On-site Investigation Report

Etowah County Jail

April 9-11, 2018

(b) (6)

MD, FACP

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Introduction

This report responds to a request by the Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) to review and comment on the medical care provided to detainees at the Etowah County Jail (ECJ) in Gadsden, Alabama. My opinions are based on the materials provided and reviewed in advance and an on-site investigation of the facility on April 9-11, 2018. My opinions are expressed to a reasonable degree of medical certainty. ECJ personnel were most pleasant and cooperative during my investigation.

Expert Qualifications

(b) (6)

(b) (6)

Methods of Review

In advance of the on-site investigation, I reviewed documents provided by CRCL. During the on-site investigation, I toured the facility including housing units, pill lines and the medical clinic, reviewed documents and medical records, and interviewed staff and detainees. I did focused reviews of medical records for those detainees who had chronic medical conditions such as asthma or high blood pressure. Clinical performance was measured by a focused review of medical records using a standardized methodology. (The full methodology for the review is described in the document entitled Assessment of Quality of Medical Care in Detention Facilities, and its accompanying Reviewer Pocket Guide.) The measures are based on nationally accepted clinical guidelines, or consensus guidelines where there are no published clinical guidelines. I reviewed roughly 55 individual detainee medical records in total. I conducted individual interviews with twelve detainees selected at random from chronic care rosters or selected because of complaints received. Where relevant to findings, reference is made to the National Detention Standards (NDS) and the National Commission on Correctional Health Care Jail Standards (NCCHC 2014).

Overview

This report represents the result of an off-site review of documents (including medical records) and my focused three-day on-site medical review at the facility in response to a request by CRCL to investigate specific complaints at ECJ.

ECJ is located in Gadsden, Alabama. It has the capacity to house roughly 850. During the onsite investigation, the ICE detainee census was 287 detainees. Medical care is provided by a local contractor, Doctors' Care Physicians, P.C. Doctors' Care has held that contract since 2005 and was the contractor during the 2012 CRCL visit. The medical program is accredited by the National Commission on Correctional Health Care (NCCHC).

At the previous CRCL investigation, the medical expert identified a number of deficiencies that have been addressed, including sick call process, problems with privacy related to clinic space, timely access to dental, and problems with pill line timing and gaps in delivery of medications. Except as noted below, I saw improvements in these areas.

Overall, I found the medical care at ECJ to be good, but there were five areas where the current program did not meet the NDS or the NCCHC 2014. This report will focus on deficiencies and areas requiring further attention in order to meet those standards.

Findings

Overall medical care of ICE detainees at ECJ meets 2000 NDS and 2014 NCCHC Jail Standards

with the exception of the following areas where care **does not** currently meet those standards:

1. **Insufficient Medical Provider Staffing:** The facility staff has inadequate provider staffing hours (physicians and/or nurse practitioner on-site availability) to provide care for the population of up to 850 inmates and detainees or to support five day a week provider sick call as required by the NDS.

   PERFORMANCE does NOT meet NDS (III A, C, and F).

2. **Use of Laboratory Services:** Medical records reviewed for chronic medical conditions were missing standard orders for basic diagnostic labs, including basic measurements for diabetes control and metabolic profiles for patients with diabetes, hypertension, and heart disease, among others. For example, initial measurement of basic lab results, including measurement of diabetes control by hemoglobin A1C or even blood sugar by finger stick with a handheld glucometer are not routinely being performed on diabetics. Another example: assessment of kidney function is not routinely performed during initial evaluation of diabetic and hypertensive patients.

   PERFORMANCE does NOT meet NDS (I, III A) and 2014 NCCHC J-D-04.

3. **Underdeveloped Quality Assurance (QA) Program.** The medical program does have a quality assurance program, but only performs one or two projects per year (and most years only one). The quality of those projects is good, but a reasonable QA program would perform one or two projects every *quarter*. The minimal quality assurance approach barely meets NCCHC standards and deprives the facility from proven approaches to identify and fix problems and potential problems in an effective and data driven process.

   PERFORMANCE minimally meets 2014 NCCHC J-A-06 but should be improved

4. **Dental**: ECJ does not provide timely access to emergent or urgent dental care. A review of medical records revealed patients with acute and symptomatic dental problems often waited two or three weeks to be seen and treated.

   PERFORMANCE does NOT meet the 2000 NDS III (E)(1).

5. **Physical Plant**. The new exam rooms lack sinks or wall mounted hand sanitizer dispensers.

   PERFORMANCE does NOT meet the 2000 NDS III (B) and the 2014 NCCHC J-D-03 8a.

Complaints and Issues Reviewed

1. 16-12-ICE-0638 - **alleged inadequate medical care for herniated discs in the lower back.** *[Case 1 in Appendix I]* My investigation of the medical record *did substantiate* this complaint. ECJ medical staff ordered a neurosurgical consult but failed to request approval form ICE or follow up on scheduling the appointment. This complaint had previously been substantiated by IHSC on October 13, 2016 in their response to a CRCL inquiry. In addition to failing to follow through on the recommended neurosurgical consultation, the facility physician did not sign off on an orthopedic consult until one month after the visit.

2. 16-04-ICE-0574 - **alleged inadequate medical care for knee problems, back pain, and headaches**. *[Case 2 in Appendix I]* My investigation *did substantiate* this complaint by confirming that ECJ medical staff conducted much of the medical care remotely by reviewing and acting on the reports and recommendations of outside providers without conducting their own provider face-to-face visits and examinations with the patient following off-site consultation. This complaint had previously been substantiated by IHSC on June 10, 2016 in their response to a CRCL inquiry.

3. **Other substantiated complaints:** CRCL received a number of complaints about medical care that were not referenced in the retention memo. These include complaints received in writing prior to the on-site investigations and complaints raised verbally by detainees during the on-site investigation. *Substantiated* complaints included complaints about infrequent use of laboratory diagnostics and infrequent follow up for chronic diseases.

4. **Findings from the 2012 CRCL Onsite Investigation:** As part of this onsite investigation, CRCL asked me to review the implementation of recommendations made during CRCL's last onsite investigation at ECJ in May 2012.

Discussion

While this report focuses on deficiencies in the medical care at ECJ, it is important to comment briefly on the medical program as a whole. Performance of the medical program met the NDS in all other areas not cited. Strengths include the quality of the personnel that make up the medical leadership team in the facility, specifically the medical doctor (who is also the Chief Medical Authority) and the Health Services Administrator. Another strength is the use of an electronic health record. Finally, the model of a care program being provided by a respected local contractor has a number of advantages including the ability of the contractor to leverage professional relationships to secure timely and quality specialty and hospital level care for the patients when needed.

The focus of this report is on deficiencies. The deficiencies cited in this report are all correctable, and recommendations for correction are provided below.

While I cite four specific areas requiring attention, it should be appreciated that deficiencies in those cited areas create other problems. For example, inefficiencies created by the combination of inadequate staff and inadequate administrative support of the clinical operation all have impact on the timeliness of medical care. My review of 55 medical records of patients requiring ongoing care for chronic medical problems such as diabetes, hypertension, HIV, and asthma revealed that frequency of evaluation does not meet published disease specific standards guidelines (including NIH and NCCHC guidelines). Likewise, the practice of not checking routine labs for detainees with chronic illness until they had been detained for six months resulted in unacceptable delays in access to care. Many patients with chronic illnesses were only scheduled for follow up with the doctor every six months, also well below the standard.

During the on-site investigation, medical leadership shared a plan to recruit a full-time nurse practitioner to provide on-site services 40 hours a week on a Monday through Friday schedule. I believe that if this additional staffing were provided, without reducing the current physician or nursing schedule, many of the deficiencies cited in this report could be resolved.

Summary of Recommendations

Overall medical care of ICE detainees at ECJ meets 2000 NDS and 2014 NCCHC Jail Standards with the exception of the following areas where care **does not** currently meet those standards:

1. **Insufficient Medical Provider Staffing:** The facility staff has inadequate provider staffing hours (physicians and/or nurse practitioner on-site availability) to provide care for the population of up to 850 inmates and detainees or to support five day a week provider sick call as required by the NDS.

   Recommendation: In addition to the current part-time physician (who also serves as the Clinical Medical Authority), ECJ should add an additional licensed provider (a primary care MD, nurse practitioner, or physician's assistant) at 1.0 FTE (40 hours weekly) with a five-day schedule. This staffing should be in addition to the current physician staffing, not in place of it. Current nurse staffing should be maintained. The facility's medical contract language should be revised to be consistent with NDS in specifying minimum number of days per week for provider on-site sick call based on detainee census. (NDS, Medical Care, § III(A), (C), and (F)) (Level 1)

2. **Use of Laboratory Services:** Medical records reviewed for chronic medical conditions were missing standard orders for basic diagnostic labs, including basic measurements for diabetes control and metabolic profiles for patients with diabetes, hypertension, and heart disease among others.

   Recommendation: As part of a chronic disease program, diagnostic labs should be ordered in accordance with accepted standards of practice. For example, all diabetics should have a hemoglobin A1C ordered on initial assessment or at least within 30 days of intake, and then every 90 days for those not at goal. Patients with heart disease, high blood pressure, or high cholesterol should have their metabolic and lipid profiles drawn

within 30 days of intake and thereafter as clinically indicated. (NDS, Medical Care, §§ I, III(A); NCCHC 2014 J-D-04) (Level 1)

3. **Underdeveloped Quality Assurance (QA) Program.** The medical program does have a quality assurance program, but only performs one or two projects per year (and most years only one). The quality of those projects is good, but a reasonable QA program would perform one or two projects every *quarter*. The minimal quality assurance approach barely meets NCCHC standards and deprives the facility from proven approaches to identify and fix problems and potential problems in an effective and data driven process.

   Recommendation: ECJ should expand its use of the quality assurance framework by performing a minimum of two investigations per quarter. (NCCHC 2014 J-A-06) (Level 2)

4. **Dental**: ECJ does not provide timely access to emergent or urgent dental care. A review of medical records revealed patients with acute and symptomatic dental problems often waited two or three weeks to be seen and treated.

   Recommendation: ECJ must recruit additional dental consultants to back up the main contract for urgent dental visits in order to address urgent dental issues in a timely manner. (NDS, Medical Care, § III(E)(1)) (Level 1)

5. **Physical Plant**. The new exam rooms lack sinks or wall mounted hand sanitizer dispensers.

   Recommendation: All exam rooms should have sinks installed for hand washing. Until sinks can be installed, wall mounted hand sanitizer dispensers should be installed. (NDS, Medical Care, § III(B); NCCHC 2014 J-D-03(8a)) (Level 1)

These corrective measures will require monitoring to ensure they adequately address the substantiated deficiencies.

Appendix I

This section includes identifiers to protected health information. Disclosure/distribution of this appendix should be limited accordingly.

Identity of Cases Cited in this Report

My Case No.	A #	Name	CRCL Complaint #
1.	(b)(6)		16-12-ICE-0638
2.			16-11-ICE-0594

(b) (6)

PH.D.

CONFIDENTIAL

REPORT FOR THE
U.S. DEPARTMENT OF HOMELAND SECURITY
OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES
June 25, 2018

Investigation regarding Etowah County Detention Center

Prepared by (b) (6) Ph.D.

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CRCL INVESTIGATION OF ETOWAH COUNTY DETENTION CENTER'S MENTAL HEALTH DELIVERY SYSTEM

INTRODUCTION

Referral Issue

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation of complaints it received that included issues regarding the adequacy of Etowah County Detention Center's (ECDC) mental health delivery system for ICE detainees. I specifically reviewed the mental health care provided to the complainants. I also reviewed the care provided to other detainees by: interviewing staff and detainees; reviewing randomly selected medical records; and reviewing deliberately targeted medical records of detainees who had been on suicide watch, placed in segregation, and sent to a psychiatric hospital. CRCL also asked me to review the implementation of recommendations made during CRCL's last onsite investigation at ECDC in May 2012. Finally, I reviewed other documents including forms and administrative records to assess ECDC's mental health delivery system's compliance with national and professional standards.

Professional Oualifications

(b) (6)

Standards, Policies and Procedures, and Best Practices

- National Detention Standards 2000 (NDS 2000)
- ECDC Policies and Procedures:
  a) Basic Mental Health Services (J-G-04) 2017
  b) Mental Health Screening and Evaluations (J-E-05) 2017
- National Commission on Correctional Health Care's Standards for Jails 2014 (NCCHC)
- Prison Rape Elimination Act of 2003 (PREA)
- Psychiatric Services in Jails & Prisons 2000 (American Psychiatric Association (APA))

Sources of Information

- **Facility Tour**

- **Observations of Mental Health Delivery System in action**

- **Documents Reviewed**
  - ECDC Basic Mental Health Services Policy and Procedure (J-G-04)
  - ECDC Mental Health Screening and Evaluation Policy and Procedure (J-E-05)
  - Cherokee Etowah Dekalb Mental Health Center Form (Physician Evaluation)
  - Doctors' Care Physicians' Electronic Health Record Mental Evaluation Forms
  - Behavioral Healthcare Records of six Complainants
  - Behavioral Healthcare Records of 12 ICE Detainees
  - CRCL Mental Health Expert Report from May 2012 Onsite Investigation
  - ICE Health Service Corps Final Report of Findings 08/15/2017
  - Etowah County Staff Breakdown
  - Mental Health Staff Credential's Packet
  - ECDC PREA Training Verification (2017)
  - CQI Mental Health Process Study (2018)
  - Quarterly Health Care Administrative Meeting Minutes (3-12-2018)
  - Monthly Health Care Services Staff Meeting Minutes (3-12-2018)
  - ECDC Medical Unit Staff Meeting Minutes (3-12-2018)
  - Behavioral Healthcare Record of two detainees sent to a psychiatric hospital in 2017
  - Behavioral Healthcare Record of a detainee housed in Unit 3 Segregation for an extended period of time in 2017-2018
  - Use of Force Reports
  - Signed Consent Forms for Psychotropic Medications

- **Interviews Performed**
  - Staff Interviews
    1) (b)(6)
    2)

3) (b)(6)
4)
5)
6)
7)

- Detainee Interviews (Ten detainees were interviewed, eight of whom were receiving mental health services, refer to Appendix I)

- **Detainee Medical Records Reviewed**
  - Medical Record Reviews (Seventeen detainee medical records were reviewed. Six of these 17 detainees were complainants. Eight of the 17 were included in the group of 10 detainees who were interviewed. The remaining three of those 17 detainees were receiving mental health services, but they were not interviewed, refer to Appendices II and III)

Description of Etowah County Detention Center (ECDC)

Etowah County Detention Center is a multistory detention facility which opened in 1997. In 2005, ECDC contracted with Doctors' Care Physicians to provide medical, dental, and mental health care to detainees and inmates. In 2015, Doctors' Care Physicians subcontracted the delivery of mental health services to Cherokee Etowah Dekalb County Mental Health, located in Gadsden, Alabama.

The facility has a reported capacity of approximately 850 occupants, 325 ICE detainees and 525 inmates. ICE detainees are placed at this facility under the authority of an Intergovernmental Agreement with the U.S. Marshals Service. They are housed in units specifically designated for ICE. All detainees are assigned a security classification. Low or medium security detainees are placed in Units (b) (7)(E)) and (b) (7)(E)). Detainees pending an action and/or having been placed on protective custody are also placed in Unit (. High security detainees are housed in Unit (b) (7)(E) . The actual detainee count on Units (b) (7)(E) (b) (7) during CRCL's visit was (b) (7)(E) Detainees serving time in disciplinary segregation or administrative segregation are placed in (b) (7)(E) county inmates. There were no detainees in segregation during CRCL's 2018 visit. There were also four "Suicide Watch" cells in the medical unit. There were no detainees on "suicide watch" during CRCL's site visit; however, there were inmates in suicide watch cells on continuous observation.

The number of detainees and inmates receiving mental health services is fluid, changing daily. The mental health staff estimated that the caseload ranges from 20 to 30% of the total facility population, with a larger percentage of inmates receiving mental health services than detainees. In other words, the facility mental health caseload usually ranges between 170 to 255 detainees and inmates. At the time of the 2018 site visit, there were 39 detainees (14% of all detainees) receiving mental health services, with 20 (approximately 50%) being treated with psychotropic medication.

ECDC leadership, custodial staff, and more specifically medical/mental health staff were accommodating, dedicated, candid and receptive to recommendations to improve ECDC's mental health delivery system. I received full cooperation from all staff and unrestricted access to detainees, documents, medical records, and the facility units.

EXECUTIVE SUMMARY

CRCL conducted four onsite investigations at ECDC (2006, 2008, 2012, and 2018). ICE also conducted a medical and mental health inspection in 2017. In the past six years, ECDC's mental health delivery system was reviewed by CRCL in 2012 and 2018 and by ICE in 2017.

The 2012 CRCL investigation of ECDC's mental health delivery system revealed serious deficiencies due to an absence of qualified mental health care providers. Evaluations, treatment, and follow-up appointments were being performed by a radiology technician who was trained by an unlicensed Bachelor's Degree Community Mental Health Officer and by the facility's Medical Director, a family practice physician. There was no licensed psychiatrist, no licensed psychologist, no licensed clinical social worker, and no licensed mental health counselor on staff. Consequently, it was no surprise to discover that the quality of mental health services was below an acceptable standard of care. Additionally, there were problems with privacy, access, and safety. Recommendations included hiring qualified mental health professionals to include a psychiatrist, enhancing the quality of the mental health services, and ensuring sound privacy, access to services, and safety in specialized units.

Three years later, in 2015, DCP subcontracted ECDC's mental health services to the Cherokee Etowah Dekalb County Mental Health Program (CED). That same year, CED hired an unlicensed Master's Degree Mental Health Counselor, an individual with a Bachelor's Degree in Criminal Justice to work as a Mental Health Care Manager, and a psychiatrist. The psychiatrist worked at ECDC for approximately one year. Another psychiatrist was hired in October 2016 and resigned three months later. In January 2017, the current psychiatrist was hired. For the past year, he has been working onsite every other Tuesday for 4 to 5 hours, which is equivalent to a .05 FTE (two hours/week). He is also available for phone consultation, and (b)(6) the Medical Director, is available as his backup.

Six years later, in 2018, many of the recommendations made in 2012 were followed. For example, many of the anchor points and obstructions in the suicide watch cells were eliminated, increasing line of sight and decreasing opportunities to commit suicide. Treatment in the suicide watch cells was also enhanced by changing the suicide watch procedure, allowing patients to have property on a case by case basis. In other words, patients were no longer automatically stripped of their property and placed in a suicide smock. The mental health counselor and the mental health care manager, who were hired in 2015, continue to work at ECDC. Additionally, (b)(6) a psychiatrist who was hired in January 2017, continues to work at ECDC. Pill call and segregation wellness checks were changed from 4:00 AM to 6:00 AM, reducing problems with

access. Additionally, the intake office in the Booking Area was modified to enhance sound privacy for intake screens. In many ways, the mental health delivery system has been improved over the past six years. The overall quality of mental health care (i.e., evaluations and treatment), is better than the quality of services provided in 2012; however, it continues to be below an acceptable standard of care. The primary reason for this shortfall is an insufficient number of qualified mental healthcare providers. Significantly more onsite psychiatry time is needed along with at least one licensed clinical social worker and/or a licensed professional counselor.

A REVIEW OF THE MENTAL HEALTH CARE PROVIDED TO COMPLAINANTS

A. Complaint No. 17-08-ICE-0557

1) **Document Reviewed:** The Case Summary Report dated 4/18/2017 was reviewed.
2) **Summary of Findings:** There was no evidence the Detainee #B6 ever needed mental health services while at ECDC or was ever treated for mental health problems.

B. Complaints No. 16-12-ICE-0638

1) **Document Reviewed:** Detainee #B2 correspondence dated August 28, 2016 and a preliminary response from ICE for the Detainee dated October 13, 2016 were reviewed.
2) **Summary of Findings:** There was no evidence the Detainee #B2 ever needed mental health services while at ECDC or was ever treated for mental health problems.

