Date **August 6, 2019**

To: (b)(6)
Policy Advisor
Office for Civil Rights and Civil Liberties
U.S. Department of Homeland Security

From: (b)(6) **RN, MN, CCHP-RN**
Medical Expert

Subject: **Onsite Investigation of the York County Prison (YCP) - July 29, 2019**

Introduction

Department of Homeland Security Office for Civil Rights and Civil Liberties (DHS/CRCL) has received allegations of violations of detainee's civil rights and civil liberties at the York County Prison (YCP) in York, Pennsylvania. The purpose of the onsite investigation was to determine if allegations in the complaints could be verified or disproven; whether the facts suggest violation of laws or Departmental policies; and what steps if any, ICE should take to address the complaints, both individually (if the problem is ongoing) and as a matter of policy. We also evaluated the general operation of the facility in relation to the Performance-Based National Detention Standards 2008 (PBNDS 2008). The onsite took place July 29-31, 2019 and was conducted by CRCL Policy Advisors (b)(6) The subject matter experts were myself as CRCL's medical expert and (b)(6) CRCL's conditions of detention expert. I was on site only for one day, July 29, 2019, therefore my review focused on the allegations regarding medical care, use of force and Sexual Assault and Abuse Prevention Intervention (SAAPI) cases listed in the retention memo, dated June 11, 2019. I participated by telephone at the exit conference, held on July 31, 2019.

Expert Qualification:

(b) (6)

List of Materials Reviewed[1]

- The medical file of 24 detainees listed in Appendix 1.
- Complaint filed by (b)(6) (18-11-ICE-0608)
- ICE Significant Incident Report for (b)(6) dated July 18, 2019
- Complaint filed by (b)(6) (19-08-ICE-0328)
- List of health care positions, shift allocations, and number of positions filled or vacant.
- Grievance Log from March 9, 2018 through April 22, 2019.
- ICE Uniform Corrective Actions Plans for YCP in 2017 and 2018.

Onsite Investigation

Description of the Medical and Mental Health Program

YCP's medical and mental health care is provided by Prime Care Medical, Inc, a private for-profit company, specializing in providing health care services to correctional facilities in the northeastern part of the United States. Pharmacy services are contracted to BosWell and managed by a pharmacy technician at YCP; prescription medications are delivered daily. According to the Health Services Administrator (HSA), the facility health care program is accredited by the National Commission on Correctional Health Care (NCCHC). The last accreditation site visit was in 2017. YCP's medical staffing consists of a HSA, who is the designated Health Authority; a Medical Director, who works 25 hours a week[2]; three and a half primary care providers (PCP). The medical staffing also has three medical record technicians and an electronic medical record (EMR) is used. The mental health program is managed by a licensed psychologist and staffed with a part time psychiatrist (8 hours per week); 1 FTE psychiatric nurse practitioner (NP) (filled by two NPs); 4 licensed mental health providers and two psychiatric technicians. YCP's dental program includes one full time dentist and dental assistant. There is also an oral surgeon who consults at the facility as needed.

Nursing services are available every day and every shift (day, evening and night shifts[3]) at YCP. These staff are managed by a Director of Nursing (DoN) and two Assistant Directors of Nursing (one on day and one on evening shift). There are 10.6 FTE registered nurses (RNs), 20 FTE licensed practical nurses (LPNs) and 13.2 certified medical assistants (CMAs). There are 8.6 vacant positions amongst the nursing staff (22%). Amongst RNs 3.6 FTE are vacant, amounting to a 34% vacancy rate.

The minimal coverage requirements for RNs and LPNs is six on duty on day and evening shift and two on duty during the night shift. At least one RN is on duty each shift and identified as the "charge nurse" responsible to see any detainee brought to the clinic and to back up other staff as

[1] Of 17 items related to medical care that were requested for review prior to the site visit only two were provided in whole and two were provided in part.
[2] Staffing information in this paragraph is from a table of filled and vacant positions that was provided by the facility in advance of the site visit.
[3] For nursing, a day consists of three 8-hour shifts.

necessary. On day and evening shifts, five nursing staff are assigned to administer medication, conduct sick call and if an RN, complete the 14-day health appraisal required by the PBNDS 2008. Both LPNs and RNs conduct sick call. Except for the 14-day health appraisal and the "charge nurse" designation, there is no distinction between the scope of practice for RNs and LPNs. Regarding sick call, it is not apparent that LPNs communicate with a RN when the focused nursing assessment indicates that the detainee's condition is deteriorating, not responding to therapy, or is unstable, as outlined in the state nurse practice act[4]. A best practice to ensure compliance with the state nurse practice act and the PBNDS 2008[5], which indicates the establishment of a mechanism to document the LPNs communication with an RN when the focused assessment indicates that the detainee's condition is deteriorating, not responding to therapy, or is unstable.

