OFFICE OF INSPECTOR GENERAL

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"Oversight of ICE Detention Facilities: Is DHS Doing Enough?"

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Chairwoman Torres Small, Ranking Member Crenshaw, and Members of the Subcommittee, thank you for inviting me here today to discuss oversight of U.S. Immigration and Customs Enforcement (ICE) detention facilities and the results of the Department of Homeland Security (DHS) Office of Inspector General's (OIG) recent reviews of ICE programs and efforts aimed at detention oversight. My testimony today will focus on the OIG's recent evaluations and inspections of ICE detention facilities and its oversight of those facilities, and our related recommendations for improvement.

While ICE has developed a multilayered approach to detention oversight, the shortcomings and challenges the OIG's work has identified render ICE's overall approach less effective than it otherwise could be. Until ICE fully addresses the issues identified in our work, it will continue to struggle to ensure comprehensive, consistent compliance with detention standards.

Background on OIG Reviews of ICE Detention Facilities and Detention Facility Oversight

ICE Enforcement and Removal Operations (ERO) apprehends removable aliens, detains these individuals when necessary, and removes them from the United States. ICE detainees are held in civil, not criminal, custody. ICE detention is administrative in nature, aimed to process and prepare detainees for removal. At the end of Fiscal Year (FY) 2017, ICE held nearly 38,000 detainees in custody. As of the summer of 2019, ICE had approximately 54,000 beds occupied nationwide.

During our reviews, these beds were spread across more than two hundred facilities, only five of which ICE owns. ICE contracts for use of the other two hundred facilities through contracts with private entities, inter-governmental service agreements (IGSA), or inter-governmental agreements. For example, at the end of FY 2017, ICE maintained eight Contract Detention Facilities, or facilities owned and operated by private companies and contracted directly by ICE, and 87 IGSAs, or facilities, such as local and county jails, housing ICE detainees (as well as other inmates).

ICE began operating its detention system under the *National Detention Standards* (NDS), issued in 2000 to establish consistent conditions of confinement, program operations, and management expectations in immigration detention. Along with stakeholders, ICE revised the NDS and developed *Performance-Based National Detention Standards 2008* (PBNDS 2008) to improve safety, security, and conditions of confinement for detainees. With its *Performance-Based National Detention Standards 2011* (PBNDS 2011), ICE aimed to enhance immigration detention conditions while maintaining a safe and secure detention environment for staff and detainees. ICE also uses *Family Residential Standards* for Family Residential

Centers holding families and juveniles. ICE's detention facility contracts and agreements identify the detention standards that apply to those facilities.

As early as 2006, when the OIG first reported on inadequate treatment of ICE detainees in its facilities,[1] and more recently, in response to congressional mandates, concerns raised by immigrant rights groups, and complaints to the OIG Hotline, the OIG has conducted inspections of detention facilities to evaluate compliance with ICE detention standards. We generally limit the scope of our inspections to the relevant standards for health, safety, access to medical and mental health care, grievances, classification and searches, use of segregation, use of force, and language access. We focus on the elements of the detention standards that can be observed and evaluated by OIG staff who do not have specialized training in the fields of medicine, mental health, or corrections. In addition to a physical inspection of areas used by detainees, during our visits to facilities we also review written documentation and interview ICE and detention facility staff members and detainees. Our public reports about these inspections discuss facility conditions at the time of our visits, and include analysis and conclusions based on our direct observations, review of documentary evidence, and interviews.

The OIG's inspections in 2016 and 2017 raised concerns about detainee treatment and care. For example, in March 2017, we issued a Management Alert after an unannounced inspection of the Theo Lacy Facility (TLF) in Orange, California, raised serious concerns, some that posed health risks and others that violated PBNDS 2008 and resulted in potentially unsafe conditions at TLF.[2] We recommended that ICE take immediate action to ensure compliance with PBNDS 2008 and strengthen its oversight of TLF. ICE concurred with our recommendations.

Our unannounced inspections of detention facilities in FY 2016 also gave rise to significant concerns about the treatment and care of detainees at four of the facilities visited.[3] For instance, some facilities had misclassified some detainees with high-risk criminal convictions and, as a result, housed them with low-risk detainees. At one facility, all detainees entering the facility were strip-searched in violation of ICE standards. We also observed potentially unsafe and unhealthy

[1] *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities* (OIG-07-01).
[2] *Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California* (OIG-17-43-MA). Management Alerts are a unique product issued by DHS OIG in relatively rare circumstances in which we identify an issue so serious that we deem it necessary to report on the issue before completing our standard inspection or review process. In such instances, we prepare a "Management Alert" to notify the Department of the issue so it can take immediate action to mitigate and/or correct the situation.
[3] *Concerns about ICE Detainee Treatment and Care at Detention Facilities* (OIG-18-32).

detention conditions, including delayed medical care, mold on walls and showers, and spoiled food.