C. Complaint No. 16-04-ICE-0574

1) **Documents Reviewed:** Detainee #B3 correspondence dated November 17, 2015, the Case Summary Report dated December 22, 2015, and a medical referral dated June 10, 2016 were reviewed.
2) **Summary of Findings:** There was no evidence that Detainee #B3 ever needed mental health services while at ECDC or was ever treated for mental health problems.

D. Complaint No. 17-09-ICE-0358

1) **Documents Reviewed:** The Booking Information dated September 28, 2016, the Use of Force Initial Report dated June 9, 2017, and the Incident Report dated June 9, 2017 were reviewed.
2) **Summary of Findings:** There was no evidence the Detainee #B4 ever needed mental health services while at ECDC or was ever treated for mental health problems.

E. Complaint No. 18-04-ICE-0100

1) **Document Reviewed:** Detainee #B5's complaint was reviewed.
2) **Summary of Findings:** There was no evidence the Detainee #B5 ever needed mental health services while at ECDC or was ever treated for mental health problems.

F. Complaint No. 18-03-ICE-0115

1) **Sources of Information:**
   a) **Documents Reviewed:** Detainee #B1's behavioral health record was reviewed.

b) **Interviewed:** (b)(6) M.S. was interviewed about the mental health services provided to Detainee #B1. (b)(6) reviewed the detainee's medical record and said that he was vaguely familiar with the case. He said that he was surprised a complaint was filed by the detainee. He talked about Detainee #B1's traumatic history in Iraq and said that he was being treated for Post-Traumatic Stress Disorder and Depression.

2) Nature of the Complaint:

On December 20, 2017 CRCL received a referral from the DHS OIG regarding Detainee #B1, an ICE detainee at Etowah County Jail in Gadsden, Alabama. In a call to the OIG hotline on 12/12/2017, the detainee claimed that he was taking medication for PTSD, but the facility has "reduced" his medication because the facility does not allow his medication. Detainee #B1 stated that his medicine should be allowed because of his anxiety. The detainee also stated that the facility did not call his name to receive his medication. The detainee stated that he has talked to the facility about this matter and "the facility says that they will fix it, but never did."

3) Behavioral Health Record Review:

a) Complainant's Detention History:

Detainee B1 was detained at ECDC for approximately four months from September 27, 2017 until January 29, 2018. He was previously held at Pine Prairie ICE Processing Center in Pine Prairie, Louisiana.

b) Complainant's Personal History:

Detainee #B1 was a 22-year-old male who originated from Iraq. He was married and is currently separated. He graduated from high school and was attending college when he was detained. He reported a history of violence, saying that he was charged with aggravated assault on a law enforcement officer. He denied a history of drinking alcohol; however, he reported a history of smoking marijuana and using crystal methamphetamine. He said that he last used illicit drugs in December 2015. He denied ever attending a drug and alcohol treatment program.

c) Complainant's Mental Health History:

Detainee #B1 reported having been diagnosed with PTSD and a Bipolar Disorder in South Dakota. He stated that he was treated as an inpatient at a psychiatric treatment facility and as an outpatient at a psychiatric treatment clinic. The details of his psychiatric history are unclear; however, the full mental health evaluation from ECDC noted that he attempted suicide once by cutting his wrists in 2011 when he was approximately 16-years-old. When he entered ECDC, he was being treated with (Wellbutrin) Bupropion HCL SR 150MG, Gabapentin 300MG, and Ventolin HFA 18GM PROAIR HFA.

d) Complaint's Chief Complaint:

On September 29, 2017, Detainee #B1 reported that his primary symptoms were feeling "edgy and anxious, related to his diagnosis of PTSD."

e) Complaint's ECDC MH Treatment History:

(1) Detainee #B1 arrived at ECDC on September 27, 2017. He received his 14-day History & Physical Examination on September 28, 2017 and a Full Mental Health evaluation on September 9, 2017. He received mental health services from the day of his Full MH evaluation on September 29, 2017 to the day he left on January 29, 2018.

(2) Detainee #B1 was evaluated by (b)(6) one week after arriving at ECDC on October 3, 2017. On the Physician Evaluation Form, (b)(6) noted that Detainee #B1's current medication s were Wellbutrin 150 Mg and Gabapentin 300 MG BID. The detainee's chief complaint was "anxiety." (b)(6) s evaluation revealed that Detainee #B1's mood was "depressed," his energy/motivation was "poor" and his risk level was "moderate." Appetite, judgment and insight were "fair." His sleep pattern, attention/concentration, thinking, and behavior were within normal limits. (b)(6) also noted that the detainee said that he responded to Wellbutrin; however, he was on a higher dose. (b)(6) noted that Detainee #B1 appeared moderately depressed during the session; thus, he decided to increase the Wellbutrin from 150 MG once a day to 150 MG twice a day. The order was written for five refills (180 days).

(3) Detainee #B1 was seen by the mental health care manager a week and a half later, on 10/13/2017, to conduct a segregation evaluation in Unit 3. The observation of the Detainee (Mental Status Examination) was unremarkable. No changes were noted since the last evaluation and no changes in the Detainee's mental status were observed by the officer.

- Appearance: Calm
- Behavior: Normal
- Affect: Normal
- Consciousness: Normal
- Orientation: Normal
- Thought Process: Well Organized

(4) Detainee #B1 was seen by the mental health counselor one week later, on October 20, 2017, for a segregation evaluation in Unit 3. The mental status was identical to the mental status on 10/13/2017. No changes were noted.

(5) Detainee #B1 was once again seen one week later by the mental health counselor, on November 3, 2017, for a segregation evaluation in Unit 3. The Detainee's mental status was unchanged, and no changes were noted.

(6) On December 21, 2017 Detainee #B1 was seen by the mental health care manager for a Brief Mental Health Evaluation. His mental status was unchanged. His feelings, thoughts, and behaviors were unremarkable. The treatment plan was reviewed, and it was noted that no changes were necessary. The treatment plan, which was developed during the Full Mental Health Evaluation on September 29, 2017, had the following four GOALS and OBJECTIVES.

- GOAL: Assess risk of harm to self and others
- OBJECTIVE: Mental health evaluation

- GOAL: Develop self-care skills
- OBJECTIVE: Self-care counseling
- GOAL: Assess need for psychotropic medications
- OBJECTIVE: Review of mental evaluation by CRNP
- GOAL: Continue to assess mental stability and efficacy of meds if prescribed
- OBJECTIVE: Follow up per protocol or on an as-needed basis

f) **Findings: Detainee #B1 claimed that ECDC reduced his medication for PTSD/anxiety "because the facility doesn't allow this medication."** A review of the complainant's medical record revealed that his prescription for Wellbutrin was never discontinued. In fact, it was increased by the psychiatrist one week after he arrived at ECDC, with 150 MG being administered twice a day instead of once a day.

Detainee #B1 claimed that his name was not called during "Pill Call." A review of the Medication Administration Record (MAR) revealed that he tended to be adherent; however, he occasionally refused his morning and/or afternoon medications. His compliance during the four months at ECDC was inconsistent. There was no evidence that "his noncompliance was attributable to his name not being called during Pill Call." It remains unclear: if at times his name was not called during "Pill Call"; if he would accidentally miss "Pill Call"; if he occasionally did not hear his name being called; or if he occasionally refused "Pill Call." An analysis of the MAR did not reveal a clear pattern of compliance and noncompliance. His variable compliance was probably due to all of the reasons listed above. Unfortunately, no documentation was found on medication noncompliance counseling, which would have revealed the reasons for his occasional noncompliance.

For a detailed review, please refer to Appendix III, Detainee #B1.

4) **Summary of Findings:**
Detainee #B1 received an adequate mental health evaluation in a timely manner. He was referred and met with psychiatry within one week of this evaluation. His medication was increased as requested in his complaint. Despite responding to his specific request, a number of concerns remained. **First**, there was no medication non-adherence counseling when he missed pill call. **Second**, medication orders should not be written for 180 days. Psychiatry should monitor patients for side effects every 30 to 90 days via a face to face doctor-patient contact. **Third**, the patient's history of suicidality and a psychiatric hospitalization should have been explored, and **fourth**, his treatment plan was generic instead of being individualized.

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CRCL conducted four onsite civil rights/civil liberties investigations at ECDC (2006, 2008, 2012, and 2018). ICE also conducted a medical and mental health inspection in 2017. In the past six years, ECDC's mental health delivery system was reviewed by CRCL in 2012 and 2018 and by ICE in 2017.

In the 2012 CRCL investigation of ECDC's mental health delivery system, there were seven findings. The first finding was an absence of any qualified mental healthcare providers. Mental health services, for a facility which had a total population of 749 detainees/inmates, were provided by a radiology technician who was trained by an unlicensed bachelor's degree "community mental health officer" and by the facility's family practice physician, (b)(6) (b)(6) Given this finding, the second and third findings were not surprising; namely, that counseling services were inadequate (i.e., evaluations, treatment plans, interventions, and documentation) and psychiatry services were inadequate (i.e., diagnostic assessments, treatment, monitoring, medication education, and supervision). The fourth finding was inadequate sight and sound privacy, especially in the "booking area." The fifth finding was inadequate access of mental health services because of a 4:00 AM "pill call" and a 4:00 AM segregation wellness rounds. The sixth finding was insufficient safety in the segregation unit (i.e., leaving the segregation unit unmonitored when the control room officer made rounds). The seventh finding was deficient suicide prevention practices (i.e., minimal therapeutic contact, over utilization of safety smocks, the presence of anchor points in suicide watch cells, and inadequate suicide risk assessments). Recommendations were made and the rationales/justifications for these recommendations were presented.

The ICE investigation for 2017 found only one shortcoming on three quality assessments performed on the mental health delivery system. ICE's Final Report noted that mental health services were contracted to Cherokee Etowah Dekalb (CED) County Mental Health as of November 2015. Their mental health staffing model included: a part-time psychiatrist who worked 20 hours per week with two other psychiatrists on staff for backup coverage, a full-time clinical psychologist, a full-time counselor, and two part-time aftercare managers. There was on-call coverage 24/7. An assessment of the quality of suicide screening procedures was performed on the medical records of two detainees. Both detainees were evaluated by a mental health professional within 24 hours of identification. Both were also evaluated by a qualified mental health professional daily while on suicide watch. They were also appropriately observed by staff and they showed no evidence that earlier interventions might have prevented deterioration to the point of needing placement in a suicide watch cell. There was also an assessment of the quality of the mental health screening procedures. Six charts were reviewed with the IHSC quality of care audit tool for mental health screening procedures. Five of six detainees with a positive screen for mental illness were evaluated by a mental health professional in a timely manner. One detainee was not referred to mental health, despite having a positive screen. Additionally, an assessment for the quality of mental health treatment planning revealed that 10 of 10 charts for detainees with mental illness had a clinical assessment, a treatment plan, and follow-up documentation. Seven of seven treatment plans were updated every 90 days. (Note, three detainees had not yet been followed for 90 days.) The only recommendation for ECDC's mental health program was to ensure that proper referral procedures were in place for detainees with a positive mental health screen.

The CRCL 2018 investigation revealed improvements in the mental health delivery system since the 2012 investigation; however, there continued to be significant shortcomings. As stated above, Doctors' Care Physicians subcontracted with Cherokee Etowah Dekalb County Mental Health in 2015, hiring mental health staff to deliver services to the detainees and inmates. Unfortunately, the staffing pattern was not as rich as the staffing pattern reported by ICE in their 2017 report. The current staffing pattern is slightly better than the 2012 staffing pattern; however, it is significantly worse than the reported 2017 staffing pattern. It is an improvement in that there is currently a mental health counselor and a mental health care manager. Additionally, these two providers have staggered their work days to ensure that one of them is at the facility seven days a week. On-call psychiatric coverage is performed by (b)(6) 24 hours a day, seven days a week.

The major shortfall revealed in the 2018 investigation was a general substandard quality of care. Variability in the quality of service delivery was primarily due to an inadequate number of onsite psychiatry hours (four to five hours every two weeks) and an insufficient number of qualified counselors or social workers. This staffing pattern was and continues to be unable to provide quality services to ECDC's large and complex population.

ECDC has a reported occupant capacity of 850, 325 ICE detainees and 525 county inmates. The detainee population during CRCL's 2018 on-site inspection was 278. The average monthly detainee population for the past six months was 303. Since the detainee and inmate populations were fluid, an accurate count of the population receiving mental health services was difficult. Based on interviews with the mental health counselor and the mental health care manager who have provided mental health services since 2015, the mental health caseload ranges from 20 to 30% of the total population with the percentage of mentally ill detainees being less than the percentage of mentally ill inmates. Given the capacity count of 850, the size of ECDC's mental health program can be expected to fluctuate between 170 to 255 detainees and inmates.

During the current investigation, there were at least 39 detainees out of 278 (14.0%) receiving mental health services in comparison to the 2012 mental health count of 25 out of 325 detainees (7.7%). Of those 39 mental health detainees, 20 (51%) were being treated with psychotropic medication in comparison to the 2012 medication count of 25 (100%).

Data from mentally ill county inmates was not available; however, if 20 to 30% of the facility's capacity receives mental health services, then the total mental health caseload would fall between 170 to 255 patients. And, if at least 50% of them are being treated with psychotropic medication, then the total number being treated with psychotropic medication would fall between 85 to 127 patients. This number is significant because the American Psychiatric Association suggests a staffing pattern of at least one full-time-equivalent (FTE) psychiatrist per every 200 patients being treated with psychotropic medication.

This data on the mentally ill incarceration rate is consistent with my personal experience and with statistics from both Alabama and the Bureau of Justice Assistance at the U.S. Department of Justice; however, the data on the number of mentally ill patients being treated with psychotropic medication is lower than my experience. The relatively low number of detainees on medication may be secondary to an inadequate number of onsite psychiatry hours. From another perspective,

it may reflect a continuum of care at ECDC. In other words, ECDC is not only providing care to acutely and seriously mentally ill patients, but also to those who are mildly to moderately mentally ill, and only in need of non-pharmacological interventions.

The importance of having a sufficient number of qualified mental healthcare providers cannot be overstated. It is imperative that ECDC has a sufficient number of qualified mental healthcare providers, given the volume and diversity of its population, the complexity of the various mental health evaluations, the gravity of the clinical decisions that must be made, and the breadth of the interventions that must be provided. The current staffing pattern is insufficient (a part-time on-site psychiatrist working 4 to 5 hours every other week, a full time unlicensed Master's Degree mental health counselor, and a full time mental health care manager who has a Bachelor's Degree in Criminal Justice).

The duties of the counselor and the care manager are more overlapping than unique. The counselor performs all Full Mental Health Evaluations and all Initial Suicide Evaluations; however, they both monitor mentally ill detainees by: performing "follow-up" brief mental health evaluations; re-assessing detainees' mental status; determining if their thinking, emotions, and/or behavior have recently changed; and reviewing/updating their treatment plan. They also both perform Daily Suicide Assessments to determine a detainee's risk of committing suicide, and Segregation Evaluations to clear detainees for placement in segregation and to monitor their mental status for decompensation.

The decisions that are made, based on these evaluations, are critical. Performing a comprehensive mental status examination, rendering an accurate diagnosis, and developing a meaningful treatment plan for patients from diverse cultures requires a lot of training and experience. The evaluations performed on specialized units (i.e., segregation and suicide watch) are even more challenging and the consequences for being wrong are significant. Performing a suicide risk assessment by determining a detainee's state of mind and by identifying salient risk and protective factors is complex. Additionally, performing a segregation evaluation to determine if a detainee's mental status is deteriorating due to being locked down is often complicated by a detainee's manipulations and a provider's implicit bias.

The current counselor and care manager can telephonically consult with psychiatry; however, there was no evidence of consultation on any of the risk assessments or segregation evaluations. Such consultation could have been helpful with Detainee #B7. He was in segregation, agitated, pacing and threatening to cut his wrists with a razor. Officers were able to recover the razor and place him in a suicide watch cell. The Suicide Evaluation and the Full Mental Health Evaluation dismissed the event as a ploy "to get the attention of SOD officers." The mental status examination described the detainee as calm, alert, and logical. He was not given a psychiatric diagnosis and he was cleared to return to Segregation in Unit 3 within 24 hours of threatening suicide, without any explanation for his agitation or flight into health (i.e., shallow affect). Additionally, there was no discussion of the fact that the detainee spent most of his time at ECDC in Segregation.

Telephonic psychiatric consultation appears to be used to obtain an order for the continuation of

psychotropic medication when a detainee enters ECDC with psychotropic medication. Occasionally, these detainees are seen by psychiatry; however, in most cases, a 180-day order is given without ever meeting the patient. The counselor and the care manager subsequently monitor the detainee. Psychiatry only appears to meet with detainees after receiving a referral from the counselor or care manager. There was no evidence that an upper level provider was ever consulted to render a diagnosis or participate in the development or implementation of a treatment plan (i.e., see discussions regarding Detainee #B11, #B12, #B15, #B16, and #B17).

As noted above, the quality of clinical services has improved since 2012; however, the services as reflected by documentation, are still below an acceptable standard of care. Both the mental health counselor and the mental health care manager are extremely busy during the day: responding to requests/referrals; evaluating, diagnosing, treating, and monitoring patients; documenting their work/decisions with minimal time and with minimal oversite/supervision from an upper level provider. Documentation of evaluations (Full, Brief, Suicide Assessment, Suicide Daily Assessment, Segregation Evaluation, etc.) and the creation of treatment plans tend to be timely, which indicates that the counselor and care manager are responsive to referrals and complaint with the facility's policies and procedures; however, the documentation tends to be minimal, generic, and redundant. Consequently, the rationales for rendering diagnoses, prescribing/changing medication, setting treatment goals, and selecting intervention strategies are unclear.

Psychiatry began working onsite two-and-a-half years ago in 2015, after DCP subcontracted ECDC's mental health program to CED County Mental Health. The first psychiatrist, (b)(6) worked for one year from November 2015 to October 2016. The second psychiatrist, worked for three months from October 2016 to January 2017. Currently, (b)(6) has worked for the past 15 months. In contrast to the psychiatry staffing pattern reported by ICE in 2017 (20 hours per week and two backup psychiatrists), ECDC currently has only 2 to 3 hours a week onsite, plus he is available via phone. Additionally, (b)(6) appears to be acting as psychiatry's backup. In comparison to 2012, having a psychiatrist available onsite for a four to five hours every two weeks and by phone daily is much better than not having any psychiatry consultation. Unfortunately, ECDC still does not have enough psychiatry hours to meet legal and professional requirements (i.e., perform psychiatric evaluations and monitor patients being treated with psychotropic medication). In summary, psychiatry coverage still does not meet an acceptable standard of care.

In ECDC, like most secure facilities, privacy is a challenge because of limited space and security requirements. Over the past six years, ECDC appears to have deliberately attempted to provide medical and mental health clinicians with space where they have sound privacy while simultaneously ensuring safety. ECDC's efforts to improve sound privacy are exemplified by the modification of an office in the booking area where mental health reception screens are performed. In general, sound privacy did not appear to be a significant problem for clinicians at ECDC; however, a few detainees who were interviewed complained about sound privacy, primarily because a correctional officer was present during the session.

The mental health evaluation forms, which are part of the electronic health record, are simplistic and redundant. They appear to be made for speed rather than for collecting meaningful information. For example, the suicide risk assessment could be improved by identifying risk

factors (i.e., placement in segregation, first incarceration, lack of a support system, impulsivity), protective factors, the detainee's sense of courage/competence to attempt suicide, the availability of means and opportunity, the specificity of a plan, preparations for attempting suicide, the intensity and duration of suicidal ideation, and the reasons for living.