The staffing roster was reviewed for July 3, 2019 through July 11, 2019 and actual staffing met or exceeded the minimum coverage levels defined by the staffing plan. There were only two double shifts out a total of 27 shifts. The Assistant DoN advised that there are several part time staff who are willing to pick up additional shifts so achieving minimum coverage without using double shifts is easy to accomplish. It appears that services are not adversely affected by the vacancy rate amongst nursing positions.

During the onsite, I also toured the medical area. I did not find any issues with the space or organization of the clinic. The controlled substance count was accurate; medications are administered from patient specific, unit dose packages; emergency equipment was adequate and readily available and infection control appeared from a brief review to be consistent with PBNDS 2008 standards.

Mental health (MH) services are available on-site from 6:30 am until 8:00 pm, Monday through Friday, and on weekends from 6:00 am until everyone is seen, as scheduled. I talked with several patients in the mental health area. It was evident that the MH Director has a good rapport with MH patients. No issues with MH services and the PBNDS2008 standards were identified, except the practice of having a psychiatric provider ordering the use of the restraint chair for custody-initiated restraint (to be discussed later in this report and a recommendation made).

I also interviewed the facility training manager. All staff receive First Aid and CPR training and Suicide Prevention Training annually. Curriculum for both these courses were reviewed. These are generic programs that, while adequate, do not include specific information about related procedures at the facility. A best practice would be to modify this curriculum to more closely match the needs for training of facility staff. Virtually no training is provided for correctional officers on the housing units in basic mental health conditions and how to work effectively with mentally disordered detainees. Of approximately 450 facility employees only 16 staff were trained in 2018 in Mental Health First Aid which is only offered once a year and hasn't taken place yet in 2019. Only 27 staff have been trained in Crisis Intervention and 12 more are on the waiting list. A best practice is to have at least 80% of line correctional officers knowledgeable and competent to work with mentally ill offenders.

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[4] Pennsylvania Code 21.145 (a) (1) (iii) accessed 8/4/2019 at https://www.pacode.com/secure/data/049/chapter21/s21.145.html

[5] 2008 PBNDS V. Expected Practices, B. Designation of Authority

Complaints:

Complaint No. 18-11-ICE-0608: In a letter to the DHS OIG[6], dated July 6, 2018, detainee (b)(6), alleged he received inadequate medical care for a shoulder injury and herniated disc. Additionally, (b)(6) stated, that on July 26, 2018, a YCP officer discussed his medical care with medical staff in his absence and then refused to provide him with a grievance form to address the violation of his medical privacy. In a grievance submitted by (b)(6) he was requesting permission to rest on a lower bunk because of a shoulder injury and an ongoing problem with a disc in his back. The complaint alleges that the officer called medical and was told that they would not see him because he refused to have a chest x-ray earlier in the day.

Findings: (b)(6)'s allegations were not substantiated. At intake on June 26, 2018, the detainee was noted to have a bad disc at L-5 but had no mobility restrictions. The detainee did not identify that he had a shoulder injury. The detainee did not request accommodation or medical attention for the bad disc or a shoulder injury. There is no documentation in the record that the detainee refused to have a chest x-ray done. A chest x-ray was ordered for June 27, 2018, but the detainee had been released from the facility by that time. There is no documentation of a call to medical by an officer or other request for care during the short time the detainee was held at YCP.

Evaluation of medical and mental health response to detainees who allege sexual assault or are involved in use of force incidents.

A disproportionate number of sexual assault and use of force incidents were reported at YCP in FY19[7]. The medical records of all detainees alleged to have been involved in a sexual assault or use of force to date in FY19 were reviewed for compliance with PBNDS 2008 standards. The results of the medical record review follow in the paragraphs below.

