



## ICE's Detention Inspection Program Is Systemically Flawed and Has Not Improved

### I. Introduction

This white paper addresses failures in Immigration and Customs Enforcement's (ICE) system of detention oversight. Specifically, we address ICE's inspection system, which fails to identify violations by detention facilities and ensure compliance with detention standards, allowing facilities with clear records of poor conditions to evade accountability. This analysis is based on a review of the 88 inspection reports performed by the Nakamoto Group (Nakamoto) of ICE detention facilities in 2021 — the most current information that is publicly available.<sup>1</sup>

An effective inspection system is critical to detecting and deterring abuse of people detained by ICE. ICE should adopt and implement a rigorous inspection regime that will both identify facilities that do not comply with ICE's detention standards and hold them accountable for those failures — including through facility closure.

ICE currently monitors compliance with detention standards through external audits performed by Nakamoto and internal audits conducted by the Office of Detention Oversight (ODO). Nakamoto inspects about 100 facilities per year to determine compliance with 39 to 42 applicable detention standards that include over 650 elements. Historically, ODO inspected approximately 30 facilities per year to determine compliance, with only 15 to 16 "core" standards that most directly impact detainee health, safety, and welfare. At this time, most facilities are audited only by Nakamoto.

In 2018, the Department of Homeland Security Office of Inspector General (OIG) issued a report examining ICE's inspection and monitoring system. In its report, the OIG concluded that Nakamoto's "inspection practices are not consistently thorough," noting that ICE employees in the field and managers at headquarters told OIG that Nakamoto inspectors "breeze by the [detention] standards." ICE officials described Nakamoto inspections as being "very, very, very difficult to fail" and as "useless."<sup>2</sup> In 2020, the House Homeland Security Committee issued a similarly scathing critique, finding that Nakamoto "has demonstrated a lack of credibility and competence" and is "ill-equipped" for its oversight work.<sup>3</sup> Congress has further indicated its concern with ICE's inspection system, requiring that no later than January 1, 2021, appropriated funds shall be used for ICE inspections conducted by ICE's Office of Professional Responsibility.<sup>4</sup>

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<sup>1</sup> ICE, *Facility Inspections*, <https://www.ice.gov/detain/facility-inspections> (last visited Nov. 9, 2021).

<sup>2</sup> DHS OIG, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* 4 (June 26, 2018), <https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf> [hereinafter "DHS OIG"].

<sup>3</sup> United States House of Representatives, Committee on Homeland Security, *ICE Detention Facilities Failing to Meet Basic Standards*, <https://homeland.house.gov/imo/media/doc/Homeland%20ICE%20facility%20staff%20report.pdf> (Sept. 21, 2020).

<sup>4</sup> Consolidated Appropriations Act, Pub. L. No. 116-260, § 215(b) (2021), <https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf>.



As our analysis below concludes, the problems identified by the OIG and House Homeland Security Committee have not been resolved, and have only grown worse this year. In the meantime, detained people continue to suffer from abusive conditions of confinement, and their abusers continue to face little to no accountability.

Flawed inspections have allowed a gross failure in ICE's oversight of the immigration detention system. ICE should terminate its contract with Nakamoto. But ending this contract alone is insufficient to ensure robust and effective oversight of the detention system. There are three additional steps that are critical to meaningful reform of ICE's detention oversight system: (1) ICE must ensure frequent and rigorous inspections conducted by independent actors, on the basis of objective criteria, with clear procedures for evaluating detention conditions; (2) ICE must establish and enforce specific consequences for failed inspections, including probation and termination of facility contracts within 60 days upon repeat findings of non-compliance; and (3) ICE must provide transparency into ICE's inspection system, making all findings of non-compliance and information regarding all enforcement actions against non-compliant detention facilities publicly available.