On all evaluations, including the suicide risk assessment, the mental status examination is sparse. Its superordinate categories are limited to **Appearance**, **Behavior**, **Affect**, **State of Consciousness**, **Orientation**, and **Thought Processes** and the subordinate options within each category are limited to a few options. The superordinate categories with subordinate options could be expanded by including: **Facial Expression** (appropriate to verbal content, inappropriate, bizarre, fixed); **Tone of Voice** (normal, loud, soft, monotone); **Rate of Speech** (appropriate, rapid, slowed); **Manner of Speech** (normal, pressured, hesitant, stuttering, slurred, emotional); **Speech Content** (no unusual aspects, morbid, perseverative, ideas of reference, excessive somatization, hyper-religiosity); **Delusions** (none, persecutory, self-deprecatory, grandiose, somatic); **Hallucinations** (none, auditory, visual, tactile, other); **Mood** (euthymic, apathetic, dysphoric, anxious, fearful, suspicious, irritable); **Insight** (good, fair, poor, extremely limited); **Memory** (immediate, short-term, long-term); **Distractibility** (unremarkable, moderately, highly); and **Interactive Style with the Examiner** (cooperative, uncooperative, domineering, manipulative, evasive, defensive). The mental status examination should paint a detailed picture of the patient rather than an impressionistic image of the patient.

The Diagnostic Impression rendered on the Full Mental Health Evaluation is based on the American Psychiatric Association's Diagnostic and Statistical Manual-IV (DSM-IV), which was replaced by DSM-5 in 2013. The five Axes listed on the Full Mental Health Evaluation form have been eliminated in DSM-5. The diagnosis should be justified in the Full Mental Health Evaluation; however, the mental health history usually lacks detail and the Mental Status Examination does not match the diagnosis (i.e., Detainee #B12 with a "normal affect" and a diagnosis of a "Major Depressive Disorder, Moderate").

The Treatment Plan which is included at the end of the Full Mental Health Evaluation is generic. It seldom changes over time or between detainees. It should be a living document that directs treatment and changes over time, based on the patient's progress. The contents of the treatment plan should include the detainee's strengths and problems which are identified in the evaluation through the psycho-social history, mental status examination, and DSM-5 diagnosis. The treatment plan goals and objectives should be individualized and the treatment strategies should be evidence based. The specific treatment plan format and the intervals when it is reviewed should be based on its function. For example, a treatment plan for a patient on suicide watch should be reviewed daily by a stabilization team. A treatment plan for a patient in segregation should be reviewed at least weekly, and a treatment plan for a patient in general population should be reviewed at least every 90 days.

The informed consent used for psychotropic medication was generic, addressing all psychotropic medications, rather than specifically informing the patient about their specific medication. There was also no evidence that the psychiatrist discussed the contents of the informed consent, making sure the patient understood the potential benefits and side effects.

Treatment appeared to be limited to monitoring patients at least every three months, administering psychotropic medication, placing patients in a suicide watch cell, or transferring patients to a psychiatric hospital. There were usually no clear treatment goals and no progress notes documenting the efficacy of the interventions. Instead of doing individual or group therapy/counseling and documenting the progress in "progress notes," the counselor and care manager performed regular "Brief MH Evaluations," assessing the detainee's mental status. That said, I suspect both the counselor and care manager are providing supportive counseling while conducting the brief evaluation. Unfortunately, it is rarely documented and it is usually disconnected from the evaluation and treatment plan.

Privacy, which was a finding in the 2012 CRCL investigation, has been corrected in the "Booking Area." Privacy and space are common problems in detention centers, jails, and prisons. After talking with staff and detainees, sound privacy does not appear to be much of problem. Custody, medical, and mental health appear to be working together to provide sound privacy for mental health staff and detainees. Very few detainees complained about privacy. Out of 10 interviews, two detainees complained about officers listening to their sessions with mental health staff. Both the counselor and the care manager said that officers rarely insist on being present during mental health sessions.

The specific access problem identified in the 2012 investigation has been corrected by changing the medication administration and segregation wellness checks from 4:00 AM to 6:00 AM. Despite this correction, there continues to be a problem accessing qualified mental health care providers who can provide quality services. Detainees do not have a problem accessing the mental health counselor and the mental health care manager who provide quality counseling and case management services; however, detainees have an access problem when they need services that are supposed to be provided by an upper level provider such as rendering diagnoses, providing medication education, and monitoring medications.

The 2012 findings on inadequate monitoring by custody in segregation was partially corrected by no longer requiring the control room officer to conduct 30 minute rounds on other units. A program manager reportedly, "covers these units by making rounds every 30 minutes." Unfortunately, detainees and inmates in segregation continue to have periods without direct observation or supervision because the cameras in the unit cannot view the detainees in their cells. Additionally, the situation is made worse by the removal of the call buttons from the cells. Consequently, the control room officer would have to rely on other detainees/inmates to detect a suicide attempt/emergency.

The 2012 findings on suicide risk assessments and suicide watches were also partially corrected. Staff no longer require all inmates on suicide watch to always wear safety smocks. Staff are now using smocks on a case-by-case basis, based on the risk level. Problems with the line of sight have also been corrected; consequently, staff are now able to stand at a suicide watch cell door and have an unobstructed view of the detainees/inmates in their cells. The three findings which continue to be problems are: 1) eliminating anchor points; 2) providing daily therapeutic contact with a licensed mental health professional; a 3) conducting adequate suicide risk assessments.

In summary, ECDC and DCP began to correct all shortfalls identified in the 2012 CRCL investigation dealing with: staffing shortages; quality of care; psychiatric services; sound privacy; access to services; segregation; and suicide prevention.

- The staffing shortages began to be addressed when DCP subcontracted mental health services to Cherokee Etowah Dekalb County Mental Health (CED) in November 2015.
- The specific privacy shortfall in the "booking area" was corrected by making structural modifications to an office.
- The specific access shortfall was corrected by changing the time of morning medication administration and segregation wellness checks.
- To help correct a specific segregation monitoring shortfall in Unit 3, the task of making rounds every 30 minutes was removed from the control room officer's list of duties.
- And lastly, some specific shortfalls in the suicide prevention program were addressed by removing some suicide cell anchor points, improving line of sight in the suicide watch cells, and changing the parameters on property allowed in the suicide watch cell.

All shortfalls were partially corrected. ECDC's mental health delivery system is better in 2018 than it was in 2012; however, many of the clinical functions discussed above continue to fall below an acceptable standard of care. The reason for this status is not due to lack of effort or incompetence. The mental health staff are dedicated, enthusiastic, and responsive to patients. They are able to manage their time; however, the volume of work is overwhelming and some of the work is beyond their scope of practice (i.e., rendering diagnoses without supervision from an upper level provider, providing medication education, and monitoring medication side effects). They are continually busy, responding to referrals/requests, performing evaluations, and occasionally counseling detainees. Because of the volume and the complexity of the detainees, the quality of their work product is variable.

RECOMMENDATIONS AND RATIONALES FOR ECDC's MENTAL HEALTH DELIVERY SYSTEM

The recommendations presented below are based on "best practices" and on the National Detention Standards 2000 (NDS 2000), the National Commission for Correctional Health Care Standards for Jails 2014 (NCCHC 2014), and the American Psychiatric Association's Standards for Jails and Prisons 2000 (APA 2000). The Alabama Mental Health Counselor Licensing Law (Code AL 4-17-12) was also referenced.

Recommendation 1. The number of qualified non-psychiatric mental healthcare providers should be increased: a) to improve the quality of the mental health evaluations by making the psycho-social history section and the mental status examination comprehensive instead of cursory; b) to improve the accuracy of the psychiatric diagnosis by thoughtfully justifying rule-in and rule-out diagnoses; c) to improve the utility of the mental health treatment plan by individualizing treatment; and d) to improve nonpharmacological interventions by increasing treatment modalities and treatment approaches. Three non-

psychiatric mental health staff are recommended. At least two of the three non-psychiatric staff should be counselors and at least one of those counselors should be licensed. The third staff member can be an unlicensed Master's Degree counselor or an individual with a Bachelor's Degree in a mental health related field (licensed counselor and/or social worker, and one mental health care manager). (NDS, Medical Care, § III(A) and (C)) (Level 1)

The American Psychiatric Association's Jail & Prison standards state "staffing levels are a particularly thorny and complex subject, because systems vary widely in their organization, physical plants, resource availability, and population characteristics. Nevertheless, concrete statements of such levels are often quite specifically sought……" The standards continue to say, "the task force does not seek to promote anyone rigid staffing formula for all jails and prisons, nonetheless, it is important to note that something of a consensus has been reached among correctional mental health experts, as well as in prison and jail litigation, as to caseloads of psychiatric patients receiving psychotropic medications. Because of the unique importance of psychotropic medications, and the unique role of psychiatry in providing such medications, it is imperative that every system have enough psychiatrist to provide these services. To begin, it must be appreciated that jails are much more diverse than prisons and thus their staffing needs will vary. It is suggested that in jails for every 75-100 inmates with serious mental illness who are receiving psychotropic medication, there be one full-time psychiatrist or equivalent." Additionally, they state, "More important than the number of staff is access to adequate care."

NDS 2000 states, "All facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees" and "health care staff will have valid professional licensure and/or certifications."

Alabama Licensed Professional Counselor Licensing Law Chapter 8A, Sec. 34-8A-2 (5) a, states "a licensed professional counselor or associate licensed counselor may diagnose and develop treatment plans but shall not attempt to diagnose, prescribe for, treat, or advise a client with reference the problems or complaints falling outside the boundaries of counseling services."

NCCHC 2014, state, "A sufficient number of health staff of varying types provide inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care." They continue to state that qualified mental healthcare providers are "psychiatrists, psychologists, psychiatric social workers, licensed professional counselors, psychiatric nurses, or others who by virtue of their education, credentials, and experiences are permitted by law to evaluate and care for the mental health needs of patients." It also states, "mental health staff do not perform tasks beyond those permitted by their credentials."

Access to adequate care is a problem because the volume of patients is too large, the clinical tasks are too many, and the number of staff who have the credentials required to perform many clinical tasks is too small. Clinical tasks include performing intakes, referrals, evaluations, crisis stabilization, and follow-up appointments with patients being treated with psychotropic medication and nonpharmacological interventions. Clinical tasks that require an upper level provider include rendering psychiatric diagnoses and discussing psychotropic medication options, reference Detainee #B9.

Currently, the mental health counselor has a Master's degree in counseling but he is unlicensed and the mental health care manager has a Bachelor's degree in criminal justice. The counselor usually takes the lead by performing almost all full mental health evaluations, initial suicide evaluations, and initial segregation evaluations. The amount of information documented in his evaluations is variable. Some evaluations are rich in documentation, allowing clinicians to render a diagnosis and develop a meaningful treatment plan; however, the information documented in many evaluations is minimal, making it impossible to render a diagnosis with confidence and to develop a meaningful treatment plan. One of the big reasons for the variability of these evaluations is the volume of the work flow.

Follow-up evaluations (i.e., brief mental health evaluations, suicide daily assessment, and segregation evaluations) are performed by both the mental health care manager and the counselor. Both the counselor and care manager are committed to providing quality services to patients. The counselor is qualified to perform basic evaluations; however, upper level consultation should be used for specialty evaluations (suicide risk assessments to determine placement and initial segregation evaluations to determine if lockdown is contraindicated by the patient's mental status). Of larger concern is having the mental health care manager perform brief mental health evaluations, suicide daily assessments and segregation evaluations to determine appropriate placement for vulnerable populations. Her undergraduate classes in criminal justice and her limited hands-on clinically supervised experience do not qualify her to perform these evaluations.

Recommendation 2. The hours of an onsite Board-Certified Psychiatrist, a Physician who is Board Eligible in Psychiatry, and/or a psychiatric mid-level provider (i.e., a psychiatric nurse practitioner) should be increased from 4 to 5 hours onsite every other week to at least 20 hours onsite every week. These onsite hours can be a combination of being physically present onsite and being electronically present through telepsychiatry. These hours should be spent: performing initial psychiatric evaluations on all detainees entering ECDC with psychotropic medication, rather than giving a telephonic order to continue their current medication for 180 days; explaining the risks, benefits, and potential side effects as part of the informed consent process; monitoring patients' responses to medication, usually every 30 days, never to exceed every 90 days; and consulting with the treatment team on rendering diagnoses and performing suicide risk assessments. (NDS, § Medical Care, III(A) and (C) (Level 1)

NDS 2000 states, "All facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees" and "health care staff will have valid professional licensure and/or certifications." Additionally, ICE Health Service Corps requires psychiatrists to be board-certified or physicians to be Board Eligible in psychiatry. They continue to say that psychiatry's duties and responsibilities include, "prescribing and monitoring psychiatric medication treatment services to include monitoring side effects of medication and/or adverse reactions."

American Psychiatric Association's Jail standards 2000 state, "it must be appreciated that jails

are much more diverse prisons, and thus their staffing needs will vary. It is suggested that in jails, for every 75-100 inmates with serious mental illnesses who are receiving psychotropic medication, there be one full-time psychiatrist or equivalent."

NCCHC Jail Standards 2014 states, "physician time must be sufficient to fulfill both clinical and administrative responsibilities. Clinical duties include, but are not limited to, conducting physical examinations, evaluating and managing patients and clinics, monitoring healthcare professionals by reviewing and cosigning charts, reviewing laboratory and other diagnostic test results, and developing individual treatment plans." They continue to say, "The general expectation is that the staffing plan includes, at a minimum, one position on site 3.5 hours a week for each 100 inmates housed in the facility."

The non-psychiatric mental health staff are not psychiatry extenders. They augment rather than replace direct contact between the psychiatrist and the patient. At this time, there is a void in psychiatric evaluations and diagnostic assessments, patient education, and follow-up appointments monitor efficacy and side effects every 30 days, not to exceed 90 days.

One part-time onsite psychiatrist (20 hours a week) is recommended, given APA's guidelines, NCCHC's guidelines, and NDS 2000 standards. The current psychiatric staffing pattern is grossly inadequate, given the volume of work (a capacity facility population of 850 detainees and inmates of whom an estimated 170 to 255 are receiving mental health services with at least 50% (85 to 127) of them are being treated with psychotropic medication), the complexity of the patients, and the gravity of the clinical decisions.

Recommendation 3. The continuous quality improvement program should be expanded to monitor and improve the quality of services delivered by ECDC's mental health delivery system. More specifically, standard clinical practices need to be updated (i.e., using DSM-5 instead of DSM-IV), standardized forms need to be revised (i.e., medication informed consent, mental status examination templates, and treatment plan templates), and data bases need to be expanded (i.e., needs assessments and outcome studies). (NCCHC 2014 J-A-06 an d J-C-02) (Level I)

NCCHC Jail Standards state, "a continuous quality improvement (CQI) program monitors and improves healthcare delivery in the facility." (J-A-06) They also state, "a clinical performance enhancement process evaluates the appropriateness of services delivered by all direct care clinicians, and RNs and LPNs." (J-C-02)

APA Jail and Prison Standards 2000, state "it is imperative that the facility administrator be able to gather and assess information relevant to the prevalence of mental illness in the correctional setting, for purposes of needs assessment."

There is a CQI program with a CQI committee and a recent (2018) CQI mental health study on the timeliness of mental health evaluations. Given the longstanding deficiencies in ECDC's mental health delivery system, a three-prong approach is recommended. First, the system needs to be updated by replacing psychiatry's Diagnostic and Statistical Manual-IV (DSM-IV) with

DSM-5, which was published five years ago. Training also needs to be offered to both medical and mental health staff on psychiatric diagnoses that have been eliminated, diagnoses that have been added, and diagnostic criteria that have been changed.

Second, mental health evaluation templates need to be revised to focus on the questions being asked (i.e., Does a detainee need mental health services? Is a detainee at risk for committing suicide? Is placement in segregation contraindicated? Is a detainee's mental status deteriorating in segregation?). They also need to expand their mental status examination which is discussed above, eliminate DSM-IV Axes I-V, create a text box to discuss rule-in and rule-out diagnoses, and remove the treatment plan from the Full Mental Health Evaluation, making it a stand-alone form (refer to the treatment plan discussion above).

Third, a mental health data base of critical indicators needs to be developed for administrative reasons (i.e., budget justifications and human resource issues) and clinical issues (i.e., programming needs for complex co-occurring disorders, diagnostic trends, treatment outcome studies, and SOP compliance). Clinical performance enhancement studies (peer reviews) are also recommended.

Recommendation 4. To improve access to mental health services and to enhance detainee safety in the segregation unit: the call buttons/intercoms need to be replaced; cell maintenance needs to be enhanced; and continuous monitoring needs to be performed by adding more officers and/or upgrading the camera system. Until such time as these changes are made, detainees should not be housed in Unit 3. (NDS, Special Management Unit (Disciplinary Segregation), § III (D)(16), Special Management Unit (Administrative Segregation), § III(D)(12) (Level 1)

The American Psychiatric Association Jail Standards 2000 state, "The difficulties of providing appropriate and adequate access to mental health care and treatment are especially acute in the segregation environment." They also state, "the challenge of providing adequate mental health services to inmates in segregation housing is a critical reflection of and a crucial component of the facilities quality of care." Additionally, "when an inmate is placed in segregated housing for appropriate correctional reasons, the facility remains responsible for meeting all of the serious medical and psychiatric needs of that inmate. Thus, such inmates must receive any mental health services that are deemed essential, there segregation status notwithstanding."

NDS 2000 states, "In addition to the direct supervision afforded by the unit officer, the shift supervisor shall see each segregated detainee daily, including weekends and holidays."

NCCHC Jail Standards 2014 state that access to care is the foundation of their standards.

Inadequate monitoring of detainees who are locked down in segregation is an example of a barrier to accessing mental health care and to maintaining a safe environment. Detainees need continuous access to an officer, who is either physically on the unit and/or available through an intercom. Officers also need continuous observation of detainees by either physically being present on the floor or by observing them on a monitor. Currently, the call-button and the

intercom system do not work, the cameras are unable to observe detainees in their cells, and an officer is only on the unit for a brief time when making rounds every 30 minutes. Consequently, there are long periods of time when the detainee does not have access to an officer and the officer does not have access to the detainee. Given the stressful nature of segregation and the prevalence of mental illness in jails and detention centers, it is imperative that these conditions be corrected. Until such time as these changes are made, detainees should not be housed in Unit 3.

Recommendation 5: ECDC's suicide prevention program should be improved: by revising the suicide evaluation; by eliminating anchor points used by detainees to hang themselves; and by providing daily therapeutic interventions to detainees locked in suicide watch cells. (NDS, Suicide Prevention and Intervention, §§ I and III(B) and (C)) (Level 1)

NDS 2000 policy states, "staff will act to prevent suicide with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainee will receive preventive supervision and treatment." The standards and procedures section states, "suicidal potential will be an element of the initial health screening of a new detainee, conducted by either the health care provider or a specially trained officer." Additionally, NDS states "if danger to life or property appears imminent medical staff has the authority, with written documentation, to segregate the detainee from the general population. A detainee segregated for this reason requires close supervision in a setting that minimizes opportunities for self-harm. The detainee may be placed in a special isolation room designed for evaluation and treatment. The isolation room will be free of objects or structural elements that could facilitate a suicide attempt."

APA Jail Standards 2000 state, "and adequate suicide prevention program must include the following components: timely evaluation by mental health clinicians to determine the level of risk posed by an inmate who has been referred by screening or correctional staff; and timely provision of mental health services, including medication, verbal therapies, and crisis intervention, for chronically or acutely suicidal inmates."

NCCHC Jail Standards 2014, state, "and evaluation, conducted by a qualified mental health professional, determines the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any change in condition indicating a need for change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individuals discharge from suicide precautions."

NCCHC Jail Standards 2014, also state, "a treatment plan should be developed or revised for any inmate expressing suicidal ideation. This treatment plan should be developed by the mental health staff in conjunction with the patient to address relapse prevention and initiate a risk management plan. Risk management plans should describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions the patient or staff can take if suicidal thoughts do occur." On treatment, the standard state, "treatment strategies and services to address the underlying reasons (e.g., depression, auditory commands) for the inmate's suicidal ideation are to be considered. The strategies include treatment

needs when the patient is at high risk for suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse."