Incidents involving Use of Force

1. (b)(6)

Description of the incident: On April 27, 2019, the detainee was brought to medical after injuring his hands. His hand was scratched when the wicket was closed on his hands after refusing to remove them from the wicket. He was assessed by an RN as having a scratch on his left elbow and a reddened area on his left index finger. The detainee also had declared a hunger strike but was drinking water and eating intermittently. The detainee refused the officer's orders to leave the clinic and became combative. A physician's order was obtained, and he was placed in the Emergency Restraint Chair (ERC) at 1850. When the detainee was released at 2020, he was placed on constant suicide precaution watch until April 29, 2019.

[6] The detainee was removed on June 26, 2018 so the complaint was not referred to ICE as a medical referral.
[7] York Retention Memo dated June 11, 2019.

Findings: Health care, including mental health care was timely and appropriate. All required checks were completed timely (while in restraint, on suicide watch and while in segregation). This detainee was seen frequently by the MH staff for ongoing behavioral issues. The first shift of constant suicide watch documentation was at regular 15-minute intervals rather than staggered. Best practice would be to review documentation expectations with the officer responsible for the first shift of constant observation on April 27, 2019. Documentation requirements for medically ordered restraints were not met[8].

2. (b)(6)

Description of the incident: On February 16, 2019, the detainee refused officer commands and was non-compliant during a search of the housing unit. Officers used a hard take down to gain control of the detainee.

Findings: Medical and mental health care was timely and appropriate. The detainee was brought to medical immediately after the incident and the nurse's assessment of potential injury was appropriate and complete. The detainee verbalized suicidal intent during this nursing encounter and was placed on constant suicide watch. The second day suicide watch was reduced to intermittent and on the third day it was discontinued. The detainee was seen by MH at appropriate intervals after release from suicide watch (1 day, 72 hours and 1 week). The detainee is on the MH caseload and seen regularly.

3. (b)(6)

Description of the incident: On February 16, 2019, the detainee refused officer commands and was non-compliant during a search of the housing unit. Officers used a hard take down to gain control of the detainee. The detainee was taken to the emergency department for evaluation of injuries and upon return to the facility refused to comply with officer's orders and was placed in the ERC until cleared by medical staff.

Findings: Medical and mental health care was timely and appropriate. The detainee was evaluated immediately after the first use of force incident (1050). The nurse completing the evaluation noted that the detainee had surgical repair of a rectal fistula two days earlier. The detainee complained of pain in his forearm. The nursing evaluation was appropriate. Shortly after this encounter, the detainee was placed in the ERC for refusal to follow officer's orders.

At 1305 the provider was called, and orders were received to transport the detainee to the emergency room to evaluate the injury to his arm and complaints of pain at the surgical site. The detainee returned at 1608 and the nurse noted that the emergency room found no fracture or other injury of the detainee's arm and his surgical site was unchanged. There were no recommendations for further procedures or treatment. At 1723 the detainee was placed in the ERC again for refusal to follow orders and removed at 1837. At this time, he was released back to his cell. This detainee is on the MH caseload and seen regularly.

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[8] PBNDS 2008 Medical Care, V. K. 6. Restraints: documentation of efforts to use less restrictive alternatives and an after-incident review to identify areas of needed improvement in use of restraints and patient specific treatment interventions to reduce the likelihood of restraint in the future.

The same concerns are raised in this case about not obtaining a provider order for use of the ERC if the restraint is for custody, rather than treatment purposes. If restraint is for treatment purposes PBNDS 2008 for documentation of less restrictive interventions and an after-incident review must be met.

4. (b)(6)

Description of the incident: (b)(6) reported in a complaint to CRCL[9] that he sustained injuries following an alleged use of force incident on December 23, 2018. He claimed that an officer grabbed him "roughly" to see his armband during count. (b)(6) stated, "I tell him ask me to show you my armband, but don't grab my hand like that." Allegedly, the officer told him to sit in the hallway then repeatedly pushed him on his back. (b)(6) reportedly asked what the officer's problem was and the officer responded with profanity, then threw him on the ground. (b)(6) alleged that he has not been provided with proper medical care for pain in his left and right legs, chest and back.