## **II. Findings: ICE's Detention Inspection Program is Systemically Flawed and Has Not Improved**

ICE's inspection system continues to endanger detained people, turns a blind eye to violations of inspection standards, and fails to provide accountability and remedy conditions of abuse. Our analysis of the 88 inspection reports prepared by Nakamoto in 2021 reveals that ICE's inspection system continues to suffer from the same structural deficits described by the OIG and the House Homeland Security Committee. These problems include inadequate staff and time for inspections; pre-announced inspections; failure to verify representations by ICE and detention facility officials; and failure to conduct proper detainee interviews. Indeed, oversight has only diminished as conditions in detention have grown more deadly during the COVID-19 pandemic. For these reasons, ICE's inspections rarely lead to accountability.

**Virtually No Facility Fails.** Nakamoto reviews a facility's compliance with over 40 separate detention standards in each inspection. However, Nakamoto found that only 18 facilities ever failed to meet a single detention standard — and 17 of those 18 facilities were found to fail only one detention standard during inspection. Nakamoto issued an overall recommended rating of "Meets Standards" for 77 of 83 detention facilities it rated in 2021, and only recommended that detention facilities did comply with all ICE standards three times.<sup>5</sup>

**Failure to Account for Clear Indications of Poor Conditions.** Inspection reports of facilities with well-established records of poor conditions clearly illustrate the failures of ICE's inspection system. For example, Nakamoto's inspection of the Stewart Detention Center in Georgia found that the facility "Meets Standards," identified only one deficient component in the standard of "Correspondence and

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<sup>5</sup> In one instance, Nakamoto issued a rating of "acceptable," and in two instances rated a facility as capable of receiving a "Meets Standard" rating in future inspections.

Other Mail,” and stated that “there were no areas of concern or significant observation.”<sup>6</sup> Yet more detained people have died at Stewart than any other ICE facility in the last four years; since May 2017, eight people have died in custody at Stewart. Felipe Montes, a 57-year-old man from Mexico detained at Stewart, had died only a few weeks before Nakamoto’s inspection.<sup>7</sup> Nakamoto’s inspection, however, failed to note any concerns about the provision of medical or mental health care or COVID-19 protocols at the facility.

Likewise, Nakamoto’s inspection of the Glades County Detention Center in Florida found that the facility “Meets Standards,” and found “no areas of concern or significant observations from this remote inspection.”<sup>8</sup> Yet community groups filed a well-publicized civil rights complaint on behalf of 300 detained people at Glades, reporting inadequate medical care and lack of COVID-19 protections, during Nakamoto’s inspection of the facility.<sup>9</sup>

**Pre-Announced, Remote Inspections.** Structural flaws in ICE’s inspection system continue to undermine robust oversight. All inspections by Nakamoto and ODO continue to be pre-announced, which permits detention facilities to temporarily cure or mask deficiencies solely for the purpose of the inspection. Inspections take place over three days at most with a limited number of inspectors (often no more than five). Ninety percent of all Nakamoto inspections in 2021 were conducted remotely or using a hybrid format. These inspections relied on photos submitted by facilities to inspectors, who then reviewed “photographs and/or videos to validate the observation of many standards.”<sup>10</sup> These inspections constitute a remarkable failure of oversight during a time where detained immigrants faced inherently dangerous, congregate conditions due to the COVID-19 virus. Although health and safety considerations during the pandemic may have supported the temporary use of hybrid or remote inspections, Nakamoto could have taken additional steps to ensure more robust inspections, including unannounced, live video inspections, and additional, randomized document review.

**Flawed Detainee Interviews.** Inspectors also fail to properly interview detained people, and often rely almost exclusively on self-serving representations of detention facility employees to conclude compliance with standards, even in the face of contrary evidence. Nakamoto inspections lack consistency with regard to how many detainees are interviewed, whether they are formal or informal interviews, and whether they are conducted confidentially or not. In some inspection reports, Nakamoto deflects responsibility for its failure to interview detainees by stating that no one volunteered to be

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<sup>6</sup> Nakamoto, *Annual Detention Inspection of the Stewart Detention Center*, May 6, 2021, [https://www.ice.gov/doclib/facilityInspections/StewartDetCtrGA\\_CL\\_05-06-2021.pdf](https://www.ice.gov/doclib/facilityInspections/StewartDetCtrGA_CL_05-06-2021.pdf).

