrated some deficiencies in Otay Mesa's use of force practices. PBNDS standards restrict use of force to situations where "all reasonable efforts to resolve the issue have failed,"[385] and they require that officers "attempt to gain willing cooperation before using force."[386] Nonetheless, in one instance, facility staff found that a detainee was not offered the opportunity to submit to restraints voluntarily. Moreover, although PBNDS require that Otay Mesa provide communication assistance to detainees who do not speak or understand English,[387] Cal DOJ's file review revealed a use of force case where Otay Mesa staff was unable to communicate with a detainee because of a language barrier. Cal DOJ also reviewed a case where, according to Otay Mesa's after-action review, facility staff found that leg restraints were applied to a detainee when not necessary. This violates the PBNDS requirement that restraints be applied only as "necessary to achieve the desired behavioral objectives."[388] PBNDS also require that a mental health professional be consulted before a detainee with a mental disability or mental illness is placed in segregation.[389] However, in that same case, staff involved in the incident failed to verify whether the detainee had a serious mental illness before placing the individual in restrictive housing. Finally, contrary to PBNDS standards, which require that each officer involved in an immediate use of force incident provide a written report to the shift manager by the end of the officer's shift,[390] there were multiple instances where not all involved detention officers submitted statements.

3. Staff and Detainee Relations

Detainees reported mixed experiences in their interactions with staff. While some stated that staff were friendly and did what they could to help, detainees also reported that some staff try to intimidate them, which detainees said can be particularly jarring for individuals who have suffered prior trauma such as domestic violence or acts of torture. Fourteen detainees (48%) stated that Otay Mesa staff had insulted or yelled at them. One person said that the officers often yell at detainees and sometimes call them "animals." Another stated that when distributing forks, an officer threw the items at the detainees and when a detainee asked why the officer had done that, the officer responded "go back to your country." Detainees also reported incidents where during random searches, officers threw

384 ICE, PBNDS 2011, Part 2.4 Facility Security and Control, Part V, § A, p. 82; Part 2.11 Sexual Abuse and Assault Prevention and Intervention, Part IV, § E, p. 151.
385 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part I, p. 200.
386 *Id*. at Part V, § B, p. 202.
387 *Id*. at Part II, p. 201.
388 *Id*. at Part V, § B, p. 202.
389 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, § A, p. 216.
390 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part II, p. 201, Part V, § H, p. 206.

a detainee's religious book on the floor or took away important case documents. Although PBNDS prohibit the deprivation of food as a form of discipline,[391] detainees reported two instances where detainees were denied a meal as a disciplinary measure.

4. Language and Culture

PBNDS require that all facilities provide language access to limited English proficient detainees to ensure meaningful access to programs and activities.[392] The interpretation service Otay Mesa uses was reported to encompass 60 languages. Regardless, as reported above, review of use of force files revealed one incident where staff was unable to communicate with the detainee because of a language barrier. Detainees also reported issues with language access. One detainee described being exhausted from being asked by detention officers to translate for them. Two detainees also reported being yelled at by officers due to them not understanding instructions because of a language barrier. Despite the availability of language services, detainees stated that officers often did not take the time to call for an interpreter. Detainees who are deaf also reported feeling isolated due to their inability to communicate.

E. Access to Social and Programming Opportunities

1. Strip Searches After Non-Legal Visitation

Contact visitation for family and friends (non-legal visitation) is available Saturdays or Sundays for one hour.[393] Detainees must receive a "thorough pat-down search" before entering the visiting room, and upon exiting, detainees are subjected to a strip search.

One of the main concerns regarding visitation at Otay Mesa is the facility's policy and practice to strip search detainees after non-legal contact visits. **Otay Mesa is the only facility in California that strip searches detainees after each non-legal contact visit. While this policy on its face does not violate PBNDS,[394] it has an overwhelming impact on the mental health and dignity of detainees.** Female detainees described having to fully undress in front of officers, in some cases including male officers, even when menstruating. Both male and female detainees described feeling "violated" and the experience as "humiliating" and "denigrating." One person reported that they stopped having in-person visits to avoid having to be strip searched.

For Otay Mesa's practices regarding post visitation strip searches to comply with PBNDS, detainees must have the option to opt for a non-contact visit instead and be fully informed of this right.[395] Additionally, all strip searches must be documented, and accommodations for persons with disabilities must be provided.[396] While the facility handbook does state that detainees have the option to choose non-contact video visitations, due to the short duration of the site visit, Cal DOJ was not able to assess whether Otay Mesa is complying with these requirements.

2. Telephone Calls

A majority, or 20, of detainees interviewed (71%) reported having issues contacting their families or loved ones. While telephones in the housing units are available every day, they are turned off during counts, which occur three times per day. Detainees reported that the telephones often do not work

391 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, § A, p. 216.
392 ICE, PBNDS 2011, Part 2.13 Staff-Detainee Communication, Part II, p. 188.
393 ICE, *Otay Mesa Detention Center, Hours of Visitation* (Apr. 10, 2026) <https://www.ice.gov/detain/detention-facilities/otay-mesa-detention-center> (as of Apr. 15, 2026).
394 ICE, PBNDS 2011, Part 2.10 Search of Detainees, Part II, p. 118 (strip searches allowed when properly authorized by a supervisor and as outlined in facility procedures for post contact visits).
395 *Id*. at Part V, § D, p. 122 (explaining that "facilities may not adopt policies permitting strip searches after contact visits in the absence of reasonable suspicion unless detainees are provided the right to choose non-contact visitation instead of contact visitation and are fully informed of such right").
396 *Id*. at p. 121.

or are out of order; that calls drop or they have difficulty hearing the person they are calling; and that the cost of making phone calls is high, particularly to foreign countries. One person also described not being able to contact their family for 3 to 5 days while in medical segregation due to not having access to telephones or tablets. These challenges to detainees' ability to contact their loved ones has a great impact on their well-being, especially for detainees whose family is unable to visit in person.

Figure 53. Telephones in Housing Unit at Otay Mesa

3. Programming and Recreation

People detained at Otay Mesa have some access to recreation and distraction items.

Each housing unit at Otay Mesa has a small outdoor recreation area attached to the unit. The area, while small, allows access to sunlight and has a basketball hoop. PBNDS require that, if outdoor recreation is available at the facility, detainees housed in general population must have at least one hour of outdoor recreation per day, seven days a week, at a reasonable time per day, weather permitting.[397] If scheduling and weather permit; however, this requirement increases to four hours per day of outdoor recreation.[398] Otay Mesa appears to be following this requirement. General population detainees reported that the outdoor recreation area is usually open all day except during count, although some stated that it was only open for 1.5 to 2 hours per day.

397 ICE, PBNDS 2011, Part 5.4 Recreation, Part V, § B, p. 371.
398 *Id*.

Figure 54. Exterior Walls of Housing Units' Outdoor Recreation Areas at Otay Mesa

Figure 55. Basketball Hoop in Outdoor Recreation Area at Otay Mesa, 2019

The PBNDS also require that detainees have access to "daily indoor recreation."[399] At Otay Mesa, televisions are available in the common areas; however, each person needs to purchase headphones from the commissary. A detainee reported that while some distraction items such as puzzles and balls are available, they are not always replaced, and people get into fights because there is nothing to do. Housing units also have tablets for detainee use; however, their availability varies by housing unit. Detainees can use the tablets to, among other things, make phone calls, pay for programming, or file grievances. On the day of Cal DOJ's visit, Housing Unit A (Low and Medium-Low custody female detainees) had about 30 tablets for approximately 128 detainees, or one tablet for every 4.25 persons;

399 ICE, PBNDS 2011, Part 5.4 Recreation, Part V, §§ A-B, p. 371.

and housing unit D (male segregation unit) had 12 tablets for about 27 detainees (19 USMS and 8 ICE detainees), for a ratio of one tablet for every 2.25 persons.

Figure 56. Tablets and Puzzles in a Housing Unit at Otay Mesa

Finally, Otay Mesa provides a library for detainee access. Cal DOJ observed a variety of books in English and a few shelves of Spanish-language books at the library. However, one detainee who did not speak English stated there were no books in their native language, which is underrepresented at the facility, and there were no books available to help them learn English.

VI. Due Process

Cal DOJ also evaluated due process rights of detainees held at Otay Mesa, including access to legal services and representation and access to materials needed for immigration cases. Otay Mesa also has an Attorney of the Day Program spearheaded by the San Diego County public defender's office, which appears to meaningfully impact detainees' access to legal representation.

A. Access to Legal Services and Representation

Of the 29 detainees interviewed, 26 detainees (90%) reported that they were represented by an attorney or other legal representative and had been able to communicate with their attorney. This percentage is a high percentage compared to the national average.[400] However, 12 of the 26 detainees

400 A 2025 study found that 31 percent of detained immigrants are represented. Eagly, Shafer, & Moulton, *Access to Counsel in Immigration Court, Revisited* (2025) <https://ilr.law.uiowa.edu/sites/ilr.law.uiowa.edu/files/2025-11/A1_Eagly_1.pdf> p. 26 (as of April 3, 2026) (covering 2013-2024).

with legal representation (46%) experienced difficulties communicating with their attorney. Out of the 17 who reported having sent or received documents from their attorney while at Otay Mesa, seven (41%) stated that they had issues sending or receiving documents from their attorney. Twenty-four of the detainees interviewed (83%) stated that they had had an immigration hearing while at Otay Mesa.

A court is located on site at Otay Mesa.[401] The facility permits an Attorney of the Day Program at the facility. This program is coordinated by the County of San Diego through the public defender's office and is staffed by volunteer attorneys. The program is part of the Immigration Rights Legal Defense Program, which connects these pro bono volunteers with unrepresented detainees who have court hearings each day.

Cal DOJ personnel encountered an attorney volunteer from this program in the visitation area who provided information and materials to Cal DOJ personnel. This individual reported that they see 20 to 30 detainees when they volunteer. This attorney had available an informational packet for detainees that contains legal information about the removal process; the rights and obligations of detainees in court; master calendar hearings; individual hearings; and the differences between parole and a bond request. The availability of this program contributes meaningfully to the protection of detainees' due process rights and access to counsel at Otay Mesa and is a commendable contribution by the county public defender's office and the local pro bono community of volunteers.

B. Access to Materials Needed for Immigration Case

During the facility tour, Cal DOJ also observed relevant postings in at least one dormitory relating to the following cases, which affirmed procedural protections for some detainees in immigration detention: *Cancino-Castellar v. Mayorkas* (S.D. Cal. Mar. 14, 2024, No. 17-cv-00491-BAS-AHG) [class settlement requiring faster, written notifications of the right to a first appearance and addressing systemic processing delays]; *Franco-Gonzalez v. Holder*, (C.D.Cal. Apr. 23, 2013, No. CV 10-02211 DMG (DTBX)) [requiring that detainees diagnosed with certain mental health disorders be appointed an attorney, among other processes, and that facilities post information notifying detainees of the settlement]; and *Gonzalez v. Barr,* (9th Cir. 2020) 955 F.3d 762 [requiring that class members receive a hearing after six months of detention]. A *Franco* notice was also observed in the RHU.

The facility's detainee handbook appears only to be available in English and Spanish in practice, although versions in other languages were produced by CoreCivic to Cal DOJ. In addition, detainee access to attorneys is limited at Otay Mesa by their access to working phones.

VII. Health Care

Cal DOJ also reviewed Otay Mesa's provision of health care, including but not limited to the following areas: 1) medical staffing; 2) intake assessments, evaluations, and response to detainee sick call requests; and 3) diagnoses, referrals to outside care, and continuity of care.

Deficiencies were present, particularly around recordkeeping, which impacted all other areas of care. Cal DOJ's medical expert had difficulty following the information in medical charts to assess whether a perceived problem was due only to limited records or reflected an underlying lapse in care. Recordkeeping issues appeared to impact detainees' receipt of all the follow up care they required in the facility, and especially impacted the consistency of referral to, and follow up with, outside specialty care. Detainee reports and medical chart review both reflected delays and absences of care even though Otay Mesa had made several staffing improvements since Cal DOJ's last site visit in 2023. Cal DOJ also identified improper management of a case of recurrent tuberculosis.

401 U.S. Department of Justice, Executive Office for Immigration Review, *Otay Mesa Immigration Court* (Feb. 27, 2026) <https://www.justice.gov/eoir/otay-mesa-immigration-court> (as of Apr. 15, 2026).