ICE's Inspections and Monitoring of Detention Do Not Lead to Sustained Compliance or Systemic Improvements

The deficiencies and concerns identified in our detention facility inspections raised questions about the effectiveness of ICE's oversight of these facilities. ICE uses a multilayered approach to oversight of detention facilities, with various entities — including ICE ERO, ICE's Office of Professional Responsibility (OPR), and private contractors — conducting inspections and onsite monitoring to determine compliance with ICE detention standards. We reviewed the adequacy of these oversight activities, as well as ICE's use of contracting tools to hold detention facilities to applicable detention standards. In 2018, we published a review evaluating whether ICE's immigration detention inspections ensure adequate oversight and compliance with detention standards. Our report found deficiencies in both types of immigration detention inspections ICE uses, as well as in ICE's post-inspection follow-up processes.[4]

ICE uses two inspection types to examine detention facility conditions: (1) inspections performed by a private company, Nakamoto Group, Inc. (Nakamoto), contracted by ICE ERO Custody Management, and (2) inspections performed by personnel and contractors from ICE's Office of Detention Oversight (ODO) within ICE OPR. ICE also uses Detention Service Managers (DSMs) to provide onsite monitoring of day-to-day facility conditions, and report on and seek to correct issues as they arise.

In conducting our review, we evaluated policies, procedures, and inspections practices. We also observed Nakamoto and ODO inspections and reviewed a judgmental sample of both types of inspection reports. We concluded that neither type of inspection nor the onsite monitoring ensure consistent compliance with detention standards or promote comprehensive deficiency corrections.

We found that the inspections performed by Nakamoto do not fully examine actual conditions or identify all compliance deficiencies, because the Nakamoto inspection scope is too broad and inspection practices are not consistently thorough. Also, although ICE provides Nakamoto with the scope for the inspections, detention review summary forms, and inspection checklists, it does not provide clear procedures for evaluating detention conditions. In contrast, ODO inspections are narrower in scope and use effective methods and processes to thoroughly inspect

[4] *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (OIG-18-67).

facilities and identify deficiencies, but the inspections are too infrequent to ensure the facilities implement all corrections.

Moreover, ICE does not adequately follow up on identified deficiencies and, at the time of our review, did not have a comprehensive process to verify that facilities had implemented all the corrective actions. Without holding facilities accountable for correcting deficiencies, the usefulness of both Nakamoto and ODO inspections was further diminished.

In addition, ICE ERO field offices, which are responsible for implementing corrective actions, do not provide consistent support for the DSMs who work onsite and monitor detention conditions in more than 50 facilities. Thus, while DSMs, who identify thousands of deficiencies though their work, have the expertise to propose corrective actions, they do not have the authority to implement them. The lack of consistent support for DSMs hinders implementation of needed changes.

ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards

Another way in which ICE could hold detention facilities to applicable detention standards is through contracting tools. We reviewed how ICE manages and oversees its contracts with the contracted detention facilities housing ICE detainees.[5] Between FY 2016 and FY 2018, ICE paid more than $3 billion to the contractors operating these facilities. We found that ICE is failing to use quality assurance tools and impose consequences for contract noncompliance, such as failure to meet performance standards. Moreover, instead of holding facilities accountable for noncompliance through financial penalties, ICE frequently issued waivers to facilities with deficient conditions, effectively exempting them from having to comply with certain detention standards.

In fact, ICE generally is not imposing financial penalties, even for serious deficiencies such as significant understaffing, failure to provide sufficient mental health observations, and inadequate monitoring of detainees with serious criminal histories. From October 2015 to June 2018, various inspections and DSMs found 14,003 deficiencies at the 106 contract facilities we focused on for our review. Deficiencies included those that jeopardize the safety and rights of detainees, such as failing to notify ICE about sexual assaults and failing to forward allegations regarding misconduct of facility staff to ICE ERO. Despite the quantity and seriousness of the deficiencies, ICE only imposed financial penalties twice.

[5] *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards* (OIG-19-18).