The initial suicide evaluation and the follow-up suicide daily assessments are critical procedures. The evaluation templates used to assess and monitor these patients should be more comprehensive (refer to the above discussion of suicide risk assessment) and an upper level provider should be consulted. These risk assessments need to be performed by experienced clinicians who are part of the stabilization treatment team. Additionally, the vents above the sinks in the suicide watch cells should be replaced with events that have smaller holes for airflow. At this time, detainees could fasten a ligature to the vent and hang themselves. Finally, mental health clinicians need to be actively involved in stabilizing suicidal patients by developing a special treatment plan with them and implementing that plan while they are in the suicide watch cell and when they are released from suicide precautions.

A) DETAINEE INTERVIEWS

Ten detainees were randomly selected to be interviewed from the group of detainees receiving medical or mental health services at ECDC. Eight were receiving mental health services. I interviewed these 10 detainees with (b)(6) a CRCL medical subject matter expert, and Mr. (b) (6) , a DHS senior policy advisor. All detainees were interviewed with the assistance of a professional interpreter in a multipurpose room.

Six detainees were asked if they had problems scheduling an appointment via a sick call request with a mental health provider. No problems were reported. Three said that they meet with a mental health provider once a month and five reported meeting with a provider once every three months. Two detainees added that if they request to meet with a provider before their scheduled appointment, they merely submit a sick call request. Two out of eight patients recalled the name of a mental health provider. They added that they are usually seen for 10 to 15 minutes with a male or a female counselor. In other words, the patients perceived the counselors as being interchangeable "because they just check on us."

No one reported having problems communicating with mental health care providers.

Two detainees reported having problems with privacy and confidentiality, saying "an officer is usually present."

When asked why some were seeing a mental health care provider, all knew their symptoms and/or diagnosis. Four of the eight were being treated with psychotropic medication. All knew the name of their medication.

Three of the eight "mental health detainees" were highly emotional, becoming distressed talking about their history of trauma and about being detained with ICE for over a year. Many wanted to talk about their immigration "case."

In summary, there were no problems with communication. There were also no problems with the

detainees being uninformed about their care. Everyone understood their mental health problems and they knew the names of their psychotropic medications. A few detainees appeared distressed. No one was psychotic.

B) BEVIORAL HEALTH RECORD REVIEW

Twelve medical records were reviewed. One of the records was from a complainant and two records were from detainees who were transferred to a psychiatric hospital in 2017. Nine records were reviewed from detainees currently housed at ECDC. The average length of stay for these detainees was between eight to nine months. Sixty percent were being treated with medication. All records were electronic. Access to the records was based on a "need to know." There did not appear to be any problems with confidentiality.

All records contained an intake screen. Sixty seven percent of those being treated with psychotropic medication did not have an appointment with the psychiatrist. Everyone being treated with medication had a signed informed consent. Screens and evaluations were present. Progress notes were absent. Referrals were made using the electronic health record which also scheduled detainees. There were no "rule out" diagnoses. There also was not any explanation or clear justification for "ruling in" a diagnosis. Treatment plans were placed at the end of each Full Mental Health Evaluation. They were generic, not changing over time or between detainees. The electronic record has tremendous potential in enhancing continuity of care: however, it will not be achieved if brief boilerplate forms are used.

REPORT SUMMARY

A SUMMARY OF POSITIVE ASPECTS

1. DCP subcontracted mental health to CED County Mental Health, which has a long history of being responsive to the community's mental health needs.
2. The mental health counselor and mental health care manager are dedicated, motivated, knowledgeable, and skilled mental healthcare providers.
3. ECDC was accredited by ACA in 2010 and by NCCHC in 2008.
4. Most anchor points in the suicide watch cells have been eliminated. Additionally, ECDC immediately repaired a suicide watch "light housing," which could have been used by a detainee to harm himself or staff.
5. Line of sight in suicide watch cells was unobstructed.
6. The rates of suicides and self-injurious behaviors are extremely low. Staff members were unable to recall a suicide in the past 12 years.
7. Sound privacy for mental health sessions is no longer a systemic problem.
8. The mental health counselor obtains a signed release of information from detainees who report having a history of mental health treatment. The signed release is in the medical record along with any documents received from previous mental healthcare providers.

9. Detainees in need of a level of care which is beyond ECDC's capability of providing are identified and sent to a psychiatric hospital.
10. Detainees reported that their mental health sick call requests are responded to "in a timely manner."
11. Treatment is individualized in suicide watch cells. In other words, property is removed and a suicide smock on a case-by-case basis.

A SUMMARY OF RECOMMENDATIONS

Recommendation 1. The number of qualified non-psychiatric mental healthcare providers should be increased: a) to improve the quality of the mental health evaluations by making the psycho-social history section and the mental status examination comprehensive instead of cursory; b) to improve the accuracy of the psychiatric diagnosis by thoughtfully justifying rule-in and rule-out diagnoses; c) to improve the utility of the mental health treatment plan by individualizing treatment; and d) to improve nonpharmacological interventions by increasing treatment modalities and treatment approaches. Three non-psychiatric mental health staff are recommended. At least two of the three non-psychiatric staff should be counselors and at least one of those counselors should be licensed. The third staff member can be an unlicensed Master's Degree counselor or an individual with a Bachelor's Degree in a mental health related field (licensed counselor and/or social worker, and one mental health care manager). (NDS, Medical Care, § III(A) and (C)) (Level 1)

Recommendation 2. The hours of an onsite Board-Certified Psychiatrist, a Physician who is Board Eligible in Psychiatry, and/or a psychiatric mid-level provider (i.e., a psychiatric nurse practitioner) should be increased from 4 to 5 hours onsite every other week to at least 20 hours onsite every week. These onsite hours can be a combination of being physically present onsite and being electronically present through telepsychiatry. These hours should be spent: performing initial psychiatric evaluations on all detainees entering ECDC with psychotropic medication, rather than giving a telephonic order to continue their current medication for 180 days; explaining the risks, benefits, and potential side effects as part of the informed consent process; monitoring patients' responses to medication, usually every 30 days, never to exceed every 90 days; and consulting with the treatment team on rendering diagnoses and performing suicide risk assessments. (NDS, § Medical Care, III(A) and (C) (Level 1)

Recommendation 3. The continuous quality improvement program should be expanded to monitor and improve the quality of services delivered by ECDC's mental health delivery system. More specifically, standard clinical practices need to be updated (i.e., using DSM-5 instead of DSM-IV), standardized forms need to be revised (i.e., medication informed consent, mental status examination templates, and treatment plan templates), and data bases need to be expanded (i.e., needs assessments and outcome studies). (NCCHC 2014 J-A-06 and J-C-02) (Level 1)

Recommendation 4. To improve access to mental health services and to enhance detainee

safety in the segregation unit: the call buttons/intercoms need to be replaced; cell maintenance needs to be enhanced; and continuous monitoring needs to be performed by adding more officers and/or upgrading the camera system. Until such time as these changes are made, detainees should not be housed in Unit 3. (NDS, Special Management Unit (Disciplinary Segregation), § III (D)(16), Special Management Unit (Administrative Segregation), § III(D)(12) (Level 1)

Recommendation 5: ECDC's suicide prevention program should be improved: by revising the suicide evaluation; by eliminating anchor points used by detainees to hang themselves; and by providing daily therapeutic interventions to detainees locked in suicide watch cells. (NDS, Suicide Prevention and Intervention, §§ I and III(B) and (C)) (Level 1)

(b)(6)

Clinical Director, MHM
Georgia Department of Corrections

APPENDIX I

- **Detainees Interviewed**

#A1) (b) (6) (not receiving MH services)
#A2) (b) (6) receiving mental health services)
#A3) (b) (6) (receiving mental health services)
#A4) (b) (6) (receiving mental health services)
#A5) (b) (6) (not receiving MH services)
#A6) (b) (6) (receiving mental health services)
#A7) (b) (6) (receiving mental health services)
#A8) (b) (6) (receiving mental health services)
#A9) (b) (6) (receiving mental health services)
#A10) (b) (6) (receiving mental health services)

APPENDIX II

- **Medical Records Reviewed of Complainants**
  - #B1) (b) (6)
  - #B2)
  - #B3)
  - #B4)
  - #B5)
  - #B6)

- **Medical Records Reviewed of Detainees Receiving Mental Health Services**
  - #B7) (b) (6)
  - #B8)
  - #B9)
  - #B10)
  - #B11)
  - #B12)
  - #B13)
  - #B14)
  - #B15)
  - #B16)
  - #B17)

APPENDIX III

- **Findings from the Medical Record Reviews**
  Detainee #B1 (4 months at ECDC)
  The detainee was a 22-year-old male from Iraq. His ECDC intake admission screen was completed on 09/27/2017, history & physical examinations were completed the next day, a full mental health evaluation was performed the following day on 09/29/2017, and a psychiatric evaluation was performed a week later, on 10/03/2017. The results of these evaluations were significant in that they revealed:
  a) a history of inpatient psychiatric hospitalization and outpatient psychiatric treatment;
  b) a developmental history of trauma in Iraq;
  c) a history of at least one attempted suicide at 16 years of age;
  d) a history of cerebral trauma via accidents;
  e) a history of both cannabis and crystal methamphetamine abuse;
  f) and a history of substance abuse treatment.

  These six findings suggest serious mental illness with complex diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Neuro-Cognitive Disorder, and both a Cannabis Use Disorder and an Amphetamine Use Disorder. To clarify the detainee's mental health diagnosis and determine suicide risk, the examiner needed to inquire about each of these six findings. For example, on the detainee's mental health history, we do not know why he was psychiatrically hospitalized, how many times he was psychiatrically hospitalized, where he was hospitalized, the length of his hospitalization, and the course of his treatment. Additionally, we do not have any information about his psychiatric outpatient treatment.

  On the detainee's trauma history, we do not understand the nature of his reported trauma: Was it observed? Did he feel that he was going to be killed? When did he experience the trauma? What was the frequency, duration and intensity of the trauma? Is he having intrusive memories and nightmares? Is he having flashbacks? Does he avoid certain people, places and/or activities? Has there been alterations in his cognition and social connections? Has there been negative alterations in his emotions and arousal/hypervigilance/startle response?

  On the detainee's reported history of suicidality, we do not know if it was impulsive or planned. Was he abusing illicit drugs when he attempted suicide? What were the antecedents/events leading up to the attempted suicide? Was it aborted or was he rescued? What is his history of suicidal ideation? When did suicidal ideation start? What was the frequency, duration and intensity of the ideation? When did he most recently have suicidal ideation?

  On the detainee's reported history of cerebral trauma and accidents, we do not know when it happened, how many times it happened, if he lost consciousness, how long he was unconscious, and if he was hospitalized.

On the detainee's reported history of Cannabis and Methamphetamine use, we do not know when he started, the frequency of his use, how he acquired the drugs, and if the drugs were related to his aggravated assault charge and/or his attempted suicide.

On the detainee's reported history of substance abuse treatment, we do not know if it was a residential program, the precipitants of treatment, the date of treatment, and if treatment was successful.

One week after completing the full mental health evaluation, the psychiatrist performed an evaluation. The information obtained from his evaluation was minimal. He noted that the detainee was "depressed," had "poor energy/motivation," and was at "moderate risk." Consequently, he increased the detainee's Wellbutrin and noted that "continued treatment was needed." He also noted that the detainee was "unable to manage his issues/symptoms independently." Despite an increase in his psychotropic medication, and documentation that the detainee needed "continued treatment" and was "unable to manage his issues," (b)(6) did not render a diagnosis, did not specify the number of weeks for a return psychiatric appointment, and did not meet with him again during the next four months, when he was detained at ECDC.

Within one week of the psychiatric evaluation, detainee MH was placed in segregation. Segregation evaluations were performed once a week for the next four weeks, consistent with policy and procedure. The counselor performed two of the evaluations and the care manager completed the other two evaluations. The detainee's mental status was the same in all four evaluations (Appearance was calm. Behavior was normal. Affect was normal. Consciousness was normal. Orientation was normal. And thought processes were well organized.) There was no evidence that the detainee received any counseling/treatment.

Seven weeks after being released from segregation, the care manager performed a brief mental health evaluation on Detainee #B1. The results of his mental status were identical to the results of his mental status examinations when he was in segregation. He was determined to be stable. His treatment plan was reviewed to determine if it needed to be changed. No changes were made. Five weeks after this appointment, the detainee left ECDC.

In summary, red flags were minimized and/or ignored following the evaluations. The red flags were: 1) a need to increase the detainee's antidepressant medication; 2) the comment made by the psychiatrist that "continued treatment was needed"; and 3) the comment that the detainee was "unable to manage his issues/symptoms independently." Despite these red flags, the mental status examinations provided minimal information, a diagnosis was not rendered, the treatment plan was generic, indistinguishable from other treatment plans; and the detainee did not receive any mental health treatment aside from an increase in his prescription for Wellbutrin.

Detainee #B7 (6 months at ECDC)
Detainee B7, who spoke Wolof, was a 23-year-old male from West Africa. His stay at ECDC was significant for being housed in segregation for 18 weeks from 11/03/2017 to 12/31/2017 and from 1/24/2018 to 4/08/2018, at which time he left ECDC. His stay was also significant for being placed on suicide watch for approximately 24 hours after being agitated, pacing in his cell, holding a razor blade, and threatening to cut his wrists. Officers recovered the razor and the detainee was placed in a suicide watch cell.

A suicide evaluation was performed on 01/25/2018 at 9:26 AM and a Full MH Evaluation was performed on 01/25/2018 at 9:31 AM. The evaluations did not reveal any mental health issues. His suicide threats were determined to have been a manipulative ploy; consequently, he was released from his suicide watch cell and placed in segregation, Unit 3. Suicide Daily Assessments were performed for the next two weeks along with Segregation Evaluations which continued into March 2018. A psychiatric referral was never made and a diagnosis was never rendered, except for a "Deferred Axis II Diagnosis."

This case is clinically significant because the detainee's extended stay in restrictive housing and his very brief stay in a suicide watch cell. The Segregation Evaluation and the Suicide Risk Assessment are two complex specialized mental health evaluations that carry high liability. Based on the minimal information obtained from the MH evaluations, it is unclear if the detainee's mental status was deteriorating in lockdown and if he was covering up emotional distress in the suicide watch cell. It is unclear why an upper level/psychiatric referral was not made. I suspect that the red flags were minimized by staff and detainee B9 was perceived as a "behavior problem."

Detainee #B8 (15 months at ECDC)
The detainee was a 39-year-old male from Angola. He had been at ECDC for 15 months. This case is significant because the detainee expressed a lot of frustration about being at ECDC for over one year. He talked about death and threatened to kill himself. On the day Detainee #B8 reported having suicidal ideation, his mental status was a bit confusing because he was described as being "calm, agitated, and angry." He was subsequently placed in a suicide watch cell and went on a hunger strike. He was referred to psychiatry; however, (b) (6) the DCP medical director met with him in his suicide watch cell. Dr (b) (6) noted that the detainee began eating and drinking that morning. He also noted that Detainee #B8 complained about having a headache and GERD. The plan was to "continue eating and add Ranitidine," an anti-acid. The MH counselor did an excellent job working as a liaison between the detainee and ICE, de-escalating the situation.

Detainee #B9 (10 months at ECDC)
The detainee was a 52-year-old male from Jamaica. The Intake Admission Screening was performed on 06/11/2017, and both the History and Physical and the Full MH Evaluation were performed on 06/12/2017. He was diagnosed with a "Mild Anxiety Disorder" and the medication for his anxiety, Hydroxyzine (Vistaril), was continued. On August 8, 2017

he reported that he was feeling limited results with Vistaril. The MH counselor and the detainee discussed alternative medications for the management of his symptoms. On November 26, 2017 Detainee #B9 requested "to go to an alternate medication in lieu of Vistaril. On March 20, 2018 the detainee was evaluated at Jena/LaSalle in Louisiana, where the Vistaril was discontinued and Trazadone was started.

The MH counselor appeared to be working well with Detainee #B9; however, it is unclear why a referral was not made to psychiatry to address his medication concerns. This case begs the question, "Why was the medication changed on a four-day trip to Jena/LaSalle in Louisiana, rather than at ECDC?

Detainee #B10 (2 months at ECDC)
The detainee was a 39-year-old male from Nigeria. The mental health counselor administered the full mental health evaluation on 02/07/2018. The evaluation was much more comprehensive/informative than other evaluations. The detainee was traumatized from 1986 to 1999 while he was being held by an Islamic Group. He talked about "being tortured' and seeing people being butchered, to include a pregnant woman because she was a Christian. He reported feeling anxious, having flashbacks and continuing to have nightmares. He was diagnosed with PTSD and referred to psychiatry. He was seen by psychiatry on 02/20/2018 and prescribed Buspar.

This case is significant because the mental health evaluation was more informative than most evaluations, the patient was appropriately referred to psychiatry, and he was seen and treated by psychiatry in a timely manner.

Detainee #B11 (1 month at ECDC)
The detainee was a 33-year-old male from Ethiopia. His intake admission screen was performed on 03/07/2018. History and physical evaluations were performed on 03/08/2018 and his "full mental health evaluation" on 03/09/2018. The mental health evaluation to include his mental status examination were informative, justifying a diagnosis of Depressive Disorder, Not Otherwise Specified. The detainee reported having been previously treated with Zoloft. Since he did not come to ECDC with Zoloft, the MH counselor reportedly called the psychiatrist who gave a telephonic order for Zoloft, 50MG #365. The document was dated 03/09/2018 and (b)(6) s name was in the signature block.

The mental health evaluation was thorough and the referral was timely; however, it is unclear why the detainee was prescribed Zoloft without meeting with being evaluated by (b)(6) . It is also unclear if the psychiatrist gave the order or the family practice physician gave the order.

Detainee #B12 (14 months at ECDC)
The detainee was a 53-year-old male from Pakistan. His medical/mental health intake was completed on 06/11/2017. His history and physical examination was completed on 06/12/2017, and his full mental health evaluation was completed on 06/14/2017. The

detainee reported a history of Depression which was being treated with Zoloft. The order was reportedly renewed. Approximately five months later, he was sent to Jena/LaSalle where he was evaluated. The Zoloft was continued and Trazadone HCL 50MG was added. When he returned to ECDC on 11/16/2017 a phone order was given to continue the Trazadone.

Once again, there appears to be an issue with psychiatry continuing orders without seeing the patient, and then not following up to monitor for any side effects.

Detainee #B13 (12 months at ECDC)
The detainee was a 39-year-old male from Guatemala. His intake was completed on 03/01/2017, and both his history and physical evaluation and his full mental health evaluation were performed on 03/02/2017. His MH evaluation was informative. He was diagnosed with an Anxiety Disorder NOS. The MH counselor and care manager checked on him regularly and discussed strategies to cope with anxiety. The detainee has been able to manage his anxiety without medication.

This case stands out because it illustrates how the mental health counselor, during a "brief mental health evaluation," was able to provide supportive counseling and assist the detainee with problem solving.

Detainee #B14 (12 months at ECDC)
The detainee was a 47-year-old male from the Philippines. He received a "full mental health evaluation" on 05/26/2017 after being referred to mental health for an evaluation because of question that were raise reference a grievance. The detainee's mental status was within normal limits and he denied any mental health issues. His diagnosis was deferred. To clarify the diagnosis, he was placed on the mental health caseload and as received a "brief mental health evaluation" regularly. The diagnosis was never clarified; however, the detainee has been actively participating in mental health's "brief evaluations."

This case once again illustrates the usefulness of regular mental health contacts while performing a "brief mental evaluation."

Detainee #B15 (8 months at ECDC)
The detainee was a 46-year-old male from Iraq. He came to ECDC from Jena/LaSalle where he was treated for PTSD and a Major Depressive Disorder with Wellbutrin and Trazadone. The intake and admission screen were completed on 08/20/2017. The history and physical evaluation was completed on 08/21/2017 and the full mental health evaluation was completed on 08/22/2017. Medication orders were continued and there was no evidence that he was seen by psychiatry since he arrived at ECDC approximately seven months ago.