A. Staffing

At this review Cal DOJ observed improvements in staffing as compared to the 2023 site visit, particularly in mental health staffing. At the time of Cal DOJ's October 2025 site visit, mental health staffing consisted of one full-time on-site psychiatrist, one part-time telepsychiatrist, one psychologist, two masters-level mental health clinicians, a mental health specialist, and one additional psychiatry position that is unfilled. There was an additional telepsychiatrist and two psychologists listed on the roster who did not appear on the schedule as providing service. This is a marked improvement over 2023, when there were no psychologists or masters-level clinicians–such that psychotherapy services were not available–and no on-site psychiatrists.[402]

Medical staff also saw improvements since 2023. The Clinical Director has been stable in the role for five years. Cal DOJ was unable to verify her board certification, but she could speak to the care plans of many of the patients at the facility. Staff included five physicians, many of whom were full-time, and one additional full-time physician who had just been hired. There were also eight advanced practitioners—seven active and one newly hired—on staff and two additional advanced practitioners available as needed. Advanced practitioners include providers such as nurse practitioners or physician's assistants who are qualified to attend to many medical needs and refer any more complex issues outside their expertise to a physician for further evaluation and care. Cal DOJ's medical expert noted that health care staff described having an average daily caseload of 20 patients, which is commensurate with workloads at community clinics elsewhere.

Nursing staffing levels had also improved since 2023, with 32 registered nurses and 17 licensed vocational nurses on the roster. However, the Nurse Clinical Supervisor role was vacant, which was of concern to Cal DOJ's medical expert. The Health Services Administrator and Assistant Health Services Administrator are also both nurses and able to provide both backup and appropriate supervision. Additionally, the facility had added three medication management nurses in response to grievances related to medication access, and services showed signs of improvement after they were hired. Quality improvement in general was an area of strength, with evidence of peer review, regular chart audits, and corrective actions taken, and was a noted improvement over Cal DOJ's observations during the 2023 review when the quality improvement process was deemed a weak area for Otay Mesa.[403]

Dental staffing was also an area of strength, with three full-time dentists, two hygienists, and one dental assistant on staff. Most facilities visited by Cal DOJ during this review period did not have hygienists on staff.

B. Intake Assessments, Evaluations, and Sick Call

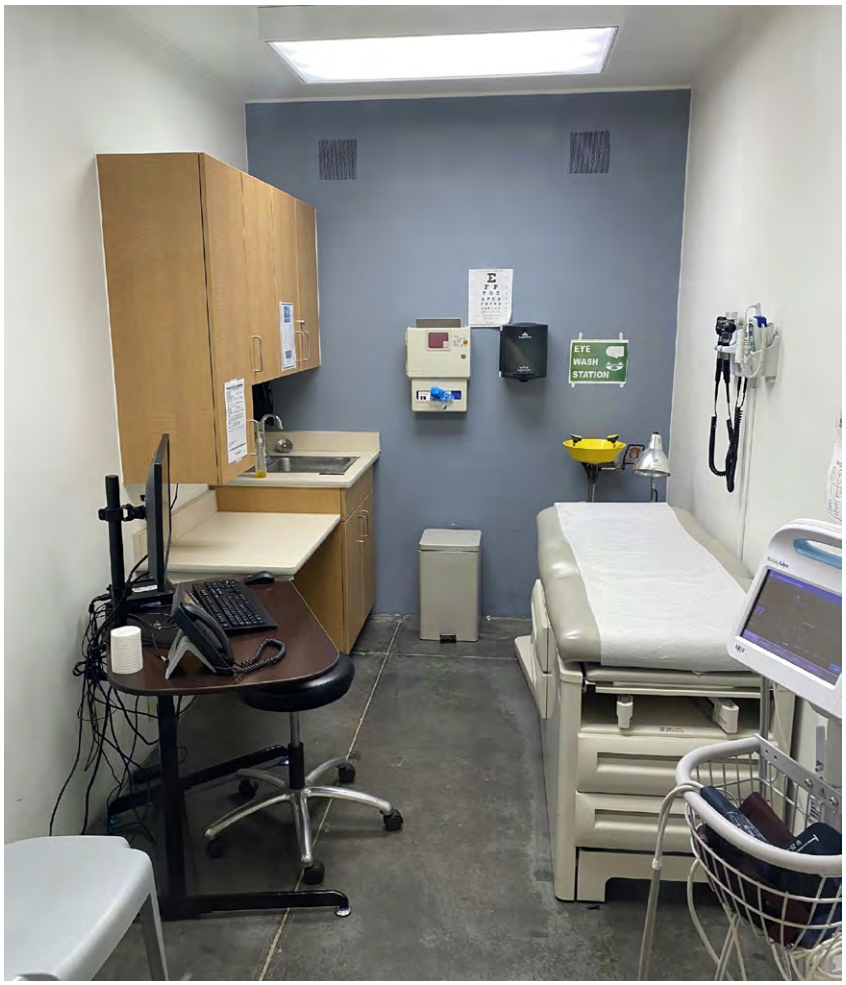
Of the 29 detainees who participated in interviews with Cal DOJ staff during the site visit, 26 detainees (90%) reported having health concerns. Twenty-seven (93%) said they had requested either medical or mental health care. Of these 27 detainees, five detainees (19%) reported they received the help they needed while 21 detainees (78%) reported they did not. Seventeen detainees (59%) reported previously taking medications or receiving treatment for a health condition before arriving at the facility. Similarly, 17 detainees (59%) said that they were asked about their treatment history. However, eight detainees (28%) reported that no one had asked them about prior care. Additionally, 19 detainees (66%) reported that they did not receive an initial health assessment.

Despite improvements in staffing levels at the facility, records reflected delays in access to needed care. As mentioned in the Intake and Orientation section above, the intake process involves pre-screens and triage by nurses on arrival, an intake area with medical exam rooms with a phone for interpreter services, and pregnancy tests applied for all female detainees entering the facility. However, some

402 *Immigration Detention in California* (Apr. 2025), *supra*, p. 139.
403 *Immigration Detention in California* (Apr. 2025), *supra*, p. 151.

records irregularities were present that may contribute to difficulties with follow up and consistency of care. The intake screen template formatting made it difficult to visually track responses, and the final designation of priority level (emergent, urgent, routine) was not reliably marked. Dates of arrival and presence of comprehensive intake exams were also not easy for Cal DOJ's medical expert to track with the assistance of the Health Services Administrator. At a later meeting the Clinical Director navigated the system more easily and was able to answer questions Cal DOJ's medical expert had about health records and patient care, and the Health Services Administrator described engaging in her own review and triage of cases along with the mental health specialist. It appears that the system for assessing and tracking the urgency of care needs relies more on the efforts of individual motivated employees than on a well running system with clear tracking and redundancies.

Figure 57. Medical Exam Room at Otay Mesa



These inconsistencies were echoed in the reports detainees shared with Cal DOJ when asked about their experiences of medical assessment at intake, as discussed in the Intake and Orientation section above. Multiple detainees reported having had inhalers or medications taken from them on arrival and not receiving them again for several days to over two weeks, or telling intake clinicians about their existing medications but not receiving these for similar periods of time. Others reported being taken to medical rooms that had not been cleaned, or receiving injections on arrival that were not explained to them in their language.

The process for timely addressing detainees' medical needs once inside the facility had similar inconsistencies, and Cal DOJ's medical expert had concerns about the impact of Otay Mesa's paper sick call system on the provision of care. The number of detainees requesting assistance through sick call

each day is high, and paper sick call requires additional nursing time to review and does not allow for translation. Chart review revealed at least one sick call request that was untranslated and indicated no sign of response from staff. Health care staff reported that despite the high caseload there was no backlog of sick call requests.

Some detainees did report receiving timely and appropriate care when they made a sick call request. However, others reported not getting care despite repeated complaints, or experiencing and observing detention officers waiting for symptoms to get serious before agreeing to contact the medical unit. One detainee reported waiting hours to be sent to a hospital after an acute injury. Another reported receiving CPR from another detainee after losing consciousness on one occasion, while it took several minutes for medical personnel to arrive. Cal DOJ could not confirm whether CPR was in fact needed in this case. Multiple detainees also complained that they had met some resistance to addressing multiple medical needs at once and felt they needed to put in a separate request or have a separate appointment for each concern.

C. Diagnoses, Referrals to Outside Care, and Continuity of Care

The recordkeeping weaknesses mentioned above particularly impacted continuity of care and referrals to specialty care, which had been areas of concern during Cal DOJ's 2023 review as well.[404] Scanned records were incomplete or unlabeled as to what they were, stays in facility medical housing or the locations at which outside care was received were not always identified in the records requiring staff to check medical housing logs or emails to provide information that should have been available in the chart, and specialty care referrals were not accessible in the health records. Chart review identified resulting lapses in providing access to specialty care. In one case, a detainee with complex health needs was treated for seizures at the emergency room within days of arrival but was never referred for neurology or other further testing, and the detainee was deported without any such recommendations in the discharge summary. Another detainee who was elderly and also had complex medical needs but who arrived at the facility with the ability to walk experienced a degree of swelling of the legs that confined them to a wheelchair, and the chart reflected no working diagnosis or referral for physical therapy or external diagnostic testing. In this case, the detainee had refused further hospitalization, which had been offered, due to not wanting to be shackled and not being permitted to bring their child who was essential as an interpreter due to the complexities of this case. However, the facility had not explored outpatient testing options as an alternative. PBNDS mandates that health care records "shall be well organized, available to all practitioners, and properly maintained."[405] Cal DOJ's medical expert was concerned about the impact of poor recordkeeping on patient care but also believed that this issue is something that CoreCivic could mitigate by engaging with its electronic health records vendor to create more streamlined and user-friendly referral and patient monitoring systems.

Detainees also reported failures in referrals for specialty care or other problems with continuity of care to Cal DOJ during interviews. Of the 17 detainees who reported they were receiving medication or treatment prior to their arrival, 10 stated they were not receiving the same medication or treatment at the facility. Of these 10 detainees, four said they had been informed of the change to their care, four said they had not, and two were unsure. Also of these 10, three said the medication or treatment provided by Otay Mesa works the same or better, five said the treatment at Otay Mesa did not work as well, and two were unsure. Two detainees reported not being referred for a necessary colonoscopy, although one reported that an outside group advocated for him to receive one and was eventually successful. Another reported not receiving a referral to address blood in the urine. Others reported not receiving necessary follow-up testing after prior health interventions. A detainee who was sent to the hospital after an acute injury had returned with discharge instructions but reported that the facility did not follow the care instructions that were provided.

404 *Immigration Detention in California* (Apr. 2025), *supra*, p. 138.
405 ICE, PBNDS 2011, Part 4.3 Medical Care, Part II, p. 259, Part V, § BB, p. 277.

Cal DOJ had particular concern about a case of tuberculosis, in which lapses in coordination and care planning with local public health authorities resulted in increased risk to the patient and to others due to the risk of spreading. A detainee with a history of tuberculosis received treatment upon evidence that the tuberculosis had reactivated, and the county public health department was notified but no specialist was consulted until eight months later. However, treatment stopped after six weeks, contrary to public health advice and infectious disease expertise, with no specialist consultation. Ending treatment early risks developing treatment-resistant tuberculosis. The patient did develop worsening tuberculosis after the treatment had been prematurely withdrawn, although it did not appear to have been a resistant strain.

Facility health care staff appeared to make some personal efforts to provide more continuity of care. Staff reported that formal holds would not be placed on detainee transfers to ensure that a detainee could remain local for a needed treatment, but that staff would alert ICE to these needs in weekly meetings. On the other hand, staff also reported that they did not inform detainees when a specialty appointment had been scheduled but not yet approved by ICE due to not knowing if the approval would come through. Effective and continuous care includes appropriate referrals to specialty care, which in turn requires a reliable and accurate health care recordkeeping system.

D. Concerns Identified During Review

Additional issues that Cal DOJ identified during review of health care services at Otay Mesa included: 1) the impact of transfer or the lack thereof on detainee health care access; 2) examples of disrespectful comments by staff to detainees about health-related topics, although this practice appears to be much improved since Cal DOJ's 2023 review; and 3) failures to offer accommodations or supports to some detainees with physical limitations.

Cal DOJ identified two significant issues impacting detainee health and medical care: 1) the fact of being detained and moved between facilities, or, conversely, 2) of not being transferred to a facility that could provide an appropriate level of care for that detainee's needs. Cal DOJ heard health care challenges from detainees ranging from having missed a scheduled cancer surgery or not having access to surgery aftercare due to being detained, to not being able to see a dentist while in custody because of never being kept in the same facility for the six months that policy recommends for eligibility for routine dental services. PBNDS 4.3(R)(2) states, "Routine dental treatment may be provided to detainees in ICE custody for whom dental treatment is inaccessible for prolonged periods because of detention for over six months." Second, detention appeared especially harmful for detainees with multiple health conditions who needed a higher level of medical care than that available at Otay Mesa. **Cal DOJ observed cases where despite medical staff describing ongoing advocacy efforts they had made, timely transfer to a facility that could provide sufficient care was not occurring and individuals with higher physical, mental health, or cognitive needs were moved back and forth between the hospital and medical housing at Otay Mesa, returning to the hospital when symptoms exacerbated without proper care.** Access to recreation or other health-promoting activities was more difficult for such patients in extended medical housing.