<sup>7</sup> ICE ERO, *Detainee Death Report: Montes, Felipe*, Jan. 30, 2021, <https://www.ice.gov/doclib/foia/reports/ddrMontesFelipe.pdf>.

<sup>8</sup> Nakamoto, *Annual Detention Inspection of the Glades County Detention Center*, Feb. 24, 2021, <https://www.ice.gov/doclib/facilityInspections/GLADEFL21-GladesCoDetCtr-CoverLtr.pdf>.

<sup>9</sup> Americans for Immigrant Justice, *Immigrant Right Advocates Submit Complaint on Civil Rights and Civil Liberties Abuses at Glades County Detention Center Amidst Reckless COVID-19 Response*, Feb. 22, 2021, <https://aijustice.org/2021/02/22/glades-complaint/>.

<sup>10</sup> See, e.g., Nakamoto, *Annual Inspection of the CCA Florence Correctional Center*, Aug. 26, 2021, [https://www.ice.gov/doclib/facilityInspections/ccaFlorenceCC\\_CL\\_08-26-2021.pdf](https://www.ice.gov/doclib/facilityInspections/ccaFlorenceCC_CL_08-26-2021.pdf).

interviewed formally.<sup>11</sup> In other reports, it is clear that the interviews took place in non-confidential settings, such as group interviews, which raises concerns of coercion and retaliation. This violates ICE’s requirement that detainee interviews “include ‘private conversations with individual detainees (in a confidential area)[.]’”<sup>12</sup>

**Failure to Thoroughly and Objectively Assess Self-Serving Representations by Facility Officials.**

Nakamoto also repeatedly considers self-serving representations made by facility officials as true, without evidence of any verification. Even when detained people raise concerns during interviews that facility officials cannot dismiss, Nakamoto fails to further investigate the concerns. For example:

- At the Prairieland Detention Center in Texas, one detainee housed in the Special Management Unit (SMU) “stated he had not seen an ICE officer while housed in the SMU.” Nakamoto accepted the facility’s documentation that “ICE officers routinely visit the SMU,” even though “[d]ocumentation that an ICE officer had visited this particular detainee was not available.”<sup>13</sup>
- When two detainees at the Hall County Department of Corrections in Nebraska expressed medical concerns regarding “vision problems and the need for eye glasses” and “not receiving insulin on a regular schedule,” the inspection report stated that the concerns were shared with the facility’s acting health service administrator, who agreed to review their medical charts and “meet with the detainees if necessary.”<sup>14</sup>
- A detainee at the Mesa Verde Detention Facility in California said he missed a medical appointment because he was unable to stand and the officer refused to take him.<sup>15</sup> Nakamoto did nothing more than review the detainee’s medical record, which confirmed that he missed his medical appointment “as he refused to stand and to be pat searched before he was transported,” and accepted at face value the medical staff’s representation that he “can stand without assistance.”<sup>16</sup>

**Dismissal of Detainee Concerns.** In other inspections, Nakamoto has failed to follow up entirely and/or minimized important concerns expressed by detained people. For instance, during Nakamoto’s inspection of Eloy Detention Center in Arizona from February 3-5, 2021, it was noted that one woman placed on administrative segregation had remained in solitary confinement since December 8, 2020,

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<sup>11</sup> See, e.g. Nakamoto, *Annual Inspection of the Chase County Detention Center*, Aug. 5, 2021, [https://www.ice.gov/doclib/facilityInspections/chaseCoDetCtr\\_CL\\_08-05-2021.pdf](https://www.ice.gov/doclib/facilityInspections/chaseCoDetCtr_CL_08-05-2021.pdf).

<sup>12</sup> DHS OIG at 8.

<sup>13</sup> Nakamoto, *Annual Detention Inspection of the Prairieland Detention Center*, Feb. 10, 2021, <https://www.ice.gov/doclib/facilityInspections/PRLDCTX21-PrairielandDetCtr-CoverLtr.pdf>.