ICE also has no formal policies and procedures to govern the waiver process, thereby allowing officials to grant waivers without clear authority, and failing to ensure key stakeholders have access to approved waivers. In some cases, officials may violate Federal Acquisition Regulation requirements because they seek to effectuate unauthorized changes to contract terms. Further, contract facilities may be exempt from compliance with otherwise applicable detention standards indefinitely, as waivers generally do not have an end date and ICE ERO does not reassess or review waivers after it approves them.[6]

Results of OIG's Recent Unannounced Inspections of ICE Detention Facilities

Continuing the OIG's program of unannounced inspections of ICE detention facilities, we recently issued Management Alerts regarding our findings from unannounced inspections of the Essex County Correctional Facility in Newark, New Jersey (Essex Facility)[7] and the Adelanto ICE Processing Center in Adelanto, California (Adelanto Center).[8] We issued these reports because, in the course of our review, we identified significant health and safety risks that violated ICE standards and required immediate action by ICE.

At the Essex Facility, one of the issues we identified was unreported security incidents. According to ICE standards, the Essex Facility must report to ICE any incidents involving detainees. However, the facility failed to do so following a detainee's discovery and reporting of a guard's loaded handgun left in a facility staff bathroom that the detainee was cleaning. This marked the fourth time in less than a year that the facility failed to notify ICE of incidents involving detainees, and raised serious concerns about the facility's ability to handle security issues.

Interviews with detainees and facility management revealed facility leadership completed a review of the incident, but did not interview the detainee who found the weapon. Rather, facility leadership reported to us that they told the detainee not to discuss the matter with anyone else. The review documented by the facility does not mention that the detainee found and reported the loaded weapon.

During our site visit, we notified ICE of the incident and ICE later issued a contract discrepancy report. The discrepancy report outlined this incident as the fourth time

[6] Following the OIG's reporting on the issue of ICE's use of waivers, Congress passed the *Consolidated Appropriations Act, 2019—House Report 116-9*, which established that the "ICE Director shall have sole authority to approve waivers, and shall notify the Committees of such waivers within 3 business days of such approval."
[7] *Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey* (OIG-19-20).
[8] *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG-18-86).

in less than a year that the Essex Facility had failed to notify ICE of detainee-related incidents. On February 27, 2019, ICE imposed a 5 percent deduction of invoiced amounts, the highest penalty allowed under the contract.

Our inspections also revealed health and safety concerns at both the Essex Facility and the Adelanto Center. At the Essex Facility, we observed extreme mishandling of meats, which can spread salmonella, listeria, and E. coli, leading to serious foodborne illnesses. We also observed facility staff serving potentially spoiled meat to detainees. Over a seven-month period in 2018, detainees filed approximately 200 kitchen-related grievances (about 12 percent of all grievances filed) with comments such as:

- "For dinner, we were served meatballs that smell like fecal matter. The food was rotten."
- "The food that we received has been complete garbage, it's becoming impossible to eat it. It gets worse every day. It literally looks like it came from the garbage dumpster; I have a stomach infection because of it and the nurse herself told me it was caused by the food."[9]

We observed violations of the ICE standards at the Adelanto Center that were equally concerning, including braided bedsheets — referred to as "nooses" by center staff and detainees — hanging from vents in 15 of the 20 cells we visited.[10] Interviews with detainees provided a variety of reasons for braiding and hanging bedsheets, with one detainee noting, "I've seen a few attempted suicides using the braided sheets by the vents and then the guards laugh at them and call them 'suicide failures' once they are back from medical." In fact, in March 2017, a 32-year-old male died at an area hospital after being found hanging from his bedsheets in an Adelanto Center cell. In the months after this suicide, ICE compliance reports documented at least three suicide attempts by hanging at the Adelanto Center, two of which specifically used bedsheets. Media reports based on 911 call logs indicate at least four other suicide attempts at the Adelanto Center from December 2016 to July 2017.[11] In total, these reports represent at least seven suicide attempts at the Adelanto Center from December 2016 to October 2017. Nationwide, self-inflicted strangulation accounts for 4 of the 20 detainee deaths reported between October 2016 to July 2018, according to ICE news releases.

[9] *Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey* (OIG-19-20).
[10] *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG-18-86).
[11] Paloma Esquivel, *'We don't feel OK here': Detainee deaths, suicide attempts and hunger strikes plague California immigration facility*, LOS ANGELES TIMES (Aug. 8, 2017), http://www.latimes.com/local/lanow/la-me-ln-adelanto-detention-20170808-story.html.