During the 2023 review, Cal DOJ reviewed many files and documents indicating a pervasive problem with poor health care staff attitudes toward detainees. This issue appeared greatly improved during the 2025 review. However, during the 2025 site visits, Cal DOJ discovered some individual instances of poor treatment, such as a detainee who reported having a recent miscarriage being told she was young and would "get a new one."

Cal DOJ also heard reports of some cases where lack of health care or disability accommodation was disruptive or harmful to detainees.[406] In one case, a detainee was denied glasses for unknown reasons and had to spend his own money at the commissary to purchase a pair to be able to read. Another

406 Cal DOJ did not receive enough information about these cases to assess whether an ADA violation had occurred.

detainee reported being denied a lower bunk that was needed due to existing physical limitations, and injuring themselves badly later on from a fall from the top bunk. And an elderly detainee reported not being allowed to have an extra pillow to support comfort living with multiple complex health conditions. Cal DOJ received reports from deaf detainees that interpreting services had not been made available to them for the purposes of communicating with their family, their attorneys, or at hearings.

12. California City Detention Facility

I. Introduction and Summary of Key Findings

California City Detention Facility (Cal City)[407] is a privately operated 70-acre civil immigration detention facility located in eastern Kern County, approximately 70 miles east of Bakersfield.[408] Cal City has been accepting civil immigrant detainees since August 27, 2025.[409] It is the newest and largest civil immigration detention facility in California.[410] Unlike other facilities in California that are subject to ICE's more protective standards (PBNDS), the National Detention Standards (NDS) apply to this facility. CoreCivic's contract with ICE for Cal City requires the facility to comply with the NDS, including with respect to the facility's provision of healthcare.[411] As of November 19, 2025, the facility held 942 detainees, and the majority had no criminal history.

On November 20–21, 2025, a team from Cal DOJ conducted an initial site visit pursuant to AB 103. During the site visit, Cal DOJ staff toured the facility, interviewed facility staff and detainees, and reviewed medical and detention files. Although CoreCivic facilitated Cal DOJ's inspection, it did not make all requested documents and information available to Cal DOJ, most notably use of force records. During the Cal City site visit, Cal DOJ had the opportunity to speak with detainees who have been detained at multiple ICE detention facilities. Detainees widely conveyed to Cal DOJ that their experiences were far superior at other facilities compared to Cal City.

Cal DOJ observed extensive violations of ICE detention standards during the site visit to Cal City. Detainees described insufferable conditions, specifically relating to cold temperatures and the lack of protective clothing, and several detainees wept during their interviews. The conditions at Cal City were so inadequate that Cal DOJ determined that the facility required an expedited notification regarding the substandard conditions to relevant stakeholders in advance of the publication of this report. On December 19, 2025, Cal DOJ delivered a letter describing its preliminary findings to the Department of Homeland Security (DHS), ICE, and CoreCivic.[412]

This report confirms these preliminary findings and provides additional findings documenting the extensive violations of NDS at Cal City. After review of conditions at Cal City, Cal DOJ found that:

- The facility opened prematurely, was not ready to accept detainees, and was inadequately staffed, including detention staff and healthcare staff, in violation of NDS. Lack of staffing impacted facility operations and resulted in the facility not offering detainees contact visits with attorneys or with loved ones, reducing quality of life.

- Cal City is a former prison, and detainees reported that Cal City was being run like a prison as opposed to a civil detention facility even though the majority of detainees were classified as Low security. Detainees spent unnecessarily long periods locked down in their cells for excessive

407 The facility is also referred to as the California City Immigration Processing Center. CoreCivic, *California City Immigration Processing Center* <https://www.corecivic.com/facilities/california-city-immigration-processing-center> (as of Mar. 24, 2026).
408 Montalvo, *ICE Awards $130M Contract to Launch California's Largest Detention Center* The Fresno Bee (Oct. 22, 2025) <https://www.fresnobee.com/news/local/article312344657.html> (as of Mar. 24, 2026).
409 CoreCivic, *CoreCivic Announces New Contract Awards At California City Immigration Processing Center and Midwest Regional Reception Center* (Sept. 29, 2025) <https://ir.corecivic.com/node/24926/pdf> (as of Apr. 2, 2026).
410 *Ibid*.
411 *Gomez Ruiz v. ICE* (N.D.Cal. Mar. 3, 2026, No. 3:25-cv-09757) ECF No. 82-1, ¶ 17 (Declaration of Christopher Chestnut).
412 Cal. Dept. of Justice, Office of the Attorney General, *Attorney General Bonta Warns of Dangerous Conditions at California City Detention Facility* (Dec. 19, 2025) <https://oag.ca.gov/news/press-releases/attorney-general-bonta-warns-dangerous-conditions-california-city-detention> (as of Apr. 2, 2026) (press release including letter from Attorney General Rob Bonta to Hon. Kristi Noem). In this letter, Cal DOJ reported preliminary findings that: (1) Cal City opened prematurely and was not prepared to handle the needs of the incoming population; (2) living conditions at Cal City were unsafe, unsanitary and unlawful, violating numerous NDS standards; (3) health care at the facility was inadequate and endangering detainees; and (4) detainees reported violations of their constitutional rights.

headcounts by facility staff who did not uniformly have clear written orders describing the duties of their positions and who reportedly yelled at detainees excessively.

- Healthcare infrastructure and systems at this new facility were inadequate and some intakes were conducted in a vacant housing pod.

- Cal DOJ observed crisis-level healthcare understaffing, including that there was only one extremely overworked physician providing care, and no backup physician consistently available to provide coverage when the single physician was unavailable. Mental health staffing and systems appeared superior to other medical resources available at Cal City, although the facility opened before mental health staff were fully onboarded as well. The Health Services Administrator appeared to be making an effort to improve care.

- Comprehensive intake medical assessments were not completed within NDS standard time-frames or were dropped altogether.

- Cal DOJ found multiple instances in health care records and detainee interviews of failures to give detainees access to outside specialists.

- Detainees described experiencing extremely cold temperatures, with leaks during rainy periods, and that weather-appropriate clothing was substandard. Detainees, especially the elderly, reported tremendous suffering and detainees wept when describing these conditions. To protect themselves from the cold, detainees were forced to modify socks to improvise sleeves and to cover air vents in their cells with sheets of paper but reported being written up when they did so.

- Detainees reported inadequate food quantities and needing to purchase additional food at the commissary to fulfill nutritional needs.

- Recreation and outdoor access were not adequate, and female detainees were provided less access to both recreation and outdoor areas than male detainees.

- For detainees who had been held at different facilities, Cal DOJ received repeated detainee reports that conditions were consistently worse at Cal City than other facilities in which they had been housed.

A federal district court issued a preliminary injunction on February 10, 2026, requiring extensive reforms at Cal City due to likely violations of detainees' constitutional rights at the facility resulting from the substandard conditions.[413] Although these court-ordered reforms may address several of Cal DOJ's concerns in this report, a comprehensive review by ICE and CoreCivic for compliance with NDS is nonetheless necessary. The conditions at Cal City require an immediate remedy by DHS, ICE, and CoreCivic to protect the health and safety of detainees at the facility.

II. Facility Background

Cal City is located in California City, California in Kern County. It is privately operated by CoreCivic, Inc. The facility was built in 1999 by Correctional Corporation of America (CCA), a predecessor company to CoreCivic.[414] The facility was the subject of a Residential Services Agreement between CCA and the City of California City pursuant to which the city would enter into incarceration agreements with

413 *Gomez Ruiz v. ICE* (N.D.Cal. Feb. 10, 2026, No. 3:25-cv-09757) ECF. No. 62.
414 Disability Rights California, *Newly Opened California City ICE Detention Facility: Dangerous for Disabled People* (Nov. 3, 2025) <https://www.disabilityrightsca.org/reports/california-city-ice-processing-center-a-dangerous-expansion-of-immigration-detention-in> (as of Apr. 2, 2026) ("DRC Report").

"governmental entities" and pay CCA to perform incarceration services. The facility was used to house federal prisoners from 2000 to 2010, USMS prisoners and ICE detainees from 2010 to 2013, and as a state prison from 2013 to 2024, when it was closed.[415]

In April 2025, ICE awarded a $130 million contract to CoreCivic to operate the 2,650-bed facility for immigration detention.[416] The facility has been operating pursuant to an April 1, 2025 letter contract between CoreCivic and ICE and a two-year September 1, 2025 contract between CoreCivic and ICE.[417] Cal City began accepting detainees on or around August 27, 2025.[418] Over 500 detainees were transferred in the first two weeks.[419] CoreCivic expected the facility to reach its full capacity of 2,560 detainees in early 2026.[420] Cal City is the seventh privately operated civil immigration detention facility in California, and the third in Kern County.[421]

Table 19. Key Data Points, California City Detention Facility[422]

Facility:	**California City Detention Facility**
Operator:	CoreCivic, Inc.
Housing Detainees Since:	August 2025
Bed Capacity:	2,560
Type(s) of Detainees Facility Can Hold:	Female and Male Adult Civil Detainees

Even though it has been open for fewer than nine months, Cal City is now the subject of two lawsuits. On September 16, 2025, the Dignity Not Detention Coalition and an anonymous detainee at Cal City sued the City of California City and CoreCivic, Inc. in Kern County Superior Court,[423] alleging that the City of California City and CoreCivic violated multiple California laws in opening the facility in August 2025.[424] That suit is pending in the United States District Court for the Eastern District of California.[425]

On November 12, 2025, seven Cal City detainees filed a class action lawsuit against ICE, DHS, and officials of those agencies in the Northern District of California.[426] The suit alleges violations of detainees' First and Fifth Amendment rights, and the Rehabilitation Act, which protects the civil rights of disabled persons.[427] In the lawsuit, plaintiff detainees reported experiencing unsanitary conditions;

415 *Dignity Not Detention v. City of California City* (E.D.Cal. Oct. 1, 2025, No. 1:25-cv-01292-JLT-CDB) ECF No. 1-5, ¶¶ 10-14 (Declaration of Bart E. Verhulst ("Verhulst Decl."); Kern County Grand Jury Final Report, FY 19-20: Law and Justice Committee <https://itsapps.kerncounty.com/grandjury/finalreports/fy1920/lawjustice.pdf> (as of Apr. 2, 2026); Elliott, *State Removes All Inmates from Cal City Prison, Remaining Staff Working to Close Facility* Tehachapi News (Nov. 18, 2023) <https://www.tehachapinews.com/news/state-removes-all-inmates-from-cal-city-prison-remaining-staff-working-to-close-facility/article_f6920d7c-864e-11ee-88b2-3f4bee2c5642.html> (as of Apr. 2, 2026).

416 Montalvo, *ICE Awards $130M Contract*, *supra.*

417 CoreCivic, *CoreCivic Announces New Contract Awards At California City Immigration Processing Center and Midwest Regional Reception Center* (Sept. 29, 2026) <https://ir.corecivic.com/node/24926/pdf> (as of Apr. 2, 2026).

418 Verhulst Decl. at ¶ 21.

419 Montalvo, *ICE Awards $130M Contract*, *supra*.

420 *Dignity Not Detention Coalition, v. City of California* (E.D.Cal. Nov. 7, 2025, No. 1:25-cv-01292-JLT-CDB) ECF No. 33, p. 2 (Order Denying Request for Temporary Restraining Order; Order Denying Motion to File Supplemental Response).

421 ICE, *Detention Facilities*, <https://www.ice.gov/detention-facilities> (as of Nov. 7, 2025).

422 CoreCivic redacted information for 24 detainees from the roster it produced to Cal DOJ in anticipation of the site visit. Cal DOJ's analysis is thus based on the 918 detainees for whom information was disclosed.

423 *Dignity Not Detention Coalition v. City of California City* (Super. Ct. Kern County, Sept. 16, 2025, No. BCV-25-103365) ("*DND* Compl.").

424 Plaintiffs allege that the defendants violated multiple state and local laws, including Civil Code section 1670.9 (Cal. Sen. Bill 29 (2017-2018 Reg. Session)); the City's Municipal Code including Zoning Regulations (California City Municipal Code Title 9, Chapter 2); the State Planning and Zoning Law (Gov. Code §§ 65000 *et seq*.); and Bus. & Prof. Code, §§ 17200, *et seq.* (*DND* Compl. ¶¶ 2–3.)

425 *Dignity Not Detention Coalition. v. City of California City* (E.D.Cal. Oct. 1, 2025, No. 1:24-cv-01292) ECF No. 1 (Notice of Removal).

426 *Gomez Ruiz v. U.S. ICE* (N.D.Cal. Nov. 12, 2025, No. 3:25-cv-09757) ECF No. 1 ("*Gomez Ruiz* Compl.").