This case once again illustrates psychiatry renewing medication orders and never following up to monitor medication side effects.

Detainee #B16 (sent to a hospital)
The detainee was a 37-year-old male from Mexico. He arrived at ECDC on 12/05/2017. His Intake Admission screening was performed on 12/06/2017 and his Full MH Evaluation was performed on 12/11/2017. He was diagnosed with Schizophrenia, Paranoid Type. He was actively psychotic (delusional), including the mental health staff in his paranoid delusions. Since ECDC was not staffed to perform involuntary treatment, the detainee was sent to Columbia Psychiatric Hospital.

Detainee #B17 (sent to a psychiatric facility)
The detainee was a 32-year-old male from Ghana. His Intake and Admission Screen was completed on 08/11/2017. His History and Physical was completed on 08/13/2017. He was not referred to mental health for a Full MH Evaluation until 09/08/2017. He denied a history of any mental health problems and reportedly "held it together." A MH diagnosis was deferred until he started exhibiting bizarre behavior in his housing unit (i.e., showering while wearing his clothing). He was once again evaluated by the MH counselor on 10/-06/2017. The detainee exhibited some manic and paranoid symptoms. A decision was made to send him to a more intensive psychiatric program.

Detainees #B16 and #B17 revealed that ECDC's mental health delivery system was able to identify and appropriately triage acute psychiatric patients. The only concern was that there was no documentation of psychiatry being involved in the evaluation, treatment and triaging of these patients.

Report for the U.S. Department of Homeland Security Office for Civil Rights and Civil Liberties

Environmental Health and Safety Report

Etowah County Detention Center, Gadsden, Alabama

(b) (6)

Prepared By:
MCJ, R.D., L.D., R.S., CCHP, CLLM
6/4/2018

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Introduction

On April 9-11, 2018, I assessed the environmental health and safety conditions at the Etowah County Detention Center (ECDC), Gadsden, Alabama. This review was provided under contract with the United States Department of Homeland Security, Office for Civil Rights and Civil Liberties (CRCL). Accompanying me on this investigation were (b)(6) Policy Advisor, CRCL, and (b) (6) Senior Policy Advisor, CRCL, as well as three other subject matter experts who examined ECDC's medical care, mental health care, and conditions of detention.

The purpose of this review was to investigate complaints made by U.S. Immigration and Customs Enforcement (ICE) detainees of various alleged violations of civil rights and civil liberties at ECDC. In particular, I examined allegations contained in Complaint Numbers 17-08-ICE-0557 and 18-04-ICE-0100. CRCL also asked me to review the implementation of recommendations made during CRCL's last onsite investigation at ECDC in May 2012. This investigation was conducted to obtain an impression of the validity of the allegations and issues by assessing the facility's adherence to applicable standards and best practices related to environmental conditions. The areas of review included the intake area, kitchen, laundry, medical unit, detainee living units, and special housing unit.

Methodology

The basis of this report includes document reviews, tour of the facility, interviews with facility staff and detainees, visual observations, and environmental measurements. The findings and recommendations contained in this report are solely those of the author. The report cites specific examples of conditions found during this review, however, they should not be considered as all-inclusive of the conditions found during the inspection. Consideration was given to national and state standards including the 2000 ICE National Detention Standards (NDS) and Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, published by the American Correctional Association (ACA).

I would like to extend my appreciation to Sheriff (b) (6), (b) (7)(C) and his staff. The facility officials and staff were cooperative and placed no limitations on my requests.

Facility Overview

The Etowah County Sheriff's Department is responsible for the daily operation of ECDC. ECDC has a contract with the United States Marshals Service (USMS) to house federal prisoners including ICE detainees. The facility currently houses ICE detainees in housing units 3, the segregation unit, 4, 7, and 9. ECDC is contractually required to adhere to the NDS.

Findings

Allegation No. 1: Complaint No. 18-04-ICE-0100 alleges that a detainee requested nail clippers and received nail clippers that had blood on the blades. The detainee requested disinfectant to clean the blades and was told that the facility does not provide disinfectant.

Findings: The allegation that the facility does not ensure adequate cleaning and disinfection of nail clipping tools is substantiated.

Applicable Standards: The NDS Environmental Health and Safety and Exchange of Clothing, Bedding, and Towels standards are applicable.

Analysis:
The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard states, "Basic hygiene is essential to the well-being of detainees." Fingernails harbor dirt and germs that can spread disease. Good hand hygiene including clipping nails facilitates clean hands and minimizes disease transmission. Furthermore, the nail clippers themselves can be a source of disease transmission, especially when used by numerous individuals in a communal living environment such as the detainee housing units. Therefore, the provision of sanitary nail clippers is essential to safeguard detainee health as indicated the NDS Environmental Health and Safety standard stating, "Sanitation of barber operations is of the utmost concern because of the possible transfer of diseases through direct contact or by towels, combs and clippers."

ECDC does not have written policy and procedures for the storage, issuance, and cleaning of nail clippers resulting in haphazard practices. The nail clippers in housing unit 4 are kept in a plastic container submerged in full strength Barbicide brand chemical disinfectant. The officer states that he changes the solution once per week and a log is utilized to track nail clipper use by detainees. Whereas, the housing unit 7 officer reports that the unit did not have nail clippers and was awaiting new ones from the supply department. When asked how nail clippers are disinfected, the officer stated that they are kept in a cup of the blue liquid and the officer then demonstrated by pulling a Styrofoam beverage cup out of a cabinet containing a light blue liquid that was determined to be germicidal cleaner. Although "Nail Cleaner" was handwritten in ink on the side of the cup, this creates a safety concern because the chemical stored in the cup could easily be mistaken for a beverage and ingested. In housing unit 9, the nail clippers were kept in a drawer and the officer stated that he usually stores them in a bowl of germicidal detergent, but did not have a bowl at that time and was therefore not issuing the clippers. Neither housing unit 7 or 9 had a nail clipper log.

Conclusion: The lack of policy and procedures for the storage, issuance, and cleaning and disinfection of nail clipping tools places detainees at risk of nail and skin infections. Furthermore, the use of Styrofoam beverage cups to store chemicals creates a safety

hazard as food containers should never be used to store, transport, or dispense chemicals due to the risk of accidental ingestion and poisoning.

Recommendations:

1. Trimming and maintaining fingernails and toenails is necessary for good health and hygiene. Therefore, it is essential that detainees have regular access to sanitary nail clippers with blades that are sharp enough to cut the nail. ECDC should ensure that detainees have regular access to clean and disinfected nail clipping tools that are replaced when the blade becomes worn to facilitate compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Basic hygiene is essential to the well-being of detainees." (NDS, Issuance and Exchange of Clothing, Bedding, and Towels, § I) (Level 1)

2. Nail clipping tools can be a source of disease transmission, especially when used by numerous individuals. ECDC administration should immediately create and implement a policy and detailed procedures for the storage, issuance, cleaning, and disinfection of nail clipping tools that complies with the NDS Environmental Health and Safety standard requiring, "Instruments such as combs and clippers will not be used successively on detainees without proper cleaning and disinfecting. ... After cleaning, the clipper blades will be immersed in the disinfectant solution and agitated for a period of not less than 15 seconds before use on any other detainee. The solution will be replaced as often as necessary." (NDS, Environmental Health and Safety, § III(P)) (Level 1)

3. Food containers, including Styrofoam beverage cups should not be used to store, transport, or dispense chemicals due to the risk of accidental ingestion and poisoning. Therefore, the use of beverage cups to store nail clippers in chemical solutions must be prohibited, as required by the NDS Environmental Health and Safety standard "Requiring use of properly labeled containers for hazardous materials, including any and all miscellaneous containers into which employees might transfer the material" and "Placing correct labels on all smaller containers when only the larger shipping container bears the manufacturer-affixed label." (NDS, Environmental Health and Safety, § III(J)) (Level 1)

Allegation No. 2: It is alleged in Complaint No. 17-08-ICE-0557 that a Muslim detainee was denied a kosher meal.

Findings: The allegation that problems exist with the provision of religious diets is substantiated.

Applicable Standards: The NDS Food Service and Religious Practices standards are applicable.

Analysis:

Although several positive practices were found regarding the provision of religious meals including a dietitian certified kosher menu and serving pre-packaged kosher meals at every lunch and dinner, serious concerns regarding religious diets were found. ECDC utilizes a "Religious Diets (Common Fare)" request form (Attachment A) for detainees seeking a religious fare accommodation. However, the form is confusing. Specifically, the form offers four choices of meals: kosher, vegetarian - fish and poultry are served, vegetarian - does not include fish or poultry, and vegan. The inclusion of poultry on the vegetarian menu does not comply with commonly accepted definitions of vegetarian; however, the facility has good intentions as it was reported that numerous detainees requested vegetarian and also stated that they eat poultry products and therefore the option of vegetarian with the inclusion of poultry was included. Additionally, the form requires the applicant to sign and agree, "I understand that 'Common Fare' refers to a no-flesh protein option provided whenever an entrée containing flesh is offered as part of a meal. Likewise, a 'Common Fare' meal offers vegetables, starches and other foods that are not seasoned with flesh. This diet is designed as the foundation from which modifications can be made to accommodate the religious diets of various faiths." However, this is confusing as the facility staff and food service department do not refer to their religious meal program as common fare and the facility does not actually offer a common fare program as defined by the NDS standards.

The greatest concern regarding religious meals stems from conversations with the facility chaplain. The chaplain did not convey a good understanding of the various types of diets associated with different religious beliefs. Specifically, when pressed about halal meals, the chaplain stated, "kosher for Muslims is really non-pork." The chaplain of a facility housing detainees should be generally familiar with Islamic religious diets and not refer to halal as "kosher for Muslims." The chaplain further stated that the main food line at the facility is pork-free and thus is all that is required for Muslims. However, halal dietary laws encompass more than just a no pork designation.

The facility does not have a kosher kitchen. The food service administrator reported they are considering installing a kosher kitchen during an upcoming major renovation project. The kitchen is currently purchasing frozen, prepackaged kosher meals and supplementing with fresh fruits, vegetables, and food items that bear the symbol of recognized kosher-certification agencies. The kitchen utilizes separate pots and pans for cooking foods such as pasta and vegetables for the kosher menu and utilizes separate plastic washtubs for ware washing.

On April 9, 2018, two detainees were receiving a kosher diet, two detainees were receiving a vegetarian diet, and four detainees were receiving a vegan diet and the total detainee census was 278. Therefore, approximately 3% of the detainee population was receiving a special religious diet. Although there is no requisite number of religious meals, this seems to be lower than average when compared to similar jails. During one

of the detainee group interviews, it was reported that at one point, the facility was providing numerous kosher meals for requested halal diets, but that the facility stopped them due to too many requests. This was also confirmed by facility staff that reported at one time the facility was providing approximately 100 kosher meals to Muslim detainees each day, but that in response to the large numbers, ICE Headquarters provided guidance on who should receive kosher meals, and the practice of providing kosher meals to Muslim detainees was discontinued and now only Jewish detainees receive kosher meals.

Conclusion: ECDC has made significant improvements to their religious fare program since 2012. The facility was previously cooking entrees for the kosher meal plan and is now serving prepackaged kosher meals at lunch and dinner, which is a significant improvement and to their credit exceeds the minimum NDS standard. However, problems still exist, including a lack of understanding of halal and a failure to recognize the specific dietary needs of various faiths. Furthermore, the plan to build a kosher kitchen is also cause for concern, as ECDC must ensure that the facility strictly adheres to the NDS Food Service standard.

Recommendations:

4. ECDC has implemented improvements in their religious meal program since 2012, however, it is difficult to sort out their process and the program needs a thorough review to identify where changes or improvements are needed. Therefore, it is recommended that ERO's Religious Services Coordinator (subject matter expert) work with staff at ECDC to review the religious fare program and ensure that it fully complies with the NDS Food Service and Religious Practices standards. (NDS, Food Service and Religious Practices) (Level 1)

Allegation No. 3: Complaint No. 17-08-ICE-0557 alleges that detainees can only take showers at certain times of the day.

Findings: The allegation that detainees can only shower during certain times of the day is true, however the practice does not violate the NDS. While assessing the showers, problems related to water temperatures and sanitation were found.

Applicable Standards: The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Basic hygiene is essential to the well-being of detainees in the custody of the Immigration and Naturalization Service (INS)" is applicable. Furthermore, the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" applies and therefore, ACA Housekeeping standard 4-ALDF-1A-04 and ACA Plumbing Fixtures standard 4-ALDF-4B-09 are applicable.

Analysis: ECDC restricts access to showers during meal periods and counts, which is a common practice in correctional facilities. The timeframes that detainees may access the showers are posted in the housing units. The unit 4 posting indicated that shower hours are 8:30 – 10:00 a.m. and 12:30 – 3:00 p.m. The unit 4 census was 98 on April 9, 2018. The unit 7 shower times are posted as 8:30 – 10:00 a.m., 12:30 – 3:00 p.m., 6:30 – 10:00 p.m., and 11:30 p.m. – 1:30 a.m. The unit 7 census was 62 on April 9, 2018. During the two group interviews and impromptu questioning in the housing units, detainees were asked if they had sufficient access to the showers and all detainees responded affirmatively and several stated that they could take multiple showers a day if they desired. Therefore, although showers are not accessible around the clock, access is adequate to facilitate personal cleanliness in compliance with the spirit of the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Basic hygiene is essential to the well-being of detainees."

During interviews, several detainees reported that the shower water temperatures felt cold. Random shower water temperatures were measured and the maximum water temperature was 96˚F in the unit 7 upper showers, 97˚F in the unit 7 lower showers, and 92˚F in the unit 9 lower showers. Although the NDS does not specify water temperatures, the NDS Environmental Health and Safety standard states, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and further specifies, "The standards include those from the American Correctional Association." Thus, ACA Plumbing Fixtures standard 4-ALDF-4B-09 stating, "Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices" is applicable. Therefore, the water temperatures of 96-97˚F, fall short of the 100˚F minimum and the water temperature of 92˚F may feel uncomfortably cool to some individuals.

Several detainee housing unit workers reported taking pride in keeping the showers clean and the shower rooms were cleaner than they were during my 2012 inspections, with the exception of the shower room in unit 3, which was found to have a dirty floor, the floor drains were partially blocked with organic matter including hair and soap residues, and several drain flies were observed. Clogged shower drains are a hazard because they can lead to the back up of potentially contaminated water from dirty drains and dirty shower drains propagate the life cycle of drain flies, which are nuisance pests that can spread disease from sewage and contaminated bathroom drains and surfaces. Additionally, the same deficiencies that were observed in 2012 were found to persist. Specifically, small areas of what appeared to be mildew growing in the grout, condensation collected on the ceiling from inadequate ventilation, and rusty metal windowsills. The facility administration reports that major renovations are scheduled to start in the summer of 2018, including complete renovations of the shower rooms, which reportedly will remedy the ongoing problems.

Conclusion:

Although the facility places restrictions on shower access, the practice does not violate the NDS and detainees have adequate access to maintain personal hygiene. The shower water temperatures were found to hover just below the minimum temperature for hot water as specified in ACA Plumbing Fixtures standard 4-ALDF-4B-09, which may lead to uncomfortably cold showers for some detainees. Although the showers were found to be generally cleaner than they were in 2012, the unit 3 shower was dirty and significant problems persist including mildew, excessive condensation, and rust.

Recommendations:

5. Cold shower water is a deterrent to good personal hygiene. The NDS Environmental Health and Safety standard states, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and further specifies, "The standards include those from the American Correctional Association." Therefore, the facility should ensure that shower water temperatures are maintained within the range specified by ACA Plumbing Fixtures standard 4-ALDF-4B-09 stating, "Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

6. A variety of illness causing organisms including MRSA, Tinea pedis or athlete's foot, and nail fungus thrive in warm, moist environments and are commonly spread in communal showers. Therefore, ongoing diligence when cleaning and disinfecting the shower walls, floors, and drains is vital to ensure good detainee health. ECDC should ensure that all shower room surfaces including the floors, walls, ceilings, and drains are routinely inspected, cleaned, and maintained in a sanitary manner in compliance with ACA Housekeeping standard 4-ALDF-1A-04, requiring "the facility is clean and in good repair." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

7. Although rust itself does not cause illness, it provides an environment in which harmful organisms, such as the bacteria that causes tetanus can hide. ECDC should ensure that the planned renovations to the shower rooms address the rusty surfaces and inadequate ventilation that leads to excess condensation to ensure compliance with ACA Housekeeping standard 4-ALDF-1A-04, requiring "the facility is clean and in good repair." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

Allegation No. 4: Complaint No. 17-08-ICE-0557 alleges that detainees receive used underwear.

Findings: The NDS does not require that detainees be issued new underwear and the facility issued undergarments comply with the NDS.

Applicable Standard: The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard is applicable.

Analysis:
The NDS Issuance and Exchange of Clothing, Bedding, and Towels standard states, "all new detainees shall be issued clean, temperature-appropriate, presentable clothing during in-processing." Therefore, the standard requires the facility to issue clothing, including underwear that is clean and presentable. The standard does not require the facility to issue new clothing. During my inspections, I observed clothing and apparel in the housing units, laundry, and intake unit and found them to appear presentable without obvious signs of damage such as rips or holes and in general, detainees were wearing appropriately sized clothing. During my 2012 inspection, ECDC was only issuing size extra-large boxer shorts to new arrivals, but has since implemented the proper practice of issuing the correct size of boxer shorts based on the detainee's actual clothing size.

Although the ECDC Personal Hygiene Policy and Procedure indicates, "Detainees are not permitted to wash bedding, linens, tennis shoes or other items in the living unit" and the Inmate/Detainee Handbook states, "Detainees are not permitted to wash clothing, bedding or tennis shoes or other items in their living unit," I observed clotheslines in every housing unit and the numerous clotheslines observed in housing units 7 and 9 indicate that a significant amount of self-laundering is occurring in these units. Detainees reported that the facility adheres to the established laundry schedule but several detainees also stated that they do not believe that the facility laundry does a good job and that clothing and linen sent to the laundry comes back gray and sometimes has an unpleasant odor, therefore, they prefer to self-launder their clothing in the cell and bathroom lavatories. This practice lacks the hot water temperatures, proper detergent, and bleach provided by the commercial laundering process, and therefore, may not result in complete pathogen destruction during the washing process. Furthermore, it is difficult to rinse out the body soap or shampoo used for washing, leading to potential skin irritation issues. Several detainees also report that occasionally, some items sent to the laundry in the mesh bags are not returned or their return is delayed and that this is particularly problematic for them when the items are non-facility issued clothing that they purchased from the commissary or retained from their personal property. The laundry staff acknowledged that problems do occur and are correct in their assessment of the problems. A primary cause of unclean returned laundry is the result of detainees tightly packing the laundry bags, which does not allow the water and laundry chemicals from all the washing machine cycles to penetrate the core of items that are tightly packed in a mesh laundry bag, which can lead to the same dirty malodorous laundry being returned to the detainee that was sent to be laundered. Another problem cited by the laundry staff is detainees not adhering to the posted laundry schedule and placing dark color items in their mesh laundry bags on days scheduled for washing white laundry. They specifically stated that detainees place the wool blankets, which are well known to bleed color even when washed numerous times,

in the bags with t-shirts, socks, and boxer shorts, which results in the bleeding of the dark gray blanket into the wash water that then stains the lighter colored items in the load and causes the items to appear dingy. The laundry staff also stated that sometimes detainees fail to tightly tie a knot to secure their laundry bag, which results in it coming untied during the laundering process and when this occurs they make an effort to return the items to the owner and if unknown, they place the items in a cart and return them to the housing unit to be claimed by the owner. This procedure was substantiated by several detainees. ECDC laundry staff stated that detainees should report lost laundry via the electronic kiosk system and the items will either be tracked down or replaced, however they also acknowledged that this process could take a week or longer. The laundry supervisor also reports that they try to correct problems with the mesh bags when observed, but the overall volume of laundry prohibits them from finding all instances. They also report that they try to educate the detainees on the proper methods for using the laundry bags, but that it is a difficult task. Therefore, although it is understandable that these problems are frustrating to detainees, in my experience, they are extremely common in facilities that use a mesh bag system for laundering. Mesh bags also provide a practical method for washing and drying non-facility issued laundry. The alternative to using mesh bags is a one-for-one exchange system by which a detainee returns facility laundry and is issued items from the facility's laundry supply. However, it is also my experience that detainees are often critical of the one-for-one exchange as they are continually receiving laundry that was previously worn by another person, which is the same issue that prompted Complaint 17-08-ICE-0557.