Findings: Medical attention and care immediately following the use of force was appropriate and timely. Medical care beginning the end of January is problematic. Sick call requests dated January 25, 2019, February 8, 2019 and March 15, 2019, all relating to ongoing pain in the detainee's chest, back and leg, were triaged but there is no documentation that the detainee was seen timely for the complaint. While he has seen providers on several occasions no one has taken a full history of his complaints or documented a thorough exam, especially in light of his ongoing symptoms. His last provider visit was on April 26, 2019 and the plan was to schedule a follow up provider visit in three weeks (May 17, 2019). This follow up visit has not yet taken place. He was seen in the clinic by a nurse on May 13, 2019 for chest pain. This assessment was incomplete. The detainee needs to have a thorough work up documented in the medical record and a comprehensive plan of care to address his complaints of his pain in the chest, back and leg developed.

5. (b)(6)

Description of the incident: (b)(6) was in a fight with another detainee on July 17, 2019. He was brought to medical immediately after the fight was broken up. The evaluation documented injuries to left shoulder and mouth. The provider was contacted and ordered transport to emergency room for evaluation and treatment.

Findings: The initial medical evaluation was timely and appropriate. Subsequent care following the evaluation at the emergency room was appropriate. The detainee returned to the facility at 2304 the evening of the fight with a diagnosis of a fractured facial bone near the sinus. No recommendations for further treatment were made by the emergency room except follow up with primary care provider. (b)(6) was placed in medical observation with 15-minute checks by officers and nursing evaluation at least once per shift. Five days later he was released from medical observation. He was seen by a provider to review the findings from the emergency room.

[9] 19-08-ICE-0328 (b)(6)

SAPPI Reports

1. (b)(6)

Description of the incident: On March 28, 2019 (b)(6) (victim) reported that (b)(6) (perpetrator) asked him for a hug while he was laying on his bunk. Both were fully clothed and there was no sexual contact. He alleged that Mr. (b)(6) had harassed him the last several days.

Findings: Medical and mental health involvement after the reported incident were prompt and appropriate. Both detainees met with medical and MH staff the day the incident was reported. (b)(6) (victim) had no mental health concerns or symptoms of trauma. He was offered another housing location, which he declined. (b)(6) (perpetrator) stated that he came from a "huggy" culture. He also had no mental health concerns. He was advised that the behavior was inappropriate. There were no further incidents reported concerning (b)(6)

2. (b)(6)

Description of the incident: The victim (b)(6) was sleeping when (b)(6) got into his bed and started jerking on his arm and the victim touched the other detainee's penis. Both detainees were fully clothed. The incident was said to have taken place the morning of April 19, 2019 but was not reported until late that same day.

Findings: Medical and mental health involvement after the reported incident was prompt and appropriate. The victim was seen by medical at 0200 April 20, 2019 shortly after reporting the incident. The victim reported no injuries but was being teased by other inmates in the dorm and he was now reminded of childhood sexual abuse. He requested to see Mental Health. Mental health staff saw the detainee on April 22, 2019 for an evaluation and to provide therapy to address previous childhood abuse and to discuss housing options. (b)(6) chose to return to the kitchen dorm and his job in the kitchen. He was seen again by Mental Health the next day and provided with suggestions to improve his ability to sleep. He saw Mental Health staff on several more occasions before leaving the facility. He was placed on suicide watch on May 13, 2019 after he refused orders to relocate from the kitchen dorm in preparation for deportation. He was evaluated and counseled by Mental Health staff while on suicide watch and for the 30 day follow up period.

The perpetrator, (b)(6) was evaluated by medical staff prior to placement in administrative segregation. No injuries were noted. He stated that he was playing; that he grabbed the other detainee's hand and stroked up and down. He was fully clothed at the time. This detainee is followed regularly by Mental Health staff and treated by the psychiatric providers. He was seen by the psychiatric nurse practitioner on April 22, 2019 and his psychotropic medication for anxiety, adjusted.

Review of health care provided detainees who grieved or complained about health care during the site visit.

The health care records of an additional 15 detainees were reviewed to evaluate whether there were any trends indicating systemic problems in health care delivery. Nine records were selected from a list of 332 grievances about medical care received by the facility between May 1, 2018 and April 8, 2019. During the site visit, interviews with detainees yielded several complaints about health care including failure to address sick call requests timely, if at all, not addressing the medical issue and treating all problems with ibuprofen, and failure to appropriately use translation services. Five additional medical records were selected for review based upon the on-site tour and interviews. The health records of the detainees who were the subject of allegations in the retention memo were reviewed as well to determine if there were systemic issues in the delivery of health care.