427 *Id*. at ¶¶ 268-294.

crumbling infrastructure; inadequate clothing, food, and water; solitary confinement and frequent lockdowns; force, threats, and excessive discipline by staff; a lack of medical care, medication, and disability accommodations; and limited access to family members and legal counsel.[428] On December 22, 2025, the parties stipulated to resolve a motion for a temporary restraining order allowing two detainees to obtain access to required medical specialists (a cardiologist and a urologist).[429]

In addition, the court in *Gomez Ruiz v. ICE* issued a preliminary injunction against the defendants regarding certain conditions of confinement at the facility. On February 10, 2026, the court issued an order requiring ICE to ensure adequate health care staffing; comprehensive, documented medical intake screening, performed by a qualified medical provider within 12 hours of a person's arrival; thorough initial appraisals performed timely by a primary care provider; timely approval and access to medical specialists; timely and responsive emergency services; continuity of medical care upon intake and thereafter, including timely completion of active medical orders, access to scheduled provider appointments, and consistent provision of medication; timely access to prescribed medications; and a responsive sick call request system.[430] To ensure compliance with these health care reforms, the court also ordered that the defendants provide access to a qualified, independent, third-party monitor for a period of 120 days.[431]

The preliminary injunction requires Defendants to ensure that detained individuals have timely and confidential access to attorneys, including but not limited to: in-person legal visitation seven days per week from 8:00 a.m. to 8:00 p.m., in private and confidential settings, with each legal visit lasting up to three hours in length; contact attorney visits that do not take place through a pane of glass, absent documented security grounds to deny such contact; scheduling of confidential legal calls with legal representatives of up to 90 minutes each, to take place within two business days of a request; and provision of written information regarding protocols for attorney-client communication to all individuals detained at Cal City.[432] Further, the court ordered the defendants to ensure that detained individuals are provided with temperature-appropriate clothing and blankets free of charge and reasonable, consistent, and adequate access to adequate outdoor recreation spaces, for at least one hour per day, seven days per week, with limited security-related exceptions.[433] On March 3, 2026, CoreCivic filed an Emergency Motion to Intervene and an Emergency Motion to Stay Pending Appeal to stop the implementation of the preliminary injunction.[434] On March 30, 2026, the court granted the Defendants' motion to transfer to the Eastern District of California.[435] On April 13, 2026, the United States filed an appeal of the preliminary injunction in the Northern District of California.[436]

III. Methodology and Limitations

Cal DOJ staff and experts, including a medical expert and an immigration detention expert, visited Cal City on November 20–21, 2025. The site visit was limited in scope and primarily in response to the opening of the new facility and sudden population increase at Cal City. Cal DOJ and its experts collected data and observed conditions at the facility, interviewed detainees and facility staff, and reviewed relevant documents and detainee files. Cal City imposed restrictions on our access to detention and health care files that limited our review. Cal DOJ analyzed documents produced by CoreCivic pursuant

428 *Id.* at ¶¶ 25-245.
429 *Gomez Ruiz v. U.S. ICE* (N.D.Cal. Dec. 16, 2025, No. 3:25-cv-09757) ECF No. 27 (Mot. for TRO); id. (N.D.Cal. Dec. 22, 2025, No. 3:25-cv-09757) ECF No. 34 (Stipulation resolving Mot. for TRO).
430 *Id.* (N.D.Cal. Feb. 10, 2026, No. 3:25-cv-09757) ECF No. 72, ¶ 1 (Order Granting in Part Plaintiffs' Motions for Preliminary Injunction and Class Certification ("Gomez Ruiz PI")).
431 *Id*.
432 *Gomez Ruiz* PI, *supra*, ¶ 3.
433 *Id*.
434 *Gomez Ruiz v. U.S. ICE* (N.D.Cal. Mar. 3, 2026, No. 3:25-cv-09757) ECF No. 82; id. (N.D.Cal. Mar. 3, 2026, No. 3:25-cv-09757) ECF No. 86.
435 *Id.* (N.D.Cal. Mar. 30, 2026, No. 3:25-cv-09757) ECF No. 113. Following transfer, the case was renumbered *Gomez Ruiz v. U.S. ICE* (E.D.Cal. No. 1:26-cv-02546).
436 *Id.* (N.D.Cal. Apr. 24, 2026, No. 3:25-cv-09757) ECF. No. 114. The citation for the appellate case is *Gomez Ruiz v. U.S. ICE* (9th Cir. No. 26-2302).

to a document request sent to CoreCivic in advance of the site visit. Cal DOJ requested but was denied access to use of force files, even though CoreCivic had disclosed that five incidents had occurred.

Cal DOJ interviewed 44 detainees, chosen by selecting a sampling of detainees from each housing unit with a range of intake dates, lengths of stay and countries of origin. Cal DOJ also interviewed detainees who signed up to speak with Cal DOJ on notices posted in housing units preceding the site visit. These interviews took place in a private setting with two Cal DOJ team members per interview. Cal DOJ interviewed detainees in their preferred language, either by Cal DOJ staff who were proficient in the language or through a telephone interpretation service. The most commonly used languages in interviews were English and Spanish; interviews were also conducted with the assistance of translation services in Hindi, Mandarin, Nepali, Punjabi and Turkish.

IV. Detained Population

As of the date of Cal DOJ's visit, Cal City had been open for almost three months. CoreCivic produced a roster of detainees held at Cal City as of November 19, 2025. A review of the roster yielded the following key data points for the detained population at Cal City at that time.

Table 20. Snapshot of Detainees Housed at Cal City on November 19, 2025[437]

No. of Countries of Origin:	74
Total Population on November 19, 2025:[438]	942
No. of Female Detainees:	189
No. of Male Detainees:	729
Average Age:	37 years for all detainees
Average Length of Detention:	46 days
Longest Length of Detention:	84 days

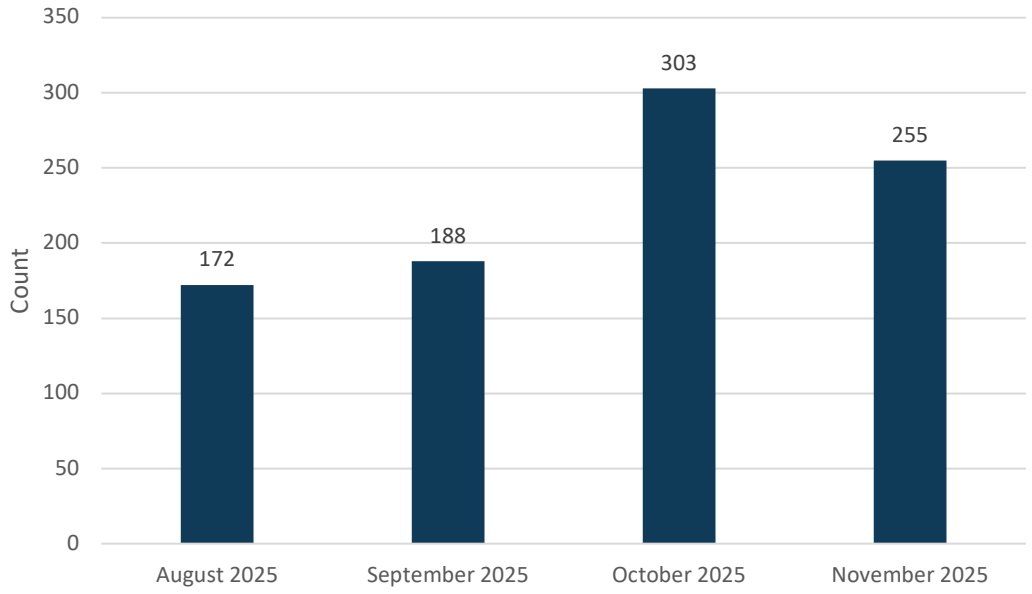
As of November 19, the population at Cal City consisted of detainees from 74 different countries, about 79% of whom were male.

In the course of its review, Cal DOJ learned that a large group of detainees were moved from Golden State on or about August 29, 2025 to Cal City. Indeed, detainees recalled a large exodus of detainees during Cal DOJ's site visit to Golden State in September 2025, and one detainee at Golden State noted that he had been told by a detention officer that the "bad apples" at Golden State were being transferred to Cal City. According to Mesa Verde facility staff, a housing unit at Mesa Verde also was reportedly emptied to provide detainees for Cal City.

Figure 58 summarizes the number of detainee arrivals per month at Cal City based on active detainee data (i.e. detainees still present at the time facility rosters were provided to Cal DOJ) reported by CoreCivic:

437 This data is derived from a roster produced by CoreCivic to Cal DOJ.
438 CalDOJ reviewed ICE detention statistics for November 20, 2025, and found that they stated that there were 711 detainees total at Cal City (566 males and 145 females). This number is substantially less than the number of detainees reported in CoreCivic's roster produced to Cal DOJ (942 detainees).

Figure 58: Arrival Month of Detainees on November 19, 2025 Roster at Cal City



The earliest arrival date reported was August 27, 2025, and the latest arrival date reported was November 19, 2025. Overall, monthly arrivals rose steadily between August and October 2025. Arrivals peaked in October 2025, when 303 detainees (33% of the population as of November 19) arrived. This data only reflects information for detainees actively held at Cal City as of November 19, 2025. It is not representative of all detainees held at the facility since it opened.

V. Conditions of Confinement

Conditions of confinement consist of various factors, policies, and practices that impact the experiences of detainees. The conditions reviewed below include: 1) the intake and orientation process; 2) food, nutrition and access to water; 3) housing units; 4) detention staffing and detainee relations; and 5) access to social and programming opportunities.

Cal City generally appeared not to meet several NDS standards that concern conditions of confinement. These violations included a non-compliant intake environment that resulted in a lengthy and overcrowded intake process; violations of standards governing the provision of adequate environmental living conditions and clothing; and a lack of healthcare staffing and infrastructure.

A. Intake and Orientation

1. Intake Process

Intake and orientation were areas of particular concern given the influx of detainees that Cal City had been receiving in the months prior to Cal DOJ's site visit. The NDS require new arrivals to "undergo custody and medical screening interviews, which will include a determination as to whether the detainee is a victim of or at risk for sexual abuse or assault and a suicide risk screening; complete questionnaires and other forms; attend any site-specific orientation program; and comply with other facility admission procedures (issuance of clothing, towels, bedding, etc.)."[439] The reception and discharge area where detainees are processed for intake, departures, and temporary transportation is extremely small for the number of detainees being processed in and out of the facility. The intake rooms were crowded without sufficient toilet access. According to staff, health screenings are performed in three private medical screening rooms where PREA questions also are asked.

439 ICE, NDS 2025, Part 2.1 Admission and Release, Part II, § A, p. 18.

The NDS require that the rooms holding detainees while they move through the intake process are of appropriate size per detainee and offer appropriate seating, ventilation, and access to water and facilities, like toilets and showers.[440] Further, male and female detainees must be kept separate.[441] The intake area at Cal City only has four cells. While each of the four cells has a purported capacity of twelve people, each cell is only approximately 12x12 feet. Although the facility found a work-around by using an empty housing unit to process larger groups of male intakes that allowed for more space to conduct the intake process in a more private manner, this option will not be available when the facility is full. Current intake infrastructure at Cal City is not equipped to handle the ebb and flow of the high volume of immigration detainees that are processed regularly through a civil immigration detention facility.

Figure 59. Intake Stations at Cal City

The NDS require that hold rooms in detention facilities be equipped with handwashing and potable water.[442] Thirty-six (82%) detainees interviewed by Cal DOJ reported that they received water during intake. Forty-three detainees (98%) reported that they received food while waiting to be processed. However, detainees reported that personal possessions were thrown away during the intake process, including medical equipment and toiletries obtained at other facilities.

The NDS state that staff "shall prepare specific documents in conjunction with each new arrival to facilitate timely processing, classification, medical screening, accounting of personal effects, and reporting of statistical data."[443] Cal DOJ and its immigration detention expert reviewed a sampling of detention files, including for some individuals who arrived at the facility when it initially opened, and many were incomplete. Cal DOJ staff noted that the primary language of detainees was not recorded on their intake forms. During file review Cal DOJ also observed intake forms for detainees who arrived in late August, but that were dated late September and were not signed. Cover sheets in detention files also frequently did not have notations for detainee-specific facts such as religion, weight, height, and eye color. Detention files available to Cal DOJ for inspection did not include any detainee requests,

440 ICE, NDS 2025, Part 2.5 Hold Rooms in Detention Facilities, Part II, § A, p. 31.
441 *Id.* at § B, p. 32.
442 ICE, NDS 2025, Part 2.5 Hold Rooms in Detention Facilities, Part II, § A, p. 31.
443 ICE, NDS 2025, Part 2.1 Admission and Release, Part II, § F, p. 189.

grievances, or discipline records. They included only intake, work program, and classification forms. Facility staff reported they were understaffed and unable to keep up with the volume of files for all the detainees, particularly those who arrived in the first three weeks after the facility opened.