Conclusion: The undergarments issued by the facility comply with the NDS standard. The practice of allowing detainees to wash laundry in sinks and showers and hang it to dry in their cells is placing detainees at risk of infections. Although there are problems with the mesh laundry bag system including inadequately cleaned laundry, stained or dingy laundry, and lost items, these problems are common throughout jail laundries and the system is still preferable to most detainees rather than a one-for-one exchange system.

Recommendations:

8. ECDC should discontinue the insanitary practice of allowing detainees to wash clothing in the lavatories and showers as evidenced by numerous clotheslines in the housing units. Ending this practice will comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard indicating, "Detainees are not permitted to wash clothing, bedding, linens, tennis shoes or other items in the living unit, unless proper washing and drying equipment are available and the policy and procedures for their use are in place." (NDS, Issuance and Exchange of Clothing, Bedding, and Towels, § III(E)) (Level 1)

9. ECDC should continue to inform and educate detainees on proper the proper use of mesh laundry bags, including instructions regarding not overfilling them and not stuffing the wool blankets in the bags to ensure the laundry process results

in clean sanitary items that comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard requiring "clean clothing, bedding, linens and towels." (NDS, Issuance and Exchange of Clothing, Bedding, and Towels, § III(E)) (Level 1)

Other Observations

Excessive Trash and Property Stored in Cells

Cells throughout housing units 4, 7, and 9 were observed to have excessive accumulations of personal property and trash. For example, observations include numerous cardboard boxes that were reported to be for the storage of legal paperwork, shelves fashioned from cardboard boxes and loaded with personal property, a stack of approximately 50 flattened Styrofoam food containers, numerous cups and bowls, and an extreme number of commissary food items that were displayed in one cell that was an obvious "store." Accumulations of trash and excessive property create harborage and breeding sites for insects and rodents including cockroaches and mice. Rodents and their parasites are capable of spreading a variety of diseases including Salmonellosis and Lyme disease. Cockroaches also spread disease-causing microorganisms and can trigger asthma. Excessive accumulations of combustible items, including cardboard provide fire-loading material in addition to being a fire hazard. In fact, a fire was set in housing unit 3 in 2017 that was caused by igniting mattresses and other objects with a modified vape pen that was purchased from the commissary. It was reported that this fire created a significant amount of smoke. Fire events are particularly dangerous in correctional settings where individuals are behind locked doors and most fire deaths are caused by smoke inhalation rather than burns. Furthermore, in addition to the strong odor of smoke in the dayroom, evidence of past fires was found in housing unit 3 including burned pieces of plastic on the top bunk in cell #304 and charring was observed in the inset toilet paper roll holder on the toilet fixture in cell #306.

Applicable Standards: The NDS Environmental Health and Safety standard, Security Inspections standard, Food Service standard, and Funds and Personal Property standards are applicable.

Conclusion: Hoards and collections of excessive quantities of detainee property and trash in the cells are placing detainees at risk of exposure to fire and disease carrying vermin.

Recommendation:

10. Accumulations of trash and rubbish provide harborage for disease carrying insects and rodents. ECDC officers should routinely inspect cells for tidiness and take corrective action when excessive accumulations of trash and unauthorized items are found to ensure compliance with the NDS Environmental Health and Safety standard stating, "Garbage and refuse will be collected and removed as often as necessary to maintain sanitary conditions and to avoid creating a health hazard." (NDS, Environmental Health and Safety, § III(U)) (Level 1)

11. ECDC officers should perform security inspections and take immediate corrective actions when violations or deficiencies are found to comply with the NDS Security Inspections standard which states, "Security inspections are necessary to control the introduction of contraband, ensure facility safety, security, and good order, prevent escapes, maintain sanitary standards and eliminate fire and safety hazards" to ensure institutional safety. (NDS, Security Inspections, § III(A)) (Level 1)

12. The NDS Food Service standard specifies. "The premises shall be maintained in a condition that precludes the harboring or feeding of insects and rodents." To comply with this standard, detainees should not be allowed to stockpile food in their cells, including commissary purchases as food may attract insects and rodents. Additionally, all kitchen meal trays and disposable food containers should be removed from the individual cells and housing units after every meal, as they contain food and residues that attract disease carrying insects and rodents, including cockroaches and mice. (NDS, Food Service, § III(H)(5)) (Level 1)

13. Storage of excessive property in cells creates a fire risk and provides harborage and breeding sites for disease carrying insects and rodents. Therefore, ECDC should implement and enforce policies and procedures regarding the retention of personal property in detainee cells to comply with the NDS Funds and Personal Property standard stating, "Detainees may keep a reasonable amount of personal property in their possession, provided the property poses no threat to facility security." (NDS, Funds and Personal Property, § III(B)) (Level 1)

14. Fire and smoke are particularly dangerous in a jail where detainees are locked behind doors without unrestricted access to egress. ECDC should limit stashes of items that are fire loading materials and ban the sale of commissary items that are known fire ignition sources, such as vape pens, to comply with the NDS Environmental Health and Safety standard stating, "Every institution will develop a fire prevention, control, and evacuation plan to include, among other thing, the following: control of ignition sources and control of combustible and flammable fuel load sources." (NDS, Environmental Health and Safety, § III(L)(3)) (Level 1)

<u>Housing Unit 3 - Segregation Unit Cells</u>

Significant problems were found in housing unit 3, including no working intercoms for detainees to contact staff members in the event of an emergency, as the cell intercom units had been removed, the ventilation units located in the cell windows were not functioning and the ambient air temperature was 60˚F on March 11, 2018, a large hole completely penetrated through the wall between cells #304 and #305, allowing access for communication or passing contraband between the cells, and the light fixtures were unsecured and can be tampered with allowing access to the ballasts and wiring, which can be used to start fires or charge cell

phones. A fire was started in this unit in 2017 as discussed in the Excessive Trash and Property Stored in Cells section of this report. ECDC administration reports that these conditions will be corrected during the upcoming renovations. However, the facility must also address the oversight and security staffing problems that led to the degraded conditions or they will reoccur, these issues are discussed in the conditions of detention expert's report, as she is best qualified to opine on this subject.

Applicable Standards: The NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" applies and therefore, ACA Standard 4-ALDF-1A-04 stating "The facility is clean and in good repair" is applicable.

Conclusion: Based on the significant problems observed including no intercoms that would allow detainees to summon help in the event of an emergency, detainees should not be housed in unit 3 until the unit is renovated to meet the conditions mandated by the NDS.

Recommendations:

15. Based on the hazardous environmental conditions found in housing unit 3, including no intercoms, nonfunctioning ventilation units, and detainee access to ballasts and wiring, ECDC should discontinue house detainees in the unit, including cells #304, #305, and #306, until renovations and repairs that bring the unit into full compliance with ACA Housekeeping standard 4-ALDF-1A-04, requiring the facility is "in good repair" are complete. The ACA standard is applicable because the NDS Environmental Health and Safety standard states, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

Hand Hygiene in the Medical Exam Rooms

ECDC expanded the medical unit and added much needed exam rooms. However, the area was not designed as medical space and therefore there are no handwashing sinks in or near the exam rooms. Hand hygiene in a medical unit is of utmost importance to prevent the spread of illness causing microorganisms to patients and medical care workers. The facility administration reports that handwashing sinks are planned to be added during the upcoming renovations.

Applicable Standard: The NDS Environmental Health and Safety standard is applicable.

Conclusion: The lack of access to handwashing sinks in the medical exam room area is placing detainees at risk of illness and infections.

Recommendations:

16. Due to the importance of hand hygiene during medical procedures to prevent the spread of illness causing microorganisms, including bacteria and viruses, ECDC administration should ensure that handwashing stations are installed during the planned facility renovations and that hand sanitizer stations are immediately installed as an interim measure. The installation of hand hygiene stations facilitates compliance with the NDS Environmental Health and Safety standard which requires handwashing after using a clean-up kit as well as complying with the Universal Precautions section which states, "Hands and other skin surfaces will be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands will be washed immediately after gloves are removed." (NDS, Environmental Health and Safety, § III(S)) (Level 1)

Ceiling Maintenance

Problems with the ceiling were found in the kitchen storeroom and the housing unit 4 dayroom. The ceiling of the kitchen storeroom has as a large area of peeling paint. Peeling and loose paint chips pose a cross contamination hazard to the food and kitchen supplies stored in the area. ECDC administration reports that the kitchen is one of the first areas scheduled for the upcoming renovation project and the storeroom will be modified into a new freezer. However, in the interim, remediation of the peeling paint is needed to ensure food safety.

Water is dripping from the ceiling in housing unit 4. The problem is extensive and runs the length of the dayroom. The facility has positioned buckets to catch the water drips, places towels on the floor to absorb water, and encircled the area with caution tape and safety cones. ECDC administration reports that the problem is related to the last building modification where a floor was added on top of the existing structure. However, the specific cause has yet to be identified. The problem is supposed to be remedied by the upcoming building envelope renovation. The dripping water presents several safety hazards including slips and falls from the constantly wet floor as well as promoting the growth of mold and mildew.

Applicable Standards: The NDS Food Service standard is applicable. The NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" applies and therefore, ACA Standard 4-ALDF-1A-04 stating "The facility is clean and in good repair" is also applicable.

Conclusion: Deficiencies in the integrity of the ceiling in the housing unit 4 dayroom and peeling paint on the ceiling of the kitchen storeroom pose health and safety hazards to detainees.

Recommendations:

17. The kitchen is scheduled for remodel and reportedly, the storeroom is being modified into freezer space. However, in the interim, remediation of the peeling

paint is needed to prevent contamination by the loose paint chips and ensure safe food as required by the NDS Food Service standard stating, "Food and ice will be protected from dust, insects and rodents, unclean utensils and work surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, overhead leakage, and other sources of contamination. Protection will be continuous, whether the food is in storage, in preparation/on display, or in transit." (NDS, Food Service, § III(D)(5)) (Level 1)

18. ECDC administration should continue to take all possible measures to limit the hazards posed by the constantly dripping water in the unit 4 dayroom. Wet floors pose slip and fall hazards and the wet ceiling and constantly dripping water facilitate growths of mold and mildew, which can exacerbate asthma and allergies. Furthermore, ECDC should work with the renovation project contractor to ensure the area is properly repaired in compliance with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" and therefore ECDC must comply with ACA Standard 4-ALDF-1A-04 stating "The facility is clean and in good repair." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

Summary of NDS Recommendations

1. Trimming and maintaining fingernails and toenails is necessary for good health and hygiene. Therefore, it is essential that detainees have regular access to sanitary nail clippers with blades that are sharp enough to cut the nail. ECDC should ensure that detainees have regular access to clean and disinfected nail clipping tools that are replaced when the blade becomes worn to facilitate compliance with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard stating, "Basic hygiene is essential to the well-being of detainees." (NDS, Issuance and Exchange of Clothing, Bedding, and Towels, § I) (Level 1)

2. Nail clipping tools can be a source of disease transmission, especially when used by numerous individuals. ECDC administration should immediately create and implement a policy and detailed procedures for the storage, issuance, cleaning, and disinfection of nail clipping tools that complies with the NDS Environmental Health and Safety standard requiring, "Instruments such as combs and clippers will not be used successively on detainees without proper cleaning and disinfecting. ... After cleaning, the clipper blades will be immersed in the disinfectant solution and agitated for a period of not less than 15 seconds before use on any other detainee. The solution will be replaced as often as necessary." (NDS, Environmental Health and Safety, § III(P)) (Level 1)

3. Food containers, including Styrofoam beverage cups should not be used to store, transport, or dispense chemicals due to the risk of accidental ingestion and poisoning.

Therefore, the use of beverage cups to store nail clippers in chemical solutions must be prohibited, as required by the NDS Environmental Health and Safety standard "Requiring use of properly labeled containers for hazardous materials, including any and all miscellaneous containers into which employees might transfer the material" and "Placing correct labels on all smaller containers when only the larger shipping container bears the manufacturer-affixed label." (NDS, Environmental Health and Safety, § III(J)) (Level 1)

4. ECDC has implemented improvements in their religious meal program since 2012, however, it is difficult to sort out their process and the program needs a thorough review to identify where changes or improvements are needed. Therefore, it is recommended that ERO's Religious Services Coordinator (subject matter expert) work with staff at ECDC to review the religious fare program and ensure that it fully complies with the NDS Food Service and Religious Practices standards. (NDS, Food Service and Religious Practices) (Level 1)

5. Cold shower water is a deterrent to good personal hygiene. The NDS Environmental Health and Safety standard states, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and further specifies, "The standards include those from the American Correctional Association." Therefore, the facility should ensure that shower water temperatures are maintained within the range specified by ACA Plumbing Fixtures standard 4-ALDF-4B-09 stating, "Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

6. A variety of illness causing organisms including MRSA, Tinea pedis or athlete's foot, and nail fungus thrive in warm, moist environments and are commonly spread in communal showers. Therefore, ongoing diligence when cleaning and disinfecting the shower walls, floors, and drains is vital to ensure good detainee health. ECDC should ensure that all shower room surfaces including the floors, walls, ceilings, and drains are routinely inspected, cleaned, and maintained in a sanitary manner in compliance with ACA Housekeeping standard 4-ALDF-1A-04, requiring "the facility is clean and in good repair." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

7. Although rust itself does not cause illness, it provides an environment in which harmful organisms, such as the bacteria that causes tetanus can hide. ECDC should ensure that the planned renovations to the shower rooms address the rusty surfaces and inadequate ventilation that leads to excess condensation to ensure compliance with ACA Housekeeping standard 4-ALDF-1A-04, requiring "the facility is clean and in good repair." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

8. ECDC should discontinue the insanitary practice of allowing detainees to wash clothing in the lavatories and showers as evidenced by numerous clotheslines in the housing units. Ending this practice will comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard indicating, "Detainees are not permitted to wash clothing, bedding, linens,

tennis shoes or other items in the living unit, unless proper washing and drying equipment are available and the policy and procedures for their use are in place." (NDS, Issuance and Exchange of Clothing, Bedding, and Towels, § III(E)) (Level 1)

9. ECDC should continue to inform and educate detainees on proper the proper use of mesh laundry bags, including instructions regarding not overfilling them and not stuffing the wool blankets in the bags to ensure the laundry process results in clean sanitary items that comply with the NDS Issuance and Exchange of Clothing, Bedding, and Towels standard requiring "clean clothing, bedding, linens and towels." (NDS, Issuance and Exchange of Clothing, Bedding, and Towels, § III(E)) (Level 1)

10. Accumulations of trash and rubbish provide harborage for disease carrying insects and rodents. ECDC officers should routinely inspect cells for tidiness and take corrective action when excessive accumulations of trash and unauthorized items are found to ensure compliance with the NDS Environmental Health and Safety standard stating, "Garbage and refuse will be collected and removed as often as necessary to maintain sanitary conditions and to avoid creating a health hazard." (NDS, Environmental Health and Safety, § III(U)) (Level 1)

11. ECDC officers should perform security inspections and take immediate corrective actions when violations or deficiencies are found to comply with the NDS Security Inspections standard which states, "Security inspections are necessary to control the introduction of contraband, ensure facility safety, security, and good order, prevent escapes, maintain sanitary standards and eliminate fire and safety hazards" to ensure institutional safety. (NDS, Security Inspections, § III(A)) (Level 1)

12. The NDS Food Service standard specifies. "The premises shall be maintained in a condition that precludes the harboring or feeding of insects and rodents." To comply with this standard, detainees should not be allowed to stockpile food in their cells, including commissary purchases as food may attract insects and rodents. Additionally, all kitchen meal trays and disposable food containers should be removed from the individual cells and housing units after every meal, as they contain food and residues that attract disease carrying insects and rodents, including cockroaches and mice. (NDS, Food Service, § III(H)(5)) (Level 1)

13. Storage of excessive property in cells creates a fire risk and provides harborage and breeding sites for disease carrying insects and rodents. Therefore, ECDC should implement and enforce policies and procedures regarding the retention of personal property in detainee cells to comply with the NDS Funds and Personal Property standard stating, "Detainees may keep a reasonable amount of personal property in their possession, provided the property poses no threat to facility security." (NDS, Funds and Personal Property, § III(B)) (Level 1)

14. Fire and smoke are particularly dangerous in a jail where detainees are locked behind doors without unrestricted access to egress. ECDC should limit stashes of items that are fire loading materials and ban the sale of commissary items that are known fire ignition sources, such as vape pens, to comply with the NDS Environmental Health and Safety standard stating,

"Every institution will develop a fire prevention, control, and evacuation plan to include, among other thing, the following: control of ignition sources and control of combustible and flammable fuel load sources." (NDS, Environmental Health and Safety, § III(L)(3)) (Level 1)

15. Based on the hazardous environmental conditions found in housing unit 3, including no intercoms, nonfunctioning ventilation units, and detainee access to ballasts and wiring, ECDC should discontinue house detainees in the unit, including cells #304, #305, and #306, until renovations and repairs that bring the unit into full compliance with ACA Housekeeping standard 4-ALDF-1A-04, requiring the facility is "in good repair" are complete. The ACA standard is applicable because the NDS Environmental Health and Safety standard states, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

16. Due to the importance of hand hygiene during medical procedures to prevent the spread of illness causing microorganisms, including bacteria and viruses, ECDC administration should ensure that handwashing stations are installed during the planned facility renovations and that hand sanitizer stations are immediately installed as an interim measure. The installation of hand hygiene stations facilitates compliance with the NDS Environmental Health and Safety standard which requires handwashing after using a clean-up kit as well as complying with the Universal Precautions section which states, "Hands and other skin surfaces will be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands will be washed immediately after gloves are removed." (NDS, Environmental Health and Safety, § III(S)) (Level 1)

17. The kitchen is scheduled for remodel and reportedly, the storeroom is being modified into freezer space. However, in the interim, remediation of the peeling paint is needed to prevent contamination by the loose paint chips and ensure safe food as required by the NDS Food Service standard stating, "Food and ice will be protected from dust, insects and rodents, unclean utensils and work surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, overhead leakage, and other sources of contamination. Protection will be continuous, whether the food is in storage, in preparation/on display, or in transit." (NDS, Food Service, § III(D)(5)) (Level 1)

18. ECDC administration should continue to take all possible measures to limit the hazards posed by the constantly dripping water in the unit 4 dayroom. Wet floors pose slip and fall hazards and the wet ceiling and constantly dripping water facilitate growths of mold and mildew, which can exacerbate asthma and allergies. Furthermore, ECDC should work with the renovation project contractor to ensure the area is properly repaired in compliance with the NDS Environmental Health and Safety standard stating, "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and specifies, "The standards include those from the American Correctional Association" and therefore ECDC must comply with ACA Standard 4-ALDF-1A-04 stating "The facility is clean and in good repair." (NDS, Environmental Health and Safety, § III(R)) (Level 1)

RELIGIOUS DIETS (COMMON FARE)

(THIS REQUEST CANNOT BE CHANGED FOR 90 DAYS FROM DATE BELOW)

Detainee/Inmate Name (Nombre Del Detenido): _____

A # _____ **Cell/Cela #** _____

_____ **–KOSHER – Fit or allowed to be eaten or used, according to the dietary or ceremonial laws: kosher meat; kosher dishes; foods not bearing kosher approved symbols will be substituted by foods bearing kosher approved symbols.**

_____ **– VEGETARIAN – The practice of excluding all beef, pork, and their bi-products from ones diet. Fish and poultry are allowed in this diet WHEN THEY ARE AVAILABLE.**

_____ **– "DO NOT" INCLUDE FISH AND POULTRY AT ANY TIME.**

_____ **– VEGAN – The practice of excluding all animal products (such as eggs, cheese, meats, etc) and animal bi-products from one's diet.**

I understand that "Common Fare" refers to a non-flesh protein option provided whenever an entrée containing flesh is offered as part of a meal. Likewise, a "Common Fare" meal offers vegetables, starches, and other foods not seasoned with flesh. This diet is designed as the foundation from which modifications can be mate to accommodate the Religious Diets of various faiths.