The record review did identify several systemic problems with health care delivery. Each is discussed in the following paragraphs.

Failure to respond to sick call requests timely, if at all.

Findings: Nearly half of all medical records reviewed contained requests with no documentation that the detainee's complaint was assessed in nursing sick call or in one case the assessment was not timely[10]. See also earlier in this report, (b) (6) , who was not seen timely for sick call requests dated January 25, 2019, February 8, 2019 and March 15, 2019. One of the expected outcomes of the PBNDS 2008 is that "Detainees will receive timely follow up to their health care requests."[11] The HSA indicated that the facility was accredited by the NCCHC and that practices met the 2018 standards. These standards require a face to face encounter with a health care professional within 24 hours of receiving a request for health care[12]. The chart review found numerous examples of health care requests for which there was no corresponding documentation of an encounter with a health care professional. This is a systemic failure to timely follow up requests for health care per the 2008 PBNDS.

Recommendation: Track all health care results on a log which includes the date the complaint was written, the date it was received, the date the request was triaged, the nature of the complaint, when the detainee was seen in response to the complaint, and the outcome of the encounter (referred to a provider, treated by nursing protocol, educated or coached in self-care etc.). Audit the EMR to ensure that each encounter is documented in the medical record and monitor the log to ensure that it is current, that all requests are logged, and all requests are seen. There should be a written request for care, the request should be signed and dated indicating review, and an encounter with the detainee addressing the request documented in the EMR.

Failure to ensure treatment refusals are observed.

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[10] (b) (6) 5/20/2019 & 5/23/2019; (b) (6) 3/5/2019 & 3/24/2019; ((b) (6) , 2/2/2019 & 2/25/2019; ((b) (6) 5/30/2018 & 12/24/2018; ((b) (6)) 10/26/2018, 12/5/2018 & 12/20/2018; (b) (6) (b) (6) 6/1/2018, 6/10/2018 & 7/13/2018; (b) (6) 5/6/2019, 5/14/2019 & 5/18/2019; (b) (6) 5/17/2019, 5/23/2019, 6/14/2019, 6/24/2019, 7/17/2019; (b) (6)) 4/18/2019 & 5/26/2019; (b) (6) 4/26/2018 (delay); (b) (6) 5/26/2019, 5/30/2019, 6/1/2019 & 7/9/2019.

[11] 2008 NDS Section II. 5.

[12] NCCHC Standards for Health Care 2018 E -07 Nonemergency Health Care Requests and Services (Essential Standard)

Findings: The records of three detainees contained documentation that the detainee refused HIV testing and yet HIV testing was conducted after these refusals were obtained and the results were evident in the medical record[13]. None of the detainees was being evaluated for HIV disease and there is no documentation that a determination was made that the procedure be completed involuntarily. The PBNDS 2008 state that medical treatment shall not be administered against a detainee's will[14] and that informed consent standards will be observed[15]. When a detainee refuses HIV testing (or any other procedure) it should not be completed unless there has been a determination that the procedure should be carried out involuntarily, with documentation of the rationale.

Recommendation: Review current practices and identify reasons HIV testing is completed when the detainee has refused. Develop and implement corrective action to ensure practices meet PBNDS 2008 for Informed Consent and Involuntary Treatment.

Failure to provide language assistance when non-English speaking detainees receive health care.

Findings: There was minimal documentation in the records reviewed of translation services used during health care encounters with non-English speaking detainees. The standard of care is to begin every encounter note with a statement whether an interpreter was used and if not the reason. If an interpreter or translation service is used, the identity of the translator is also documented. In one of the cases reviewed the Director of Nursing relied upon the correctional officer to translate after escorting the detainee for evaluation after an altercation. We discussed the inappropriateness of having correctional officers provide translation in medical encounters at the time the case was reviewed. Another nurse documented use of a detainee to translate another detainee's explanation for why he would not take a medication[16].