2. Orientation

The NDS require "[a]ll facilities [to] provide detainees an orientation to the facility as soon as practicable, in a language or manner detainees can understand."[444] The NDS also require "[u]pon admission, every detainee [to] receive an ICE/ERO National Detainee Handbook and a facility handbook."[445] However, multiple detainees stated in interviews that they did not receive any materials or handbooks at intake. Indeed, 32 detainees (73%) reported that they had not received an orientation or handbook upon arrival to Cal City.

3. Security Classification System

The NDS require facilities to use "the most reliable, objective information available" to classify detainees, including most recent and/or prior criminal offense(s), escapes, institutional disciplinary history, violent episodes/incidents, sex, potential victimization or abusiveness based on mental health and/or medical status, and age.[446] The NDS further require that "ICE/ERO offices will provide the facility with any information available to ICE to assist the facility in classifying detainees."[447] Cal City reported to Cal DOJ that ICE does not provide the facility with the detainees' criminal rap sheet or National Crime Information Center (NCIC) record. Instead, the only information about criminal history reportedly received by the facility is ICE's narrative in the DHS Form I-213 (Record of Deportable/Inadmissible Alien), a document that is not necessarily as complete as a rap sheet or NCIC.

Facility staff reported that when the facility opened, the classification supervisor and two unit-management employees completed classification for groups of between 40 to 60 detainees. As of the date of Cal DOJ's site visit, facility staff reported that intake officers complete the initial classification and over 400 reclassifications had occurred.

During the review of detention files, Cal DOJ observed that the facility uses the ICE Custody Classification Worksheet, which is a form included as an appendix to the PBNDS and is used by other private civil detention facilities in the state.[448] Facility staff reported that ICE asked the facility to use this form since the NDS does not have a similar form. However, most classifications forms reviewed by Cal DOJ did not include the detainee's primary language, as required on the form. Facilities are required to review a detainee's classification at regular intervals and when certain events occur, such as an incident of abuse or victimization.[449] Cal City appears to be conducting reclassifications under the "60 to 90" day standard required under PBNDS. Similar to Otay Mesa, detainee files contained a sheet documenting that detainees who were due for a 60 to 90 day reclassification were provided notice that their classification would be reviewed.

Cal City classifies the population's custody levels into four categories: Low, Medium-Low, Medium-High, and High. As shown in **Table 21**, the color of a detainee's uniform is assigned based on the security classification assigned to them.

444 ICE, NDS 2025, Part 2.1 Admission and Release, Part II, § H, pp. 19-20.
445 *Id*. at § I, p. 20.
446 ICE, NDS 2025, Part 2.2 Custody Classification System, Part II, § C, p. 22.
447 *Id.*
448 ICE, PBNDS 2011, Appendix 2.2A, ICE Custody Classification Worksheet, pp. 67-69.
449 ICE, NDS 2025, Part 2.2 Custody Classification System, Part II, § F, p. 23.

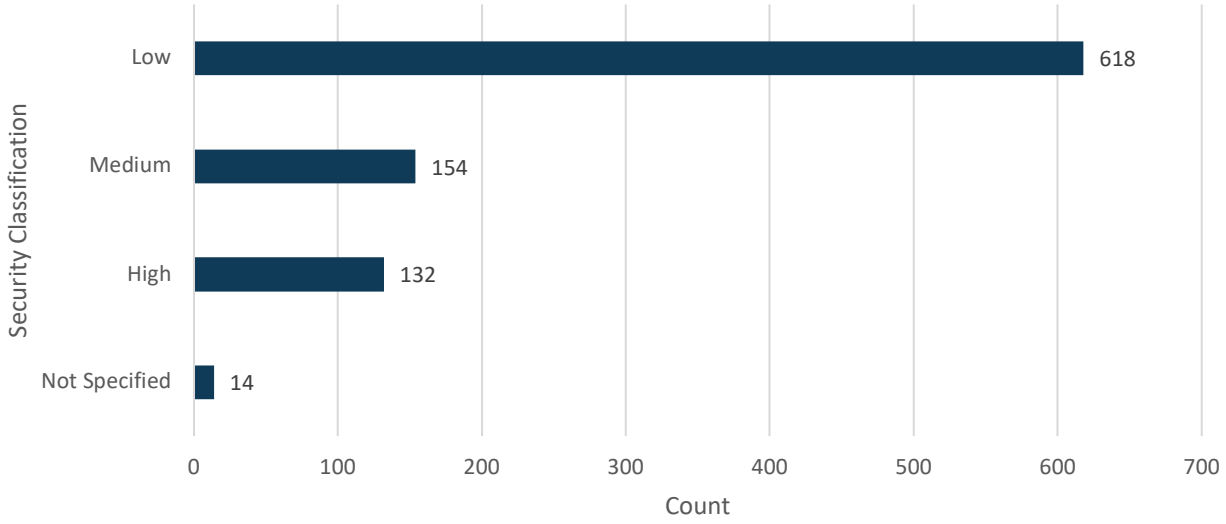
Table 21. Detainee Uniform Colors and Custody Levels at Cal City

Detainee Sex	Security Classification	Color
Female	Low	Grey
Female	Medium Low	Light Green
Female	Medium High	Pink
Female	High	Red
Male	Low	Blue
Male	Medium Low	Green
Male	Medium High	Khaki
Male	High	Brown

However, detainees reported that they received no explanation for the color of their uniform, which corresponds to detainees' assigned security classification levels; one detainee reported that she had received a green uniform because they ran out of grey uniforms.

CoreCivic also produced ICE threat level data to Cal DOJ. **Figure 60** shows the distribution of detainees' security classifications, based on active detainees' ICE threat levels, as of November 19, 2025.[450] Approximately two-thirds of the population (67%) were classified at the lowest level.

Figure 60. Cal City Detainees by Security Classification (ICE Threat Level) as of November 19, 2025



B. Food, Nutrition, Access to Water

Meals

The NDS state that "[o]rdinarily detainees shall be served three meals every day, at least two of which shall be hot meals...."[451] Facility staff has stated that detainees receive three hot meals per day and may purchase snacks through the commissary.[452] All 44 detainees who were interviewed reported that they receive three meals per day. However, detainees reported to Cal DOJ that they often supplement their nutrition with items purchased from the commissary. One detainee stated that he would go hungry if

450 Data produced by CoreCivic reported the admission types for detainees in terms of ICE Levels 1, 2, 3, and Detainee. We present these categories as Low, Medium, High, and Detainee in this report.
451 ICE, NDS 2025, Part 4.1 Food Service, Part II, § C, p. 22.
452 *Dignity Not Detention Coalition v. City of California* (E.D.Cal. Oct. 27, 2025, No. 1:25-cv-01292-JLT-CDB) ECF No. 18-4 ¶ 64 (Declaration of Christopher Chestnut) ("Oct. 27 Chestnut Decl.").

he were not able to purchase instant noodle soup from the commissary. Some detainees reported that the Cal City commissary costs three to four times what it costs at other facilities. Thus, some detainees may be unable to supplement their diets meaningfully through commissary meals.

The kitchen is operated by a third-party contractor, Trinity Services Group, and appeared clean and hygienic.[453] Staff reported that they receive one large delivery of food each week and multiple produce and dairy deliveries throughout the week. Cal DOJ observed large sacks of rice, beans, cookie and coffee cake mix, instant pudding mix, cheese sauce mix, colorless fruit punch and pink lemonade mix, cans of apple sauce, canned diced yellow peaches, and other dry goods with labels and dates in the dry storage area. Cal DOJ also observed chopped lettuce, cabbage, bell peppers, bags of onions, boxes of mechanically separated chicken, prepared sandwiches, beans soaking in water, halal burger patty meat, pre-cooked breakfast patties, frozen wild caught Alaska pollack, and hot sausage meat in the cold storage area. These items were either in the original box packaging or in plastic containers with covering and labels.

Cal DOJ observed detainees cooking large quantities of food in the kitchen. Contract workers from Trinity provide additional staffing in the kitchen. No significant issues or concerns were observed on Cal DOJ's tour of the kitchen facilities at Cal City.

The facility has two dining halls, only one of which was in use. Female detainees, male detainees with Medium-High or High classifications, and individuals in segregation appeared to exclusively eat their meals in the housing units instead of going to the dining hall. Female detainees reported that they are served food in their housing pods and it is reportedly served cold. A detainee held in the female pods reported that there are fights and issues with microwaves in the units and that it can take an hour to use the microwave to warm up their food. Another reported that at times there are not enough trays for detainees. A detainee reported that accommodations for dietary requirements, like a vegetarian diet, are inadequate, or at times simply unavailable. Vegetarians reportedly are not given the proper diet and they have to advocate for themselves to receive vegetarian meals.

Water

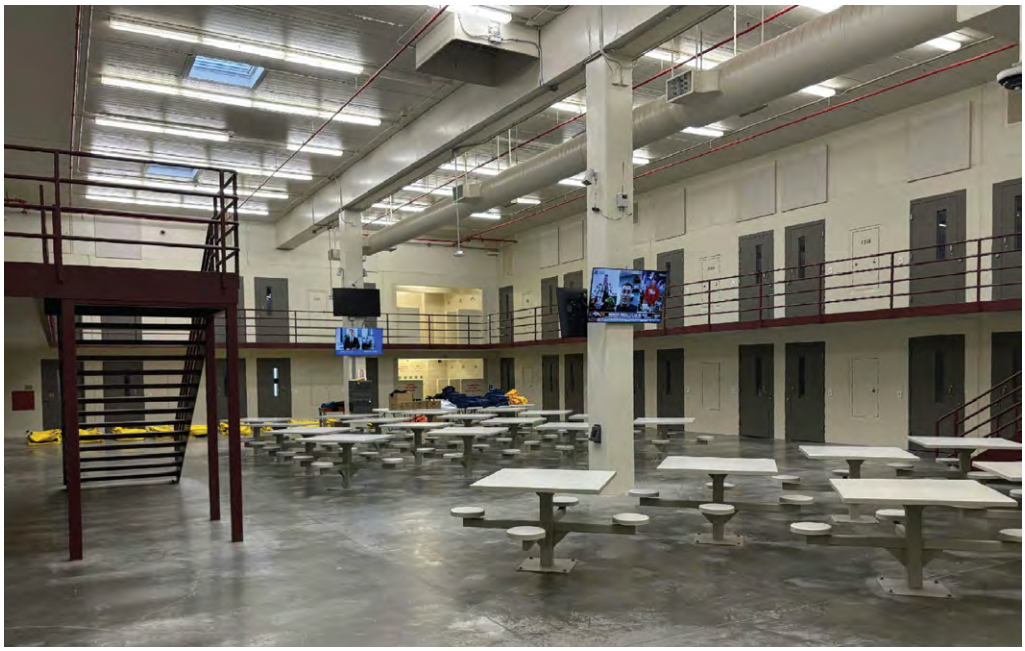
Water containers were available to detainees in the dayroom areas of the pods. Dayroom areas also contain drinking fountains.[454] During interviews, detainees reported poor water quality. They stated that they have to drink water from a sink that is connected to a toilet while they are confined to their cells, that the water has been brown at times, that it has tasted like chlorine and/or metal, and that they have experienced sore throats and skin reactions to the water.

C. Housing Units

The facility consists of 10 two-story housing units, each of which contains three pods.[455] In each housing unit, two of the pods have 44 cells, and the third has 40 cells.[456] The cells are designed to hold two detainees each and contain two bunk beds, a desk, a sink, and a toilet.[457] Each cell has a window with a view outside and each cell door has a narrow window with a view of the dayroom area.[458]

453 Oct. 27 Chestnut Decl., *supra*, ¶ 62.
454 *Id*. at ¶ 18.
455 *Id*. at ¶ 12.
456 *Id*.
457 *Id*. at ¶ 14.
458 *Id*.

Figure 61. Housing Unit at Cal City



The dayroom area contains tables with integrated seats (22 tables in the larger pods, 20 in the smaller pods), televisions, a microwave, a drinking fountain, and a shower room.[459] The shower rooms consist of six shower stalls with solid partitions and a curtain that can cover the entrance.[460]

Figure 62. Shower Facilities at Cal City

459 Oct. 27 Chestnut Decl., *supra*, ¶¶ 18, 20.
460 *Id*. at ¶ 24.

According to facility administration, the facility has central air conditioning and heating, and each housing unit has its own water heater.[461]

Detainees reported experiencing constant confinement in spaces like that shown in **Figure 63**. During the fall of 2025, detainees were required to lock down in their cells overnight from approximately 10:00 p.m. to 5:00 a.m.[462] In addition, the facility conducted seven counts each day and each could take up to 90 minutes.[463] During this time individuals were locked in their cells. There were four counts during the day and three during the nighttime lock down period.[464] Facility administration also stated that detainees may be locked down based on security considerations or behavioral issues.[465] Detainees described the number of counts as excessive and as causing mental health concerns.