Entiendo que la "Tarifa Común" se refiere a una opción de proteína de carne no proporcionada siempre un plato principal que contiene la carne se ofrece como parte de una comida. Asimismo, una comida de "Tarifa Común" ofrece vegetales, almidones y otros alimentos no salpicadas con carne. Esta dieta esta diseñada como la base desde la cual modificaciones pueden hacer para acomodar las dietas religiosas de distintos.

I understand that only I, the undersigned, have permission to eat this meal. If I give it to another person or if I eat a regular meal, I will immediately lose my Religious Diet permission.

Tengo entendido que solo el que suscribe, tienen permiso para comer esta comida. Si le doy a otra persona o si comer una comida regular, inmediatamente pierdo mi permiso de dieta religiosa.

Detainee/Inmate Signature: _____
(Firma Del Detenido)

Chaplains Signature (Firma Del capellán): _____

Date Signed (Fecha De Firma) _____

Report for the U.S. Department of Homeland Security Office for Civil Rights and Civil Liberties

Environmental Health and Safety Report

Etowah County Detention Center, Gadsden, Alabama

(b) (6)

Prepared By:
MCJ, R.D., L.D., R.S., CCHP, CLLM
6/4/2018

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ETOWAH COUNTY JAIL

I. SUMMARY OF INVESTIGATION

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) conducted an April 9-11, 2018 onsite investigation at the Etowah County Jail (Etowah County Detention Center) (ECJ) in Gadsden, Alabama. The investigation was initiated due to multiple complaints received alleging that U.S. Immigrations and Customs Enforcement (ICE) violated the civil rights and civil liberties of persons being detained at the ECJ. On the June 10, 2017, CRCL received notice of a June 9, 2017 immediate use of force on an unidentified Nigerian national, Detainee #1, housed at ECJ.[1] During the use of force incident, Detainee #1 was tased and suffered a significant injury to the head resulting in a scalp laceration and knocking him unconscious, requiring transport and treatment at the Riverview Regional Medical Center. This investigation will review the use of the taser and the incident circumstances to determine if the level of force used was within policy and the 2000 National Detention Standards (NDS). I also reviewed the progress status of deficiencies that I identified during a prior investigation that was conducted at this facility on May 23-25, 2012. This investigation and report addresses outstanding deficiencies under the NDS that continue to exist from the prior investigation.

During this onsite investigation, I reviewed the following areas: use of force, detainee safety, security, contraband control, recreation access, special management unit use and conditions, classification and screening, grievance system, mail access, law library and legal materials access, language access, retaliation, religious accommodation, staff-detainee communication, sexual assault and abuse prevention and intervention (SAAPI/PREA), and mail access.

To examine the allegations in the complaints, this investigation reviewed ECJ's adherence to the NDS in the relevant areas.

Allegations related to medical and mental health care are addressed by CRCL's medical and mental health experts; however, I did review medical and mental health care relative to SAAPI/PREA and crisis care. Allegations related to food, resident hygiene, clothing, laundry, environmental health and safety and facility maintenance were addressed by another expert and will be discussed in that expert's report.

Through this review, I found operational deficiencies related to some of the allegations in the complaints.

This report contains recommendations to address deficiencies identified that are based on ICE's detention standards, correctional experience, and recognized correctional standards including those published by the American Correctional Association (ACA).

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[1] DHS CRCL Complaint No. 17-09-ICE-0358.

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II. PROFESSIONAL EXPERTISE

(b) (6)

III. RELEVANT STANDARDS

A. ICE Detention Standards

ICE's 2000 NDS currently apply to ECJ. The facility was covered by these standards during the entire period relevant to this investigation. Consequently, I relied on the NDS when looking at the specific allegations regarding conditions at the facility. Additionally, I considered PBNDS 2011 Sexual Abuse and Assault Prevention and Intervention (SAAPI), and ICE Directive 11062.2, Sexual Abuse and Assault Prevention and Intervention, issued May 22, 2014, which was in force and in effect during this period, the Department of Homeland Security Language Access Plan, February 28, 2012, and U.S. Immigration and Customs Enforcement Language Access Plan, June 14, 2015, and Electro Muscular Disruption Devices and Facility Ratings ICE Director's Memorandum, issued October 23, 2009.

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IV. FACILITY BACKGROUND AND POPULATION DEMOGRAPHICS

ECJ is located in Gadsden, Alabama, and is operated and managed by the Etowah County Detention Center under an Inter-Governmental Agreement between U. S. Marshals Service and the ECJ to house 310 male ICE detainees. ECJ also houses County inmates. At the time of this investigation ECJ housed 278 detainees and 655 inmates.

V. REVIEW PURPOSE AND METHODOLOGY

The purpose of this review was to examine the specific allegations made in the complaints, as well as to identify other areas of concern regarding the operation of the facility. I was also tasked with reviewing facility policies and procedures. As part of this review, I examined a variety of documents; was onsite at ECJ on April 9-11, 2018, along with CRCL staff and experts who examined medical care, mental health care, food, and environmental health and safety; and interviewed ICE and ECJ staff and detainees.

The staff at ECJ was helpful and cooperative during our onsite investigation, and I appreciated their assistance. I also appreciated the cooperation and assistance provided by ICE staff before, during, and after our trip.

In preparation for the onsite and completion of this report, I did the following:

- Reviewed daily report of uses of force and sexual abuse allegations
- Reviewed the U.S. Marshals and ECJ Inter Governmental Agreement 01-99-0132
- Reviewed the April 2016 ICE National Detainee Handbook
- Reviewed relevant ICE NDS 2000 standards:
    - Contraband
    - Grievance Procedures
    - Detainee Handbook
    - Correspondence and Other Mail
    - Admission and Release
    - Access to Legal Material
    - Group Presentations on Legal Rights
    - Recreation
    - Religious Practices
    - Staff-Detainee Communication
    - Special Management Units (Administrative and Disciplinary)
    - Detainee Classification System
    - Population Counts
    - Disciplinary Policy
    - SAAPI/PREA (PBNDS 2011)
    - Funds and Personal Property
    - Suicide Prevention and Intervention
    - Telephone Access
    - Detention Files
    - Visitation
- Reviewed relevant ACA correctional standards

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While at the ECJ on April 9-11, and post-visit, I did the following:

- Toured male housing units
- Interviewed housing officers
- Interviewed male detainees
- Reviewed detainee housing rosters
- Reviewed detainee files
- Reviewed language line billing log, October 2017 – April 2018
- Reviewed the ECJ Detainee/Inmate Handbook, 2018 edition
- Inspected telephone pro bono number postings in housing units
- Tested telephone functionality
- Toured visiting room and tested telephone functionality
- Toured the Special Management Unit
- Inspected the law libraries
- Reviewed the facility schedule for the law library
- Inspected the recreation yards
- Reviewed the recreation schedule
- Reviewed the religious service area
- Reviewed detainee grievance logs for 2017 and 2018 (through date of review)
- Reviewed specific detainee grievances and responses
- Interviewed the grievance officer
- Reviewed detainee disciplinary reports
- Reviewed detainee requests made to ICE
- Reviewed the daily activity schedule
- Interviewed custody and program personnel regarding SAAPI/PREA, security, use of force, special management unit, disciplinary system, law library and legal access, religious access and services, recreation programs, grievance system, staff-detainee communication, investigations, contraband, visitation, suicide prevention policies, language access, telephone access, and mail
- Met with various ICE and ECJ staff during the course of the review
- Reviewed ECJ policies on:
    - Sexual Assault and Abuse Prevention and Intervention (PREA)
    - Admission and Release
    - Classification System
    - Detainee Housing
    - Orientation
    - Detention Files
    - Contraband
    - Visiting
    - Correspondence/Mail
    - Recreation
    - Housing
    - Use of Force
    - Taser
    - Grievance Procedures

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- Disciplinary Policy
- Detainee Handbook
- Staff and Detainee Communication
- Law Library/Inmate Advocate
- Staff Training
- Property
- Telephone Access
- Mental Health Services
- Religious Practices
- Special Management Unit

In the context of this report, a finding of "substantiated" refers to an allegation that was investigated and determined to have occurred; a finding of "not substantiated" refers to an allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred; and a finding of "unfounded" means an allegation that was investigated and determined not to have occurred. The Detainee name and alien number for the detainee described in this report is listed in Appendix A. The Staff name referred to in this report was provided to the Facility Administration and ICE for appropriate follow-up action.

VI. CONDITIONS OF DETENTION FINDINGS AND RECOMMENDATIONS

A. Excessive Use of Force, Staff Misconduct, Retaliation, Staff Detainee Communication, Grievance System Access

During this investigation I reviewed incident reports involving detainees during the period of January 2017 – March 2018. I interviewed over 40 detainees in two different groups. Group one consisted of detainees housed in units 4 and 7. Group two consisted of detainees housed in unit 9. Both groups, which were interviewed independently, raised complaints regarding disrespectful treatment and other concerns. I will address the specifics of the detainee concerns in the following sections. While I found conditions that contribute to the overall detainee-staff relations and treatment in the facility, I did not substantiate the specific use of force complaint associated with this investigation.

Complaint No. 17-09-ICE-0358

The June 10, 2017 daily report of force and sexual abuse incidents contained a report of a June 9, 2017 immediate use of force on Detainee #1, a Nigerian national housed at ECJ, during which he was tased and suffered a significant injury to the head resulting in a scalp laceration and knocking him unconscious, requiring transport and treatment at the Riverview Regional Medical Center. My investigation included reviewing the video footage of the use of force incident and subsequent incident reports. The June 9, 2017 Use of Force complaint involving the use of a taser was not substantiated; however, during the investigation it was apparent that additional training on safe use of tasers and evidence collection procedures is needed. The officer deployed the taser during the incident at the top of the staircase which resulted in the detainee sustaining a serious head injury when the detainee fell, knocking him unconscious. The officer yelled at the unconscious detainee to move. The detainee could not comply as he was unconscious and the use of the taser also temporarily immobilized him. The officer then threatened to taser the unconscious detainee again and subsequently moved the detainee

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who was still unconscious. The movement could have led to the detainee sustaining permanent physical injury of the neck and or spine. During the incident, the officer also directed another officer to put a cell phone that the detainee possessed in his pocket. This action does not comply with standard evidence collection protocols.

Grievance System

I reviewed the grievance system as part of this investigation. The NDS protects detainees' rights and ensures they are treated fairly by providing a procedure to file both informal and formal grievances and receive timely responses related to any aspect of his or her detention, including medical care. The grievance system is designed to act as an early warning system to the administration, so detainee issues can be resolved timely and at the lowest level possible. The NDS mandates that formal grievances are responded to within five days and a grievance decision appeal also be responded to within five days. ECJ's handbook states that "Staff will respond to the grievance after conducting an investigation *as soon as possible*." Per the NDS all formal non-emergency grievances must be initially responded to within five days. ECJ's policy requires a five-day response to the detainee's grievance; however, the ECJ Detainee Handbook is inconsistent with the written ECJ Detainee Grievance Procedure and the NDS. Additionally, the ECJ Detainee Grievance Procedure does not contain a five-day mandate for ECJ to respond to a detainee's grievance appeal which is required by the NDS. The introduction to each standard in the NDS specifically states that "within [this standard] additional implementing procedures are identified for [Service Processing Centers (SPCs)] and [Contract Detention Facilities (CDFs)]. Those procedures appear in italics. IGSA facilities may find such procedures useful as guidelines. IGSAs may adopt, adapt or establish alternatives to, the procedures specified for SPCs/CDFs, provided they meet or exceed the objective represented by each standard." ECJ's grievance procedure in the detainee handbook and ECJ's lack of a formal policy requirement to respond to a detainees' grievance appeal within five days are both violations of the NDS.

Beyond the issues identified above, the Grievance system at ECJ is compromised and does not comply with NDS. Policy and procedural changes were made to the grievance system at ECJ in November 2017. Detainees must ask a deputy and sergeant sign off on a grievance before the grievance can be submitted to the Grievance Officer. Grievances not following this process can be screened out by policy and not responded to by the Grievance Officer. The Grievance Officer was appointed to the position in December 2017 and correspondingly the number of grievances significantly decreased from November 2017 to March 30, 2018. Only two grievances satisfied the current requirements and were processed and logged during this five-month period as compared to over 200 during the previous 12-month period. The Grievance Officer only works part-time on grievance processing and that also contributes to the system difficulties as he does not have enough time to effectively complete the full array of duties required by the this position. Two groups of detainees reported during interviews that grievances were routinely not accepted or responded to and the detainees had no faith in the grievance system at ECJ. Detainee grievances also must be signed off by an officer and supervisor prior to submittal to the Grievance Officer. Without the signatures, the Grievance Officer can screen the grievance out by policy. The requirement to have two levels of review and supervisory sign off prior to submittal to the Grievance Officer is not required by NDS. This review process is having a chilling effect on detainee grievances as the detainees fear retaliation if they submitted a grievance. The NDS requires that each facility will maintain a detainee grievance log. Documentation in the log must include a grievance

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number, the receipt date of the grievance, and the date and disposition (outcome) of the grievance. ECJ's grievance log also does not comply with these NDS requirements. Additionally, the Grievance Officer was also unaware that ICE is to be notified of all detainee complaints against staff even though ECJ's Grievance Procedure requires it. In the past 15 months, there has not been any staff investigations related to detainee complaints, which does not seem plausible due to the size of the facility and number of detainees interviewed that had complaints, including staff complaints. Detainees reported during the group interviews that 33 detainees signed a group grievance regarding unjustified restrictions on free time and mistreatment by ECJ Officer #1. The ECJ security Captain and ICE were unaware of the grievance.

The NDS protects detainees' rights and ensures they are treated fairly by providing a procedure to file both informal and formal grievances and receive timely responses related to any aspect of his or her detention, including medical care. Another important aspect of the Detainee Grievance Procedure Standard is that detainees are protected from harassment, discipline, punishment, or retaliation for filing a complaint or grievance.

During interviews, detainees also described disrespectful and offensive language that some ECJ staff use when addressing them. The American Correctional Association's Adult Local Detention Facility Performance Based Standard 4-ALDF-6A-07 mandates that inmates [detainees] are not subjected to personal abuse or harassment.

During detainee group interviews, detainees reported ICE Detention Officer DO #1 was not routinely making rounds in the housing unit per the posted schedule and was also conducting rounds during a time that the detainees were on lockdown during count and they could not speak to him. The DO's name was provided to the SDDO, who had been previously been advised of the complaint.

Findings:

Complaint No. 17-09-ICE-0358 **is not substantiated.** The use of the taser was initially appropriate given the circumstances; however, the deputy deploying the taser failed to use the taser in conformance with standard operating protocols and endangered the physical safety of the detainee during and after the initial deployment. The deputy who deployed the taser also failed to follow standard evidence collection protocols. The performance of both deputies directly involved in the incident fail to comply with the NDS, Use of force, Section O, Training.

The ECJ grievance system logging, and grievance and appeal response policy and practice do not conform to the NDS and there is evidence to **substantiate** detainee claims that they suffer retaliation, verbal harassment, and disrespectful treatment by some ECJ staff.

The NDS, along with additional applicable guidelines, support the following recommendations:

Recommendations:

- The officer involved in the use of force I reviewed deployed his taser in a dangerous location, moved the detainee who was unconscious and immobilized and could have caused serious injury as a result to the detainee, and moved evidence without following appropriate evidence

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collection protocols. ECJ should provide officers additional training on the physical impacts of the use of taser and evidence collection protocols. (NDS, Use of Force, § III(O); ACA, 4-ALDF-6A-07) (Level 1)

- ECJ does not provide detainees with an effective working grievance system. The grievance officer position should be increased from a part-time to a full-time position and adequate training provided to the grievance officer. This will ensure that detainee grievances are processed within the NDS time-frame mandates. (NDS, Detainee Grievance Procedures , § III(A)(1) and (2)) (Level 1)
- The ECJ Grievance Log does not contain a consecutive log number, the disposition date and disposition of each detainee grievance. ECJ should add to the existing grievance log a consecutive logging number, the disposition (outcome) of the grievance and complete the disposition date for each grievance to ensure detainees receive a timely response to their grievance and grievance appeals and the outcome of each grievance is tracked. (NDS, Detainee Grievance Procedures, § III(E)) (Level 1)

B. Contraband, Security Inspections, Searches, Special Management Unit (Disciplinary Segregation)

I inspected all units currently housing detainees at ECJ. Units 4, 7 and 9 are currently used to house detainees at this facility.

Contraband

I observed significant and dangerous amounts of contraband in units 4, 7 and 9. The facility does not set property limitations by policy. I observed metal chairs in the individual detainee cells. This dangerous contraband could easily be used as weapon stock to assault detainees or staff. The cells had window coverings which prevented security staff from observing what activities were occurring inside the cells. Numerous unmarked bottles with large quantities of unknown liquids were in the cells. This liquid could be a harmful substance that could be used in an assault or bodily fluids that would also be dangerous to any staff or detainee who may be exposed to the substance during a gassing assault.[2] Sheets were hung from the upper bunk to conceal the opening between the upper and lower bund creating a safety hazard and security issue. Security could not observe what activity was going on behind the sheet covering on the lower bunk. Milk and excessive amounts of food were easily observed from outside the cells. ECJ's policy allows detainees to keep a reasonable amount of personal property in their possession. The policy does not define what a reasonable amount is. NDS, Contraband, Section III. A. states "soft contraband has the potential to create dangerous or unsanitary conditions in the facility such as excess papers that create a fire hazard, food items that are spoiled or retained beyond the point of safe consumption." The amount and type of contraband in the detainee cells created both unsafe and unsanitary conditions at this facility.

Security Inspections

[2] "Gassing" is a correctional term used to describe an assault on an officer by a detainee that involves the detainee throwing bodily fluids in some form at an officer.

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NDS, Security Inspections, Section III.A. identify "Security inspections are necessary to control the introduction of contraband, ensure facility safety, security, and good order, prevent escapes, maintain sanitary conditions and eliminate fire and safety hazards." Section III.D.5., Housing Units, requires "Every OIC will establish written policy and procedures for housing unit and personal area searches." Section III.D.5.c. mandates "Each housing unit, including the SMU, will document cell and area searches in a search log. The log will register the date, time, and findings, including location(s) where contraband is found, type(s) of contraband, and the searching officers' names." Contraband searches are not routinely conducted as mandated by NDS and no search log is maintained.

Special Management Unit (Disciplinary Segregation)

Unit 3 is the Special Management Unit at ECJ that has previously been used to house detainees on disciplinary segregation status. During my investigation that took place in 2012, I identified security, contraband, and safety issues with Unit 3. Observation of cells 304, 305 and 306, which have been used for detainee disciplinary segregation are observed only with a very poor-quality camera that observes the front of the cells with a very grainy screen located at the second-floor observation post and at a remote security post on the same floor but not connected to the unit. Detainee recreation takes place in the first-floor area in an unstaffed dayroom area directly outside the cell doors. In 2017, two detainees were allowed outside their cell in this unit and started a fire using their mattress, an authorized vaporizer cigarette that is sold in the commissary, oil, and other materials. The unit filled with smoke, and the fire department responded and put the fire out. This fire was able to occur due to the lack of effective security protocols, lack of direct and constant proximate security staff, failure to control contraband, and the selling of vaporizer cigarettes that can easily be transformed into an incendiary torch. Loss of life could have easily occurred. A relief officer maintains visual observation of the first-floor cells while the regular officer makes security rounds of the first-floor cells every 30 minutes. This security configuration does not provide adequate observation of the SMU including disciplinary cells 304, 305, and 306.