<sup>14</sup> Nakamoto, *Annual Inspection of the Hall County Dep’t of Corr.*, Aug. 26, 2021, [https://www.ice.gov/doclib/facilityInspections/hallCoDOC\\_CL\\_08-26-2021.pdf](https://www.ice.gov/doclib/facilityInspections/hallCoDOC_CL_08-26-2021.pdf).

<sup>15</sup> Nakamoto, *Annual Report of the Mesa Verde Detention Facility*, Jun. 24, 2021, [https://www.ice.gov/doclib/facilityInspections/mesaVerdeDF\\_CL\\_06-24-2021.pdf](https://www.ice.gov/doclib/facilityInspections/mesaVerdeDF_CL_06-24-2021.pdf).

<sup>16</sup> *Id.*

“due to her continued disruptive behavior,”<sup>17</sup> even though under ICE’s own standards administrative segregation is not supposed to last beyond thirty days, and disruptive behavior is not a sufficient justification for administrative segregation. Nakamoto did not state anything further in its inspection report despite the severity of the detainee’s concern. Similarly, at the Folkston ICE Processing Center in Georgia, on one of the inspection days there was a “work walk-off” and an “alleged hunger strike” by 20-25 detainees who raised concerns about the facility’s failure to provide information on the status of their cases and “transfer-outs” of individuals who were detained for the shortest periods of time.<sup>18</sup> Nakamoto failed to conduct any meaningful investigation of this incident, resting on their conclusion from their tours the next day that “[d]etainees registered no lingering issues to the previous day’s earnest complaints.”<sup>19</sup>

### III. Recommendations

As noted above, ICE must make systemic changes to its inspections of ICE detention facilities. But improvement in inspections is not enough. If no real consequences follow from inspections, the government’s message to facility operators is that they may persist in their abusive practices; that is why model standards for effective detention site investigations always include accountability measures as a critical component.<sup>20</sup> We urge ICE to establish and apply real consequences for a facility’s failure to comply with detention standards, and provide greater transparency.

- Terminate ICE’s contract with the Nakamoto Group.
- Establish frequent (at least annual) and rigorous inspections conducted by independent actors, on the basis of objective criteria, with clear and thorough procedures for evaluating detention conditions. Inspections should be unannounced, in-person, and ensure sufficient time and staffing to conduct a comprehensive review of standards. Inspections should integrate consideration of complaints made by detainees and civil society groups regarding conditions of confinement, as well as analysis of significant event reports from the facility.
- Establish and enforce specific consequences for failed inspections, including probation and termination of facility contracts within 60 days upon repeat findings of non-compliance.
- Provide transparency into ICE’s inspection system, making all findings of non-compliance and information regarding all enforcement actions against non-compliant detention facilities publicly available.

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<sup>17</sup> Nakamoto, *Annual Inspection of the Eloy Detention Center*, Feb. 5, 2021, <https://www.ice.gov/doclib/facilityinspections/EAZ21-EloyDetCenterAZ-CoverLtr.pdf>.

<sup>18</sup> Nakamoto, *Annual Report of the Folkston ICE Processing Center*, Jul. 28, 2021, <https://www.ice.gov/doclib/facilityinspections/JAMESGA21-FolkstonIPC-CL-07-28-2021.pdf>.

<sup>19</sup> *Id.*

<sup>20</sup> United Nations Human Rights Office of the High Commissioner, *Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, G.A. Res. 55/89 (Dec. 4, 2000), <https://www.ohchr.org/EN/ProfessionalInterest/Pages/EffectiveInvestigationAndDocumentationOfTorture.aspx>.



These recommendations supplement the ACLU's larger recommendations to the Biden administration for dismantling ICE's mass incarceration system. We continue to join our partner organizations in emphasizing the importance of closing detention sites, halting detention site expansion, and phasing out the role of private prison companies.

For more information, please contact Eunice Cho, [echo@aclu.org](mailto:echo@aclu.org); Patrick Taurel, [ptaurel@aclu.org](mailto:ptaurel@aclu.org), and Aditi Shah, [ashah@aclu.org](mailto:ashah@aclu.org) at the ACLU National Prison Project.