Figure 63. Interior of Cell at Cal City

1. General Condition of Facility and Housing Units

Multiple detainees who signed up for interviews with Cal DOJ wept when describing the living conditions in the facility. They described insufferable conditions, specifically relating to cold temperatures and the lack of protective clothing. Detainees reported, and Cal DOJ staff noted during its tour, that the air conditioning is kept at an extremely low temperature in housing units, particularly in the female and segregation housing units. The temperature in California City on November 20, 2025,

461 *Id*. at ¶¶ 8, 31.
462 *Id*. at ¶ 43.
463 *Id.* at ¶ 44.
464 *Id*.
465 *Id*. at ¶ 45.

had a high of 55°F and a low of 41°F.[466] The facility's central heating/AC system was not set to reflect these conditions, and Cal DOJ staff found the facility to be uncomfortably cold. Detainees reported receiving insufficient clothing and blankets to keep themselves warm. Detainees reported that long-sleeved items were not provided by the facility until just before the visit and detainees were required to purchase them from the commissary. Detainees reportedly received a windbreaker and an additional blanket the week prior to Cal DOJ's site visit, which was still insufficient to keep out the cold.

Indeed, detainees widely reported excessively cold temperatures in their units, and multiple detainees described that facility staff do not permit detainee adjustments to the space to reduce the flow of cold air. A detainee stated that if he tried to cover vents he would be reprimanded. Staff had reportedly removed paper from air-conditioning vents that detainees placed to protect themselves from the cold temperature. **In one housing pod, elderly female detainees reportedly were modifying facility-issued socks to create scarves and sleeves for themselves to endure the low temperatures. Detainees stated that the officers told them they would be written up or punished for doing so. Facility staff confirmed that altering socks constitutes "destruction of property." Many female detainees were in tears when describing these conditions and expressed incredulity at the willingness of the facility to expose elderly and infirm women to such conditions.**

Such conditions flagrantly violate the relevant detention standards. NDS 1.1 requires Cal City to "ensure appropriate temperatures, air and water quality, ventilation, lighting, noise levels, and detainee living space . . . ."[467]

Further, in Cal DOJ's interviews, detainees reported leaks from rainwater and/or plumbing that infiltrated their living spaces. Detainees reported that water was leaking into the facility from multiple sources in housing units and other spaces. A detainee reported leaks in sinks in detainee cells and that personal property had been soaked. Cal DOJ observed leaks consistent with these reports. A scorpion reportedly was found in one of the female housing units and a detainee was told that it is expected since they were in the desert. These conditions violate the relevant NDS standards regarding housekeeping and pests and vermin.[468]

2. Access to Basic Necessities

NDS state that "[a]t no cost to the detainee, all new detainees shall be issued clean, indoor/outdoor, temperature-appropriate, presentable clothing during in-processing.… Additional clothing shall be issued as necessary for changing weather conditions or as seasonally appropriate."[469] One of the first detainees at Cal City reported that he had received only one uniform when admitted and stated that there were no cups or personal items available at the time. Detainees reported receiving insufficient clothing and blankets and being forced to purchase warmer clothing from the commissary if they did not have sweatshirts from another facility.

Detainees reported having personal items that had been permitted in previous facilities confiscated at Cal City. Facility staff also reported adhering more strictly to weight limits on personal property as compared to other detention facilities in California at which detainees may have been held. A detainee who was an artist reported that although she was allowed to have colored pencils at a prior facility, she was not allowed to have them in her cell at Cal City. A detainee reported that detainees are forced to purchase new items, which CoreCivic offers for sale in the commissary.

466 Weather Spark, *November 20, 2025 Weather History in California City* <https://weatherspark.com/h/d/1986/2025/11/20/Historical-Weather-on-Thursday-November-20-2025-in-California-City-California-United-States#google_vignette> (as of Apr. 2, 2026).
467 ICE, NDS 2025, Part 1.1 Environmental Health and Safety, Part II, § I, p. 7.
468 *Id*. at §§ E, I, p. 7.
469 ICE, NDS 2025, Part 4.4 Personal Hygiene, Part II, § B, p. 127.

Restricted Housing

The NDS state that special management units should be used for detainees who need to be separated from the general population for administrative reasons, such as health and protective custody, and for disciplinary reasons.[470] CoreCivic's Special Management/Restrictive Housing Unit Management policy provides that detainees may be separated from the general population and housed in a Special Management or RHU if they threaten the physical safety of other detainees or staff, or the orderly operations of the facility; pose a risk of escape; or request to be placed in protective custody.

In practice, based on Cal DOJ's observations during the site visit, Cal City appears to house detainees under special management with detainees who have been assigned high security classifications. CoreCivic produced a report to Cal DOJ identifying six detainees as reportedly subject to "special management," but several more were observed in the RHU and interviewed by Cal DOJ. One detainee who had never been in restrictive housing at a prior detention facility reported that he was immediately placed in the RHU at Cal City, while another detainee reported that he had requested to be placed in the RHU for safety.

Detainees in this unit reported a variety of concerns. Detainees reported not being able to contact their attorneys while in segregated housing. A detainee reported asking to see a mental health provider twice but not being allowed to speak with one. Another detainee reported that after he had participated in a hunger strike, his security level was elevated to high even though it had previously been low-medium. Yet another detainee in the RHU reported that the whole unit was denied telephone and tablet access for a week as a punishment for a fight that had broken out in the yard.

D. Detention Staffing and Detainee Relations

1. Staffing

Key detention staff positions at Cal City remained unfilled at the time of Cal DOJ's site visit nearly three months after opening. Facility staff also described the facility as building up to a final staffing pattern. Facility staff stated that the facility was utilizing collapsible posts, which are non-essential posts that can be left unmanned, but anticipated not doing so in the future. An assistant warden, with numerous other duties, was acting as both a grievance coordinator and the PREA coordinator. The facility had no file clerks to maintain detainee files. The lack of staffing also meant that detainees could not have contact visits with family and loved ones.

2. Use of Force

CoreCivic produced an incident report to Cal DOJ noting that five use of force incidents had occurred: one without chemical/inflammatory agents and four with chemical/inflammatory agents. Two of these incidents involved purportedly "less than significant" injuries. Cal DOJ was not permitted to review the files associated with these incidents.

The decision to deny Cal DOJ access to these files was remarkable in light of the serious legal claims that have been made against the facility, which allege that staff routinely engage in abusive behavior and unreasonable use of force against detainees, including deploying pepper spray, hitting a detainee with riot shields and holding him down with their knees on his back, and aggressively pushing a detainee.[471]

470 ICE, NDS 2025, Part 2.9 Special Management Units, Part II, §§ A-B, pp. 53-57.
471 *Gomez Ruiz* Compl. at ¶¶ 54-60

3. Requests and Grievances

The facility appeared to lack a well-functioning and secure system for detainees to submit requests, including medical requests and grievances. Detainees may submit requests and grievances through tablets or paper requests. However, at the time of Cal DOJ's visit all medical requests had to be submitted on paper. At other facilities, mailboxes are located within the housing pod to allow detainees to submit requests and grievances confidentially. At Cal City the mailboxes for some pods are located in the hall outside the pod. Facility staff reported that the location in the hall is for the convenience of individuals collecting the forms and that detainees can submit them when they go to recreation or to eat. However, at the time of Cal DOJ's site visit, detainees reported that they did not receive regular recreation opportunities and not all detainees were eating in the dining hall. Detainees reported that to submit grievances and requests on paper they had to hand them to staff to deposit them in the mailboxes. Staff stated that detainees are accompanied by staff to deposit their own forms. However, Cal DOJ witnessed an officer unaccompanied by any detainee depositing about 10 forms into the boxes.

4. Staff and Detainee Relations

Staff responsible for the day-to-day supervision of detainees appeared to be inexperienced and lacked basic understanding of civil detention management principles. For example, most detainees at the facility had no history of criminal convictions. Such individuals are not necessarily familiar with day-to-day life in a facility like Cal City. A detainee described to Cal DOJ how the staff's bad moods would affect their level of aggression towards detainees and another detainee described staff as being "hateful" towards detainees. This lack of professionalism shows a lack of training among CoreCivic personnel. Post orders for detention officers were still in production at the time of Cal DOJ's site visit, contrary to ICE detention standards. "Each officer will have written post orders that specifically govern his or her current duties."[472] This may have contributed to staff's lack of professionalism.

Detainees reported to Cal DOJ that they were being treated like criminal inmates as opposed to civil detainees, noting that their treatment at Cal City was generally inferior compared to other detention facilities in California from which they had been transferred. Three detainees (7%) of the forty-four detainees interviewed by Cal DOJ reported that they had been physically abused or hurt by facility staff and 20 of the interviewed detainees (45%) reported that they had been insulted or yelled at. During its visit, Cal DOJ heard from multiple detainees that there had been a tense confrontation about the intolerable living conditions between female detainees in a specific pod and an officer a few weeks prior to our site visit.

5. Language and Culture

It was not clear whether Cal City was consistently providing language access support to detainees. The facility uses a Voyce interpretive service with mobile Voyce boxes to check out for use when needed. However, detainees reported that detention officers would yell at detainees instead of explaining directions or taking the time to find or call an interpreter.

E. Access to Social and Programming Opportunities

1. Non-Legal Visitation, Phone Calls

Non-legal visits must be prescheduled by calling Cal City and each detainee receives up to two one-hour blocks of visitation per week.[473] According to NDS, "Contact visits are encouraged but subject to the facility's detainee population and its physical conditions."[474] CoreCivic produced a visitation policy

472 ICE, NDS 2025, Part 2.6 Post Orders, Part I, p. 34.
473 ICE, *California City Detention Facility, Hours of Visitation* (Feb. 27, 2026) <https://www.ice.gov/detain/detention-facilities/california-city-detention-facility> (as of Apr. 14, 2026).
474 ICE, NDS 2025, Part 5.5 Visitation, Part II, § A, p. 163.

to Cal DOJ which states in part that visitation facilities should permit informal communication, including opportunity for physical contact. The policy also states that devices that preclude contact should not be used except in instances of substantiated security risk. Contrary to the NDS and this policy, when Cal DOJ visited Cal City, all family visits were no-contact and visitation was done through glass windows. Cal City's practice of forbidding contact visits for detainees appears to violate its own policy because there was no apparent, substantiated security risk requiring these measures, except that the facility was understaffed.

Figure 64. Public Side of Visitation Area at Cal City

In some instances, the no-contact visit policy deterred detainees from receiving visits. Of those detainees interviewed by Cal DOJ who were able to contact their family or loved ones, only two detainees (6%) reported that they communicated with their loved ones in person. One detainee reported that the site location is too remote for his family to travel just to visit behind glass. Another detainee reported that she did not want her children to see her behind glass, as if she were in jail. A family waiting to visit a loved one during Cal DOJ's visit reported that the facility is much more remote than when their loved one was held at Adelanto. They also reported that conditions were worse at Cal City.

Thirty-four (77%) of the detainees interviewed by Cal DOJ reported that they were able to contact their loved ones. Of these 34 individuals, 17 detainees (50%) reported that they had experienced issues with contacting their loved ones. A detainee stated that they were not able to reach family for 15 days after arrival because the phone system had not been set up when they arrived. Other detainees stated that phone calls would drop and were expensive. At the time of Cal DOJ's tour, the commissary was reportedly out of headphones, and detainees reported that they were unable to use tablets for video calls with family. A detainee reported that her family traveled to Cal City to see her in person, and had to wait all day to see her or sometimes was sent away without getting to see her at all after waiting all day.

2. Programming and Recreation

NDS 5.2 does not appear to require outdoor time if only indoor recreation is available at a facility.[475] Cal DOJ observed and was told that Cal City offers outdoor time to detainees. Staff have stated that the facility offers one hour of outdoor recreation at least six days a week.[476] Cal DOJ observed a posted schedule indicating recreation is available seven days a week. However, contrary to these claims, some detainees interviewed by Cal DOJ reported being able to go outside three or four days a week or only on weekdays. Female detainees consistently reported that they were not allowed regular time outdoors.

Opportunities for recreation at Cal City were not adequate, particularly for female detainees. Cal City has two outdoor recreation areas and one indoor recreation area. Facility staff stated that male detainees use the large outdoor recreation area, which has exercise and sports equipment, and female detainees mostly use the indoor gym area, which has exercise machines, and sometimes the small outdoor area. A female detainee reported that she had never been allowed to use the gym. Cal DOJ observed that the sole outdoor space intermittently provided to female detainees was small with no usable equipment. Detainees reported that it was full of thorns that stuck to detainees' shoes. Female detainees consistently described this experience of having to walk on thorns in their meager outdoor space, which was notably inferior to the space available to male detainees. These circumstances are inconsistent with various standards applicable to facilities where outdoor recreation is available.[477] In addition, limiting preferred recreation spaces to only male detainees raises concerns with respect to female detainees' right to equal protection under the Fifth Amendment of the United States Constitution.