In addition to the serious issues highlighted in our reports on the Essex Facility and the Adelanto Center, our program of unannounced inspections identified other instances of noncompliance with standards at these facilities, as well as two others: the LaSalle ICE Processing Center in Louisiana, and the Aurora ICE Processing Center in Colorado.[12] Overall, our inspections of the four detention facilities revealed violations of ICE's detention standards and raised concerns about the environment in which detainees are held. Although the conditions varied among the facilities and not every problem was present at each, our observations, interviews with detainees and staff, and reviews of documents revealed several common issues. All four facilities had issues with expired food, which puts detainees at risk for food-borne illnesses. At three facilities, we found that segregation practices violated standards and infringed on detainee rights. Two facilities failed to provide recreation outside detainee housing units. Bathrooms in two facilities' detainee housing units were dilapidated and moldy. Our observations confirmed concerns identified in detainee grievances, which indicated unsafe and unhealthy conditions to varying degrees at all of the facilities we visited.

ICE Has Taken Action to Address OIG Recommendations Aimed at Improving Oversight of ICE Detention

Since FY 2017, we have made 10 recommendations to improve ICE's oversight of detention and 7 recommendations aimed at improving detention conditions. In response to these recommendations, ICE has implemented a number of changes and has initiated others, some of which are nearing completion, including:

- With respect to oversight of detention facilities, we recommended that ICE develop a follow-up inspection process for select facilities where ODO identifies egregious or numerous deficiencies.[13] ICE reported in May 2019 that it has begun the follow-up inspection process and has issued two completed reports from follow-up inspections conducted in FY 2018. ICE also provided a schedule for FY 2019 follow-up inspections.

- In response to our recommendation that ICE conduct a full review of the Adelanto ICE Processing Center and the GEO Group, Inc.'s management of the facility to ensure compliance with PBNDS 2011[14], ICE provided documentation in March 2019 that it has completed a Special Assessment Review of the Adelanto facility, identified deficiencies, and completed corrective actions.

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[12] *Concerns about ICE Detainee Treatment and Care at Four Detention Facilities* (OIG-19-47).
[13] *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (OIG-18-67).
[14] *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (OIG-18-86).

- In response to our recommendation regarding the waiver process (and consistent with the Department of Homeland Security Appropriations Act, 2019 (H.R. 6776)), ICE drafted a Detention Standards Waiver Policy, which will require that the ICE Director have sole authority to approve waivers. Additionally, in May 2019, ICE made a complete list of all 181 waivers available on ICE's public website.[15]

Although ICE has been responsive to our recommendations and is taking steps in the right direction, challenges remain. Fully implementing changes and resolving the underlying issues that make ICE detention oversight challenging will require a multi-year commitment and depend heavily on adequate funding and staffing.

Ongoing OIG Work Related to ICE Detention

In FY 2020, the OIG will continue its ongoing program of unannounced inspections of facilities holding ICE detainees. We will report on the results of the FY 2019 inspections later this year. We are happy to brief you and your staff on the results of these inspections when they are finalized.

Chairwoman Torres Small, this concludes my testimony. I am happy to answer any questions you or other Members of the Subcommittee may have.

[15] ICE, Facility Inspections, https://www.ice.gov/facility-inspections.

Appendix A
List of OIG Reports

Report Number	Report Title	Date Issued	Status of Recommendations
OIG Reviews of ICE Detention Facilities and Detention Facility Oversight			
OIG-07-01	Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities	December 2006	12 Recommendations; all Closed
OIG-17-43-MA	Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California	March 2017	3 Recommendations; all Closed
OIG-18-32	Concerns about ICE Detainee Treatment and Care at Detention Facilities	December 2017	1 Recommendation; Resolved and Open
OIG-18-67	ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements	June 2018	5 Recommendations; 1, 2, 4, and 5 are Resolved and Open; Recommendation 3 is Closed
OIG-18-86	Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California	September 2018	1 Recommendation; Closed
OIG-19-18	ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards	January 2019	5 Recommendations; 1, 2, 3, and 4 are Resolved and Open; Recommendation 5 is Closed

Report Number	Report Title	Date Issued	Status of Recommendations
OIG-19-20	Issues Requiring Action at the Essex County Correctional Facility in Newark, New Jersey	February 2019	1 Recommendation; Resolved and Open
OIG-19-47	Concerns about ICE Detainee Treatment and Care at Four Detention Facilities	June 2019	1 Recommendation; Resolved and Open