Cells 304, 305 and 306 also fail to meet the SMU NDS mandate of "The quarters used for segregation must be well ventilated, adequately lit, appropriately heated and maintained in a sanitary condition at all times." Unit 3 is unsafe for occupancy and the conditions are unsanitary. There is a hole in the wall between cells 304 and 305 that is the size of two fists. The cell call button is inoperable in cells 4, 5 and 6. The emergency all box is completely missing in the three cells used for detainees and there is a hole where the call device is supposed to be. Light fixtures are unsecure in all three cells. All required NDS postings are not posted in the unit, they are contained in a binder in the second-floor observation post that cannot be directly accessed by the detainees. Detainees must request the postings book from the observation post officer. Over 45 SMU detainee placements have occurred since May 2017. When I raised the safety and security concerns to the facility administration, ECJ management issued a memorandum placing a moratorium on the use of the SMU, Unit 3, for detainees. ECJ currently has a major capital improvement project that has been authorized to renovate and remediate the substandard facility conditions that exist at ECJ; however, this project will take a significant amount of time to complete. Loss of the use of Unit 3 for disciplinary segregation creates a placement issue for ECJ detainees serving a disciplinary detention sentence. ECJ had begun using Unit 7 for disciplinary detention. High Security Unit 9 detainees should not be placed in Unit 7 which houses medium and medium low detainees. I reviewed the disciplinary placement in the building and no placement order which is required by NDS within 24 hours of placement was available. Additionally, NDS SMU, III.E. mandates "A permanent log will be maintained in the SMU." The log is to record all activities concerning

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the SMU detainees, such as meals served, recreation, visiting, etc. The log is to be maintained for each week and an SMU file created for the duration of the detainee's stay in the SMU. The records are to be maintained in the mandated SMU file and then the records are to be filed in the detainee's detention file. ECJ does not maintain a separate log as mandated by NDS nor does staff record these activities in the detainees' electronic file. Lack of completing the disciplinary lock up order within 24 hours and failure to maintain a special housing unit record of activities were also findings during my 2012 investigation. This is standard correctional practice throughout the country.

Findings:

ECJ is placing the safety of detainees and staff at risk by the enormous volume of uncontrolled contraband that exists throughout the facility is **substantiated.**

ECJ's SMU, Unit 3, cannot safely be used to house detainees serving disciplinary detention sentences **is substantiated.**

ECJ continues to violate detainee disciplinary due process and does not comply with the mandates in the NDS, SMU Disciplinary Segregation **is substantiated.**

The NDS, along with additional applicable guidelines, support the following recommendations:

Recommendations:

- ECJ is placing the safety of detainees and staff at risk by the enormous volume of uncontrolled contraband that exists throughout the facility. ECJ must search all detainee cells. All excess property must be removed from cells and detainees should be allowed to mail any excess property home. All contraband should be seized and disposed of to eliminate detainee and staff safety and security concerns and be in compliance with NDS. (NDS, Contraband, § III(A)) (Level 1)
- ECJ is placing the safety of detainees and staff at risk by the enormous volume of uncontrolled contraband that exists throughout the facility. ECJ should create a property limit policy and revise the security policy to mandate routine cell and contraband searches to eliminate excess property and to address safety and security concerns. (NDS, Contraband, § III(A), and Security Inspections, § III(A) and III(D)(5)) (Level 1)
- ECJ is not compliant with the NDS requirements regarding conducting security inspections and maintaining a corresponding log. ECJ should mandate that security staff perform routine cell searches for contraband and create a cell search log. (NDS, Contraband, § III(A), and Security Inspections, § III(A) and III(D)(5)) (Level 1)
- ECJ should remove vaporizer cigarettes from the commissary to eliminate fire safety threats for detainees and staff. (NDS, Environmental Health and Safety, § III(L)(3)(a); ACA, 4-ALDF-1C-08, 4-ALDF-1C-11) (Level 1)
- ECJ's SMU, Unit 3, cannot safely be used to house detainees serving disciplinary detention sentences. ECJ should continue to not utilize Unit 3 for Disciplinary Segregation until physical plant modifications to address safety, security and environmental deficiencies are corrected. (NDS, SMU, Disciplinary Segregation, § III(D)(6)) (Level 1)
- ECJ is not providing detainees in the SMU, Disciplinary Segregation, with adequate due process rights. ECJ should ensure the mandated disciplinary segregation placement order is provided to

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detainees within 24 hours of placement in disciplinary segregation. (NDS, SMU, Disciplinary Segregation, § III(B)) (Level 1)

- ECJ is not maintaining the mandated segregation records and SMU file for detainees housed in the SMU. ECJ should maintain the mandated activity records and the SMU file for each detainee held in segregation for the duration the detainee is housed in the SMUs. (NDS, SMU, Disciplinary Segregation, § III(E)) (Level 1)

C. Language Access

I reviewed the language access at this facility as part of this investigation. There were no open language access complaints at the time of investigation; however, during interviews of two groups of detainees which included detainees who are limited English proficient (LEP), the detainees reported language access issues.[3] LEP detainees reported being required to sign documents in a language they did not understand. All forms in the files I reviewed were completed in English. A review of detainee files indicated that detainees who were or appeared to be Spanish speakers based on requests they had written in Spanish had signed forms written in English, with no indication of interpretation or translation assistance. Detainees I interviewed reported that LEP detainees were required to sign documents that were written in English and that language line interpretation assistance was not provided. ECJ staff report that there is only one bilingual Spanish speaking staff member at the facility. Detainees also reported medical and mental health staff consistently use detainees as interpreters which requires detainees to disclose personal healthcare information in front of other detainees. "I-Speak" posters that can help literate LEP detainees identify their preferred language were not posted in some key areas of the facility.

ECJ and ICE do not currently comply with providing language access to LEP detainees. Under federal civil rights law and DHS policy, LEP detainees must be provided meaningful access to information, programs, and services within ICE detention. Title VI of the Civil Rights Act of 1964 (Title VI); Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, 65 Fed. Reg. 50,121 (Aug. 11, 2000); Department of Homeland Security Language Access Plan, February 28, 2012; and U.S. Immigration and Customs Enforcement Language Access Plan, June 14, 2015 mandate language access for individuals held in detention. This obligation includes providing access to competent interpretation (oral) and translation (written) services for a wide range of interactions and programs covered by the ICE standards, such as Admission and Release, Custody Classification, Sexual Abuse and Assault Prevention and Intervention, Special Management Units, Staff-Detainee Communication; Disciplinary System; Medical and Mental Health Care; Suicide Prevention; Detainee Handbook; Grievance System; and Law Library and Legal Materials. Furthermore, not only is this a legal requirement, but a failure to provide appropriate language services can impact the safety of detainees and staff and undermine the facility's compliance with detention standards and its own processes and procedures. ECJ's and ICE's contractual obligations require them to provide meaningful language access for residents.

ICE and ECJ staff do not consistently provide oral interpretation through Language Line or translate official documents from English to other languages for LEP detainees. LEP detainees are required to sign

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[3] CRCL staff and I conducted these interviews with the assistance of a qualified Spanish language interpreter.

documents that they do not understand, which undermines the validity of the documents and purpose of having detainees sign documents. Detainees may violate the rules because they do not understand what the rules are due to a lack of appropriate language access.

Findings:

ECJ fails to provide meaningful access for LEP detainees in compliance with the DHS and ICE language access plans and other requirements **is substantiated.**

The applicable requirements support the following recommendations:

Recommendations:

- ECJ records indicate that language access resources are not frequently used to assist LEP detainees. ECJ should provide training to its staff on their obligations to provide meaningful access to LEP detainees and the resources that are available to assist them meet this obligation and should document provision of this training. (DHS and ICE Language Access Plans) (Level 1)
- ECJ records indicate that language access resources are not frequently used to assist LEP detainees. ECJ should develop a Language Line logging system and require all facility staff to regularly record its use by date, alien number, and language of interpretation. Documenting Language Line usage is essential to validating compliance with language access obligations. (DHS and ICE Language Access Plans) (Level 2)
- ECJ records indicate that language access resources are not frequently used to assist LEP detainees, and forms and other materials contained in detainee files are written in English without any indication of translation or interpretation assistance. To ensure that ECJ complies with the arrival screening requirements in the Admission and Release standard including official forms that are signed by LEP detainees and informational postings throughout the facility are understood, ECJ should ensure the use of qualified interpreters or professionally translated forms and informational postings to ensure meaningful access for LEP detainees. (DHS and ICE Language Access Plans) (Level 1)

D. Legal Access

Law Library

I reviewed the law libraries and access to legal material as part of this investigation. I inspected the law library and Lexis-Nexis sites, interviewed detainees using the Lexis-Nexis computers, reviewed the law library schedule posted in each housing unit, and interviewed detainees regarding law library access. There is a sufficient number of computers in the law library locations to provide detainee access to Lexis-Nexis. The Lexis-Nexis software updates are routinely completed. The computers and printers are maintained in working order. Only two reams of paper are provided per week for the printers. Detainees must wait to print legal material if the two reams of paper supply is exhausted before the weekly replenishment date. The Access to Legal Material NDS mandates that "The law library shall provide an adequate number of typewriters and/or computers, writing implements, paper, and office supplies to enable detainees to prepare documents for legal proceedings."

Findings:

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The two-ream paper restriction for the legal printers does not comply with the NDS requirement to provide adequate paper supplies to prepare for legal proceedings **is substantiated.**

The NDS, along with additional applicable guidelines, support the following recommendations:

Recommendations:

- ECJ is not providing sufficient printer paper in the law libraries to enable detainees to prepare for legal proceedings. ECJ should remove the two reams of paper weekly restriction per each law library and ensure each printer has sufficient paper available to ensure detainees can prepare for legal proceedings. (NDS, Access to Legal Material, §III(B)) (Level 2)

E. Recreation Access

While onsite I reviewed recreation access at this facility. I interviewed detainees and inspected the recreational area. Recreation time provided to detainees exceeds the NDS requirements. Detainees had no complaints regarding recreational access except for the previously addressed staff complaint regarding the officer unilaterally restricting recreation access without a legitimate reason.

Findings:

- None

F. Telephone Access

During the group detainee interviews, detainees reported adequate telephone access. Detainees complained of the high cost of the telephone rates, but the telephone equipment was in working order and adequately maintained. It is my understanding that the ECJ telephone rates are consistent with allowable amounts approved by ICE. Telephone free number listings were not consistently located near the telephones. In some instances, the telephone free number listings were placed on a different floor than the telephones in the housing unit.

Findings:

Mandated telephone number postings were not located in proximity to the detainee telephones creating difficulty for detainees to obtain consulate, OIG, and other free telephone numbers **is substantiated.**

The NDS, along with additional applicable guidelines, support the following recommendations:

Recommendations:

- Mandated telephone number postings were not located in proximity to the detainee telephones. ECJ should place the free telephone number postings near the detainee telephones for access to required information. (NDS, Telephone Access, § III(B)) (Level 2)

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G. Sexual Abuse and Assault Prevention and Intervention (SAAPI)/PREA

I reviewed ECJ's SAAPI/PREA program during the onsite investigation. I interviewed the onsite PREA Coordinator and inspected postings throughout the facility. I also reviewed the PREA/SAAPPI policy. The PREA/SAAPI Coordinator has never received any formalized PREA Coordinator training. He has only received sexual assault investigator training. The PREA Coordinator should not be the PREA investigator as it is a conflict of interest given the oversight and implementation role of the coordinator. The current PREA/SAAPI policy is written to conform to the PBNDS 2008. The current ICE policy regarding PREA/SAAPI is PBNDS 2011, Standard 2.11. There are pieces of a PREA/SAAPI program in place at the facility; however, there needs to be a decision since the facility is operated under a U.S. Marshals rider whether the facility will comply with the U.S. Department of Justice PREA Standards or ICE's PBNDS 2011, Standard 2.11. At present, ECJ does not have a sexual abuse prevention program in place that complies with the requirements of either the DOJ or DHS PREA standards, which poses significant risks for detainees and the facilities, and must be clarified and corrected. If possible, I recommend ICE and the facility agree to bring the facility under Standard 2.11 and have the facility participate in ICE's SAAPI and PREA program, including regular PREA audits. In addition, the ECJ policy and Detainee Handbook should be updated with the correct PREA/SAAPI definitions and a comprehensive program put together that fully complies with all aspects of PREA/SAAPI. It should be noted that even with the identified deficiencies, detainees at this facility feel safe from sexual assault and sexual harassment, but this is no substitute for a complete and fully compliant sexual abuse prevention program.

Findings:

ECJ's PREA/SAAPI Coordinator is not adequately trained is **substantiated.**

ECJ's PREA/SAAPI policy and program does not meet the requirements of the PBNDS 2011, 2.11 SAAPI is **substantiated.**

My findings support the following recommendations:

Recommendations:

- ECJ's PREA/SAAPI Coordinator is not adequately trained his duties related to PREA. ECJ's PREA/SAAPI Coordinator should attend PREA/SAAPI Coordinator training. (PBNDS 2011, SAAPI) (Level 1)
- ECJ does not have a sexual abuse prevention program in place that complies with the requirements of either the DOJ or DHS PREA standards, which poses significant risks for detainees and the facilities, and must be clarified and corrected. ICE and ECJ should enter into a contract modification that clearly identifies which SAAPI/PREA standards ECJ is to meet and mandate ECJ comply with all elements of the identified standards. I recommend that ICE and the facility agree to bring the facility under Standard 2.11 and have the facility participate in ICE's SAAPI and PREA program, including regular PREA audits. (PBNDS 2011, SAAPI or DOJ PREA Standards) (Level 1)

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VII. SUMMARY OF ECJ RECOMMENDATIONS

Regarding the specific deficiencies I found as part of my review of ECJ, I make the following recommendations:

- The officer involved in the use of force I reviewed deployed his taser in a dangerous location, moved the detainee who was unconscious and immobilized and could have caused serious injury as a result to the detainee, and moved evidence without following appropriate evidence collection protocols. ECJ should provide officers additional training on the physical impacts of the use of taser and evidence collection protocols. (NDS, Use of Force, § III(O); ACA, 4-ALDF-6A-07) (Level 1)
- ECJ does not provide detainees with an effective working grievance system. The grievance officer position should be increased from a part-time to a full-time position and adequate training provided to the grievance officer. This will ensure that detainee grievances are processed within the NDS time-frame mandates. (NDS, Detainee Grievance Procedures , § III(A)(1) and (2)) (Level 1)
- The ECJ Grievance Log does not contain a consecutive log number, the disposition date and disposition of each detainee grievance. ECJ should add to the existing grievance log a consecutive logging number, the disposition (outcome) of the grievance and complete the disposition date for each grievance to ensure detainees receive a timely response to their grievance and grievance appeals and the outcome of each grievance is tracked. (NDS, Detainee Grievance Procedures, § III(E)) (Level 1)
- ECJ is placing the safety of detainees and staff at risk by the enormous volume of uncontrolled contraband that exists throughout the facility. ECJ must search all detainee cells. All excess property must be removed from cells and detainees should be allowed to mail any excess property home. All contraband should be seized and disposed of to eliminate detainee and staff safety and security concerns and be in compliance with NDS. (NDS, Contraband, § III(A)) (Level 1)
- ECJ is placing the safety of detainees and staff at risk by the enormous volume of uncontrolled contraband that exists throughout the facility. ECJ should create a property limit policy and revise the security policy to mandate routine cell and contraband searches to eliminate excess property and to address safety and security concerns. (NDS, Contraband, § III(A), and Security Inspections, § III(A) and III(D)(5)) (Level 1)
- ECJ is not compliant with the NDS requirements regarding conducting security inspections and maintaining a corresponding log. ECJ should mandate that security staff perform routine cell searches for contraband and create a cell search log. (NDS, Contraband, § III(A), and Security Inspections, § III(A) and III(D)(5)) (Level 1)
- ECJ should remove vaporizer cigarettes from the commissary to eliminate fire safety threats for detainees and staff. (NDS, Environmental Health and Safety, § III(L)(3)(a); ACA, 4-ALDF-1C-08, 4-ALDF-1C-11) (Level 1)
- ECJ's SMU, Unit 3, cannot safely be used to house detainees serving disciplinary detention sentences. ECJ should continue to not utilize Unit 3 for Disciplinary Segregation until physical plant modifications to address safety, security and environmental deficiencies are corrected. (NDS, SMU, Disciplinary Segregation, § III(D)(6)) (Level 1)
- ECJ is not providing detainees in the SMU, Disciplinary Segregation, with adequate due process rights. ECJ should ensure the mandated disciplinary segregation placement order is provided to

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detainees within 24 hours of placement in disciplinary segregation. (NDS, SMU, Disciplinary Segregation, § III(B)) (Level 1)

- ECJ is not maintaining the mandated segregation records and SMU file for detainees housed in the SMU. ECJ should maintain the mandated activity records and the SMU file for each detainee held in segregation for the duration the detainee is housed in the SMUs. (NDS, SMU, Disciplinary Segregation, § III(E)) (Level 1)
- ECJ records indicate that language access resources are not frequently used to assist LEP detainees. ECJ should provide training to its staff on their obligations to provide meaningful access to LEP detainees and the resources that are available to assist them meet this obligation and should document provision of this training. (DHS and ICE Language Access Plans) (Level 1)
- ECJ records indicate that language access resources are not frequently used to assist LEP detainees. ECJ should develop a Language Line logging system and require all facility staff to regularly record its use by date, alien number, and language of interpretation. Documenting Language Line usage is essential to validating compliance with language access obligations. (DHS and ICE Language Access Plans) (Level 2)
- ECJ records indicate that language access resources are not frequently used to assist LEP detainees, and forms and other materials contained in detainee files are written in English without any indication of translation or interpretation assistance. To ensure that ECJ complies with the arrival screening requirements in the Admission and Release standard including official forms that are signed by LEP detainees and informational postings throughout the facility are understood, ECJ should ensure the use of qualified interpreters or professionally translated forms and informational postings to ensure meaningful access for LEP detainees. (DHS and ICE Language Access Plans) (Level 1)
- ECJ is not providing sufficient printer paper in the law libraries to enable detainees to prepare for legal proceedings. ECJ should remove the two reams of paper weekly restriction per each law library and ensure each printer has sufficient paper available to ensure detainees can prepare for legal proceedings. (NDS, Access to Legal Material, §III(B)) (Level 2)
- Mandated telephone number postings were not located in proximity to the detainee telephones. ECJ should place the free telephone number postings near the detainee telephones for access to required information. (NDS, Telephone Access, § III(B)) (Level 2)
- ECJ's PREA/SAAPI Coordinator is not adequately trained his duties related to PREA. ECJ's PREA/SAAPI Coordinator should attend PREA/SAAPI Coordinator training. (PBNDS 2011, SAAPI) (Level 1)
- ECJ does not have a sexual abuse prevention program in place that complies with the requirements of either the DOJ or DHS PREA standards, which poses significant risks for detainees and the facilities, and must be clarified and corrected. ICE and ECJ should enter into a contract modification that clearly identifies which SAAPI/PREA standards ECJ is to meet and mandate ECJ comply with all elements of the identified standards. I recommend that ICE and the facility agree to bring the facility under Standard 2.11 and have the facility participate in ICE's SAAPI and PREA program, including regular PREA audits. (PBNDS 2011, SAAPI or DOJ PREA Standards) (Level 1)

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CRCL ETOWAH COUNTY JAIL INVESTIGATION

APPENDIX A

Detainee Name - A Number

Staff Names

Detainee #1 (b)(6)

Staff

ECJ (b)(6)

ICE Detention Officer (DO) (b)(6); (b)(7)(C)

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