Figure 65. Yard Designated for Female Detainees at Cal City

475 ICE, NDS 2025, Part 5.2 Recreation, Part II, § A, p. 152. However, while the NDS do not appear to require detainees to have outdoor recreational access, Cal City's lack of providing outdoor time to detainees formed in part the basis of the *Gomez Ruiz* class action plaintiffs' claims that the conditions at the facility violate their constitutional rights under the due process clause of the Fifth Amendment. *Gomez Ruiz* Compl., *supra*, ¶ 272 and *Gomez Ruiz* PI, *supra*, ¶ 4. The court preliminarily enjoined ICE from denying detainees access to the outdoors. *Id*.

476 Oct. 27 Chestnut Decl. at ¶ 10.

477 ICE, NDS 2025, Part 5.2 Recreation, Part II, § C, p. 153 (requiring detainee access to toilets, water and a variety of fixed and movable equipment while participating in outdoor recreation).

At the time of Cal DOJ's visit, there was no fixed library at Cal City that was open for detainees to enter. Cal DOJ observed a library that was not open for detainee attendance but from which staff would provide books by request. A mobile librarian visited housing units twice a week and detainees could select a book from a catalog.

Detainees reported that distraction items other than books were not available at the facility. In one male unit, there were reportedly only three puzzles, and the detainee who shared this reported feeling like he was losing his mind. Facility staff stated that one of their goals was to begin in-unit programming in the future, such as getting more religious volunteers, offering crocheting and painting, and tournament recreation.

3. Access to Engage in Religion/Religious Services

Cal DOJ observed a schedule for one housing unit that indicated that Catholic, Christian, Sikh, Hindu and Muslim prayer services occur at Cal City. However, one detainee reported that there were no Hindu or Sikh services, just Christian services. Cal DOJ received multiple reports that religious headwear was unavailable to detainees. A detainee who was a member of the Sikh faith reportedly had requested religious headwear and had received no response. Another Sikh detainee reported that he had his headwear taken away during intake, but it was never returned; he became so desperate that he used a sheet, but was admonished for improper use of facility property. Such conditions violate the NDS.[478]

4. Voluntary Work Program

Cal City has a large voluntary work program. Detainees work in the kitchen and laundry, as porters, and in the housing units. Detainees receive $1 per shift, per day, except for kitchen workers, who receive $2.

VI. Due Process

Cal DOJ also evaluated due process rights of detainees held at Cal City, including access to legal services and representation, access to materials for immigration cases, and access to courts. Facilities must permit detainees access to a law library, and provide legal materials, facilities, equipment, printing and copying privileges, and the opportunity to prepare legal documents.[479]

A. Access to Legal Services and Representation

Detainees reported difficulties contacting their attorneys confidentially. Twenty-three detainees (52%) stated that they were represented by lawyers. Five of those detainees (22%), stated that they had not been able to speak with their attorneys. Cal DOJ heard detainee reports of limited access to confidential calls with attorneys, resulting in detainees only being able to access the monitored phone lines within their pods to speak to counsel, to the detriment of their immigration cases.

Cal DOJ received reports from attorneys corroborating these difficulties. In October 2025, an attorney reported that her ability to reach her clients was notably inferior at Cal City compared to her ability to speak with them while detained at another facility in California. This advocate described overall delays and confusion in the attorney visitation process at Cal City. In January 2026, Cal DOJ received a report from an advocacy group that detainee legal mail was not reaching their attorneys, that detainees had reported seeing CoreCivic personnel throwing mail away, and that CoreCivic was investigating the allegations.

478 ICE, NDS 2025, Part 5.3 Religious Practices, Part II, §§ K-L, p. 157 (discussing facility obligations with respect to religious property and dietary requirements).
479 ICE, NDS 2025, Part 6.3 Law Libraries and Legal Materials, Part II, pp. 185-190.

As noted above, the court in the *Gomez Ruiz* class action lawsuit issued a preliminary injunction on February 10, 2026, that requires ICE to ensure that detainees at Cal City have timely and confidential access to attorneys, including requirements for in-person legal visitation, contact attorney visits absent documented security grounds, scheduled confidential calls up to 90 minutes each within two business days of requests and the provision of written information regarding attorney communications to detainees.[480]

B. Access to Materials Needed for Immigration Case

The 44 detainees interviewed by Cal DOJ during its site visit entered Cal City with a wide variety of immigration statuses and associated legal cases; only a fraction of these, eight detainees (18%), reported that they were undocumented. Nine detainees (20%) reported that they had been seeking asylum; three detainees (7%) reported that they were lawful permanent residents; and the remainder reported that they were on a student or work visa or had another status.

The NDS state that "[t]he facility shall provide a law library in a designated room, or if facility design prevents a specific room for a designated law library, a suitable area will be identified. The area or room will have sufficient space and resources to facilitate detainees' legal research and writing."[481] As noted, there was no physical library space for detainees to conduct legal research, which appears to be a plain violation of NDS. Instead, staff reported to Cal DOJ that LexisNexis is available to detainees on the tablets available in the housing units.

At the time of the site visit, know-your-rights presentations were not available to detainees. NDS 6.4 (Legal Rights Group Presentations) states that "[f]acilities shall permit authorized persons to make presentations to groups of detainees for the purpose of informing them of U.S. immigration law and procedures, consistent with the security and orderly operation of each facility."[482] During Cal DOJ's visit, there appeared to be a designated space for such events at Cal City, but the facility had not begun to facilitate these presentations by nonprofits and other groups that might offer such services. Although federal funding for Legal Orientation Programs has expired, such programs continue to be available at other facilities in California.[483]

C. Access to Court

Cal City is equipped with multiple courtrooms, including virtual teleconferencing (VTC) and virtual attorney visit (VAV) booths. Of those detainees interviewed by Cal DOJ, 27 detainees (61%) reported that they had not had an immigration hearing since arriving at the facility.

480 *Gomez Ruiz* PI, *supra*, ¶ 3.
481 ICE, NDS 2025, Part 6.3 Law Libraries and Legal Materials, Part II, § A, p. 185.
482 ICE, NDS 2025, Part 6.4 Legal Rights Group Presentations, Part I, p. 191.
483 For example, California Collaborative for Immigrant Justice operates a program at Golden State, Al Otro Lado operates a program at Imperial and San Diego County operates an Attorney of the Day program at Otay Mesa (as discussed in the *Access to Legal Services and Representation* section of the *Otay Mesa Detention Center* chapter).

Figure 66. Videocall Booths and Waiting Area at Cal City

VII. Health Care

At the time of Cal DOJ's site visit, Cal City did not have an adequate system in place for providing consistent quality health care to detainees. These conditions violated numerous NDS standards.[484] Both file review and interviews with detainees indicated need for improved health care. Twenty-nine detainees interviewed (66%) stated that they had a medical or mental health concern that they wanted to share with Cal DOJ. As noted, the preliminary injunction issued on February 10, 2026, in the class action lawsuit against the facility included many provisions related to timeliness and adequacy of health care. The injunction requires Cal City to provide adequate health care including appropriate staffing, timely screening and assessment by a primary provider, timely access to medications and emergency and specialty services, continuity of medical care, and a responsive sick call request system, and ensures compliance by mandating access by an independent monitor.[485]

Cal DOJ experienced obstruction at various stages that made medical review more difficult. Items relevant to the inspection that Cal DOJ has historically been able to access at other detention facilities were not available at Cal City. The facility placed burdens on the review of medical files. This meant that some files were not accessible by Cal DOJ at all, and those that were accessible were not made available promptly, which prevented efficient use of Cal DOJ's limited time on site. Nonetheless, based on the files that Cal DOJ was able to access, we identified concerns with timeliness of care, adequacy of staffing, ability to manage records and care transitions, and accommodation of disability and other medical limitations.

484 See, e.g., ICE, NDS 2025, Part 4.3 Medical Care, Part II, § A, p. 112 ("Facilities will employ sufficient medical staff to perform basic exams and treatments for all detainees."), §§ D, E, H, I, pp. 113-116.
485 *Gomez Ruiz* PI, *supra*, ¶¶ 1-2.

A. Intake Assessments, Evaluations, and Diagnoses

Cal DOJ observed that while the facility had been receiving busloads of over 40 people upon opening, it did not have adequate health care infrastructure or systems set up at the facility. The intake area included three medical rooms behind the intake desk, which all had blood pressure cuffs, a scale, and language line access, but which did not include provision for laboratory testing, and only one of which included a sink. The work-around to date had been to use a vacant housing pod for the intake medical processing on newly arriving groups, although the area set up for medical intake in this housing pod consisted of five areas set off by dividers and thus appeared to offer limited privacy. However, as noted above in the Intake, Orientation, and Documentation section, it is not clear how Cal City will address intake medical needs as the facility reaches capacity. Health care staff reported that nurses go out to arriving buses to ask basic medical history and needs and file review corroborated this account.

The NDS require an initial medical, dental, and mental health screening as soon as possible but no later than 12 hours after arrival, which must cover acute needs, any current disabilities, medical history, and mental health history including related to past or current suicidal thoughts or actions. However, only 23 detainees (52%) of detainees interviewed by Cal DOJ reported that they received the required medical, dental and mental health screenings within 12 hours of arrival, which violates the applicable intake standards. Spot checks of medical charts indicated some cases in which intake assessments had not occurred in the required time window, and staff acknowledged working through a backlog. Health records also reflected delays following positive health screening results on intake such that a follow-up appointment did not always occur within two working days as required by the same standard.

Comprehensive intake medical assessments were not completed within NDS standard time frames or were dropped altogether. NDS Standard Section 4.3 (Medical Care) requires facilities to "conduct and document a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival at the facility."[486] Health care staff acknowledged being behind standard timeline requirements for routine health assessments, and spot checks of health care records by Cal DOJ's medical expert confirmed these reports. Twenty-three participants (52%) in Cal DOJ's interviews reported that they did not receive a health assessment within 14 days of being assigned to a housing unit. Cal DOJ's expert found that newly arrived detainees had also not been getting a dental screening examination in accordance with NDS guidance, which requires "[a]n initial dental screening exam [to] be performed within 14 days of the detainee's arrival."[487]

Cal DOJ's expert also found that routine dental care had not yet been provided for individuals who were in detention over six months.[488] NDS 4.3 provides that detainees may receive routine dental care when periods of prolonged detention for over six months prevent them from getting such care on their own. Facility staff were aware that routine treatment could be provided to individuals detained over six months and knew how to verify detainees' detention duration with ICE but had not done or scheduled any routine care for eligible individuals as of Cal DOJ's visit.

Requesting Medical Care and Medical Records

File review revealed that detainees' paper requests for medical care are not processed in a timely manner. NDS 4.3 requires that facilities have procedures to ensure sick call requests are received and triaged within 24 hours.[489] While detainees at other facilities can submit health care request via tablets, at Cal City, paper health care requests were in use rather than electronic requests. Health care staff reported that electronic requests may be possible but were not currently used, and believed that the tablet sick call request system might not integrate smoothly with the Allscripts electronic record

486 ICE, NDS 2025, Part 4.3 Medical Care, Part II, § E, p. 114.
487 *Id*. at § H, p. 115.
488 *Id*.
489 *Id*. at § I, p. 116.

system used by Cal City. However, while Housing Unit Management personnel are supposed to facilitate detainees' requests, they were unaware that health care staff cannot access electronic requests. Similarly, one detainee reported that paper forms would be followed up on, but that tablet submissions they had made were never followed up on. This report suggests that the fact that the electronic sick call request system is not in operation may not be clearly communicated to either detainees or staff. Health care request systems that include an electronic submission option have advantages such as increased capability for translation and smoother integration into electronic health records for more reliable tracking. Cal DOJ's medical expert had concerns that the paper-only system impeded consistent access to adequate health care.

Both detainee reports and file review in fact indicated lapses in responses to health care requests. Two sick call requests observed in randomly-selected health records had no indication in the record that assessment or follow up had been completed. Detainees reported that health care requests are not acted on unless the situation is a medical emergency. In one case, a detainee who had been in an accident during transport to the facility and had concussion symptoms, including vomiting, reported being denied further evaluation despite requesting care at intake and through the sick call request system.

Cal DOJ's expert found that transitions of care from other detention facilities and from community care also created risk, care delays, and drops in necessary care. File review revealed two cases in which records were not reliably transferred from a GEO Group detention facility to allow follow up on a patient under evaluation for breast masses. In another, a patient returned from a trip to the emergency room and did not receive follow up from a physician until three days later, after being sent to the emergency room a second time.

B. Referrals to Outside Care

Detention facilities subject to the NDS must provide detainees with access to specialty health care, either by providing the services directly or through contractual arrangements.[490] The Health Services Administrator at Cal City reported speaking with ICE on a weekly basis on case referrals. However, Cal DOJ received multiple reports from detainees who stated that they are widely unable to access care from specialists, an allegation also asserted by plaintiffs in the class action lawsuit that has been filed against the facility.[491] For example, a patient reported having chronic vaginal bleeding but not being referred to gynecology and having insufficient follow up after evaluation in the emergency room. Another detainee reported needing to see an eye specialist but was told that the facility is not referring to specialists. A detainee who reported having kidney stones and requiring treatment was reportedly told that Cal City does not "have that." A detainee reported seeking treatment for pain resulting from a broken elbow and being told that painkillers were available but no physical therapy or occupational therapy is offered.

Cal DOJ's medical expert found similar lapses during review of medical charts, and attributed detainee's inability to access critical specialty care to a collection of factors, including lack of adequate tracking of appointments, staffing insufficiencies, lack of connections to enough community health care services, and failure to refer or re-establish referrals for detainees whose health care appointments were cancelled when they moved between detention facilities. Tracking systems in operation at the time of Cal DOJ's visit appeared unclear, and reportedly would be under the purview of a chronic care and a quality improvement nurse who was still in the onboarding process. Two medical charts selected for review demonstrated cancelled specialty appointments following transfer from other facilities, one of which had not been resubmitted and the other of which had been resubmitted

490 ICE, NDS 2025, Part 4.3 Medical Care, Part II, § A, p. 112.
491 See generally *Gomez Ruiz* Compl., *supra*. Two of the named plaintiffs in this class action filed a TRO against ICE requiring them to provide specialist care. *Gomez Ruiz v. U.S. ICE* (N.D.Cal. Dec. 16, 2025, No. 3:25-cv-09757) ECF. No. 27 (Motion for Temporary Restraining Order).

but it was unclear whether rescheduling had been successful. Health care staff described another case of working with a detainee to reschedule an appointment based on the detainee's memory of the name of the provider, which is not a reliable method to ensure continuity of care although it was commendable for this staff member to make the effort.

C. Staffing

Cal DOJ observed crisis-level health care understaffing at Cal City. **At the time of Cal DOJ's visit, the facility only had one doctor—the Medical Director—such that the facility did not have enough medical doctors for its detainee population size.** While the Medical Director was forthcoming and experienced, he was working five 11-hour days per week and was overburdened and always on call, resulting in triaging instead of providing the necessary medical care.[492] The Medical Director, a male, also expressed a need for a female clinician to better attend to female patients. Staff reported occasions of filling in additional medical care with physicians from other facilities, but this practice was not consistent or adequate.

The nursing service was being assembled over time and was using agency staffing to cover shifts. Health care staff reported a staffing plan that included twenty registered nurse (RN) positions, along with additional licensed vocational nurse (LVN) positions, and that all RNs had been hired and were at various stages of onboarding. Several of these positions were designated as specialty nurses in the areas of infectious disease, chronic care/continuous quality improvement, and pharmacy. The Health Services Administrator also had a nursing background and appeared knowledgeable and invested.

However, at the time of Cal DOJ's visit, the staffing level was insufficient to meet the needs of the rapidly growing population. It was unclear at the time of the visit how many of the nurses who had been hired had completed orientation and were able to provide services; the December 2025 schedule provided to Cal DOJ indicated unfilled shifts for a sick call RN, a floating RN, and a pill call LVN. There was evidence in the health records that sick call triage and assessments lagged.

Cal DOJ found that Cal City's mental health department was better staffed than the medical unit, and appeared qualified and compassionate. Staff consisted of two psychologists, two mental health coordinators who were masters-level clinicians, and two prescribing clinicians, with an additional psychologist and several mental health coordinators in the hiring process. However, while in less dire condition as compared to medical staffing, the mental health team was also being assembled gradually after the facility's opening, resulting in some gaps in care. For example, no care from a psychiatrist was evidently available for individuals with psychotic illness and delays in mental health follow up care were noted in the records sampled.

Similarly, dental care was offered, but the dentist was not on clinical duty until almost two months after the facility started to receive detainees. Gaps in access to acute dental care and follow-up were noted in the charts reviewed.

D. Other Medical Concerns Identified During Review

Cal DOJ identified other areas of concern and of strength during its review of Cal City's health care services. Strengths included the investment in the mental health program, the Health Services Administrator's efforts to improve operations, and facility responsiveness to an allegation of health care misconduct. Concerns included consistency and thoroughness of chronic care and routine testing, access to female health care, capacity to care for detainees with severe mental health conditions, medication distribution, and reasonable accommodations offered to detainees with disabilities.

492 ICE, NDS 2025, Part 4.3 Medical Care, Part II, § D, p. 113.

Clinical care quality was deficient in terms of decision-making and thoroughness for acute and chronic conditions. File review identified instances of insufficient follow up testing and medication management following hospital visits, failure to order needed laboratory tests, failure to note key patient history in the electronic health record, and other lapses with potential to have health consequences for detainees.

Cal City began receiving female detainees before obtaining basic supplies for providing reproductive health care, contrary to multiple ICE standards.[493] Cal City had not been equipped to provide preventive or acute female health care on site and had not made referrals for offsite gynecology care.

Figure 67. Sink in Medical Area at Cal City

The facility appeared not fully equipped to work with patients with severe mental health disorders. Although facility health care staff appeared to make efforts to obtain higher levels of care for certain patients, they were not always able to obtain ICE approval. A female detainee with a known psychotic illness was moved to Cal City, and despite appearing to need a higher level of care, was ultimately deported without appropriate medication. One detainee reported that the suicide watch cell was filthy, and that the facility-provided vest and blanket had been used by another person. One detainee made two suicide attempts while at Cal City, and staff reported ultimately being able to have this detainee transferred to a higher level of care. Administration and health care staff described having treatment challenges due to the detainee's refusal of medication, and having periods of suicide watch and

493 See ICE, NDS 2025, Part 2.5 Hold Rooms in Detention Facilities, Part II, § D, p. 33; Part 4.3 Medical Care, Part II, §§ B, F, U, pp. 113, 115, 124-126.

attempts to reintegrate the detainee into the general population prior to the second suicide attempt and ultimate transfer. However, Cal DOJ's medical expert was not permitted to perform independent review of this patient record beyond staff description of the case.

File review also indicated delays in medication delivery. A detainee with a mental health prescription reported asking to have his pill before bed, but the pill pass personnel would show up at 1:00 a.m., so the detainee instead asked to skip the pill. Fortunately, the facility reportedly would provide medications for opioid use disorder for patients.

Cal DOJ also observed evidence of failures to provide reasonable accommodations to detainees with disabilities. A patient with deafness was not appropriately accommodated in at least one medical encounter, impeding access to adequate care. Multiple detainees reported to Cal DOJ staff that medical devices such as knee braces had been taken from them on arrival and that they had not received replacements, in some instances resulting in reduced mobility.

Certain aspects of the provision of health care at Cal City appeared to be on the right track, however. Psychology staff interviewed by Cal DOJ appeared to be handling their caseload and frequently engaging with ill detainees, according to their report (notwithstanding deficiencies noted in records), and had been making efforts to provide culturally appropriate resources to detainees for additional support. The psychologist also described an instance of creatively engaging with a patient prior to a proposed use of force and being able to stabilize the patient and obviate the need for force, and being well-supported by the facility in pursuing this approach. In addition, the Health Services Administrator had made systemic efforts to improve clinic access by instituting a trial block scheduling plan to reduce obstacles to moving detainees to appointments and allow more detainees to be seen. The Health Services Administrator also appeared to strive for compassionate care at intake and spoke mindfully of the expected emotional experience of incoming detainees. Health administration staff also described having had a validating and serious response to detainee complaints of misconduct of at least one health care provider who had been terminated after investigation of the complaint.

13. Conclusion

Surges in immigration detention in California have caused the seven detention facilities operating in the state in 2025 to increasingly violate ICE detention standards, especially with respect to the provision of health care to detainees. The rush to open the newest facility (Cal City) before it was ready to receive and house detainees led to very real human costs. Similar issues related to overcrowding of detainees and understaffing of personnel at other facilities are associated with unacceptable outcomes, including an increase in detainee deaths. The federal government and facility operators have a significant choice before them: to reform their practices and bring these facilities into compliance or to continue their noncompliant policy of prioritizing detention over safety, which likely will lead to dire human and legal consequences. Cal DOJ will continue to monitor compliance with PBNDS and NDS at the seven facilities reviewed in this report pursuant to Government Code section 12532 and the eighth facility reportedly receiving detainees as of April 2026. To the extent any new private civil immigration detention facilities open, we will also monitor and report on those facilities. We encourage facility operators and the United States to use this report as a tool for reform that can help them bring their facilities into compliance with the detention standards, the United States Constitution, and other applicable laws.

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Appendix: All Countries of Origin

Table 22 includes a list of all countries of origin of detainees across all facilities at the time of Cal DOJ's site visit to each facility. All reviewed facilities provided information about detainees' countries of origin. The countries are organized below from most frequently reported to least frequently reported. This list corresponds to the world map (**Figure 6**) in *Detained Populations: Detainee Countries of Origin*.

Table 22: All Countries of Origin Across All Facilities (Table)

Country of Origin	Count	Percentage
Mexico	1,225	21%
India	476	8%
Guatemala	419	7%
El Salvador	338	6%
China	328	6%
Russia	254	4%
Cuba	244	4%
Colombia	209	4%
Venezuela	193	3%
Honduras	173	3%
Vietnam	169	3%
Iran	152	3%
Nicaragua	149	3%
Ecuador	109	2%
Peru	103	2%
Armenia	75	1%
Afghanistan	73	1%
Cameroon	72	1%
Nepal	72	1%
Turkey	68	1%
Ethiopia	53	<1%
Brazil	49	<1%
Haiti	47	<1%
Eritrea	37	<1%
Georgia	32	<1%
Pakistan	32	<1%
Laos	28	<1%
Bangladesh	27	<1%
Romania	27	<1%
Somalia	27	<1%
Nigeria	26	<1%
Uzbekistan	25	<1%
Ukraine	24	<1%
Dominican Republic	21	<1%
Jamaica	21	<1%
Guinea	20	<1%
Egypt	18	<1%

Country of Origin	Count	Percentage
Ghana	17	<1%
Sudan	17	<1%
Jordan	16	<1%
Belize	15	<1%
Kazakhstan	15	<1%
Azerbaijan	14	<1%
Kyrgyzstan	14	<1%
Senegal	13	<1%
Syria	13	<1%
Tajikistan	13	<1%
Togo	13	<1%
Angola	12	<1%
Morocco	12	<1%
Cambodia	11	<1%
Chile	10	<1%
Philippines	10	<1%
Thailand	10	<1%
United Kingdom	10	<1%
Bolivia	8	<1%
Iraq	8	<1%
Mauritania	8	<1%
Republic of the Congo	8	<1%
South Korea	8	<1%
Costa Rica	7	<1%
Mali	7	<1%
Argentina	6	<1%
Benin	6	<1%
Fiji	6	<1%
Indonesia	6	<1%
Yemen	6	<1%
Democratic Republic of Congo	5	<1%
Israel	5	<1%
Lebanon	5	<1%
Spain	5	<1%
Taiwan	5	<1%
Burkina Faso	4	<1%
Gambia, The	4	<1%
Kenya	4	<1%
Liberia	4	<1%
Panama	4	<1%
Albania	3	<1%
Algeria	3	<1%
Bahamas	3	<1%
Belarus	3	<1%
Mongolia	3	<1%
Niger	3	<1%

Country of Origin	Count	Percentage
Trinidad and Tobago	3	<1%
Canada	2	<1%
Côte d'Ivoire	2	<1%
Hong Kong	2	<1%
Hungary	2	<1%
Ireland	2	<1%
Italy/Sardinia/Sicily	2	<1%
Japan	2	<1%
Kosovo	2	<1%
Micronesia	2	<1%
Poland	2	<1%
South Africa	2	<1%
Tunisia	2	<1%
Zimbabwe	2	<1%
Antigua and Barbuda	1	<1%
Australia	1	<1%
Bosnia and Herzegovina	1	<1%
British Indian Ocean Territory	1	<1%
Bulgaria	1	<1%
Burma	1	<1%
Burundi	1	<1%
Cape Verde Islands	1	<1%
Central African Republic	1	<1%
Equatorial Guinea	1	<1%
France	1	<1%
Gabon	1	<1%
Guinea-Bissau	1	<1%
Guyana	1	<1%
Korea (Unspecified)	1	<1%
Kuwait	1	<1%
Lithuania	1	<1%
New Zealand	1	<1%
Palestinian Territories	1	<1%
Portugal	1	<1%
Saint Lucia	1	<1%
Samoa	1	<1%
Saudi Arabia	1	<1%
Serbia	1	<1%
Sierra Leone	1	<1%
Sri Lanka	1	<1%
Sweden	1	<1%
Tonga	1	<1%
Uganda	1	<1%
Uruguay	1	<1%