Interviews with detainees revealed that several were relied upon to provide translation during medical encounters on a routine basis. The facility was unable to provide documentation of the use of a language line service. Nurses stated that they used Google Translate to interpret requests for health care and one nurse documented use of Google Translate to explain to a detainee what a positive tuberculin skin reaction was and the recommendation for prophylactic treatment. There was no evidence that qualified interpreters or a translation service is routinely used by the health care staff at YCP. The PBNDS 2008 require that non-English speaking detainees be provided interpretation/translation services as needed for medical care activities[17]. Only interpreters or translation devices qualified for medical translation should be used during clinical encounters at YCP.

Recommendation: Examine the reasons qualified interpreters/translation services are not used and determine what steps are necessary to comply with PBNDS 2008 expectations regarding

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[13] (b) (6) refusal dated 3/23/2019, HIV test results dated 3/29/2019; (b) (6) refusal dated 1/17/2019, HIV test results 1/20/2019; (b) (6) refusal dated 5/10/2019, HIV test results 5/18/2019.

[14] 2008 NDS V. T.

[15] 2008 NDS II. 32.

[16] (b) (6) 6/8/2019 progress note.

[17] 2008 NDS II. 37. and V. H. last paragraph.

language assistance (placement of telephones, training, policy and procedure revision, etc.). Engage services of a translation service or interpreters, ensure health care staff use language assistance when it is needed, and document language assistance provided at the beginning of each encounter, and if not, the reason. Keeping an updated log of detainees and their needs for language assistance so that these services can be anticipated in planning for the health care encounter is a best practice.

Concerns about the health care provided individual detainees.

There were four detainees reviewed whose health care was considered problematic. One of the four is (b)(6) discussed earlier in this report. Three others are discussed in the paragraphs below. The care of each of these detainees should be reviewed by the YCP clinical staff to identify opportunities for improvement.

A. (b)(6) was received at YCP on May 10, 2019. He has high blood pressure readings which have not been identified as a possible problem and followed up. On initial screening his blood pressure was 164/91 and when retaken was still 158/90. This was high enough to warrant periodic blood pressure readings (for example, 3 times weekly for two weeks) if not a direct referral to a provider for evaluation. The detainee's blood pressure has been elevated three of four additional times it was taken. Most recently it was 142/98 on July 17, 2019. Best practice is for nursing protocols to direct nurses to put a detainee on blood pressure monitoring and if pressures over a two-week period exceed 140/90, refer to a provider for evaluation and possible initiation of hypertensive treatment.

B. (b)(6) has testicular pain resulting from a cyst on the epididymis, which he finds painful. He had a diagnostic ultrasound on April 26, 2019 and submitted several requests beginning May 6, 2019 to receive the results, to have his testicle checked and for pain which were not responded to by the health care program. He did not see a provider until May 24, 2019 who documented no encounter but simply wrote an order for an antibiotic. In one instance, there was a delay in care and warranted documentation of an encounter that included an examination. The detainee was seen by an urologist on June 26, 2019 but the recommendation for scrotal support was never acted upon by providers at YCP. Best practice is to document the rationale for not following a specialist's recommendation and this was not done. Either scrotal support should be provided or the rationale for not doing so should be documented.

C. (b)(6) gave a history of gout at intake screening. At that time the nurse documented that the detainee had swelling of both extremities. He reported having been hospitalized prior to being transported to YCP at St. Mary's. No attempt was documented to obtain the detainee's medical records from this hospitalization which likely would have been instructive in addressing this detainee's ongoing medical care. Best practice is to obtain records of treatment that took place immediately prior to the detainee's intake to the facility.
The detainee was placed on medication to prevent symptoms of gout flare up and scheduled to be seen in chronic care clinic. He was seen in chronic care clinic promptly on April 15, 2019 and three routine medications ordered. A month later the medications ran out and were

not re-ordered until the detainee put in a written health care request. Best practice is to time provider appointments to coincide with requirements for medication renewals or orders are required. Detainees needing ongoing prescriptions for medications for treatment of chronic disease should have these continued without having to submit a sick call request.

Recommendations

This report makes four recommendations to comply with PBNDS 2008 and suggests eight best practices be adopted. They are listed below:

1. In many instances the use of the ERC was used for disciplinary purposes. It is recommended that YCP discontinue the practice of obtaining a physician's order for the use of the ERC when restraint is for custody, rather than treatment purposes. Advance approval for use of force and restraints must still be obtained. However, any member of the health care clinical staff (nursing, medicine, mental health) may make the decision and so inform custody staff. The purpose of advance approval is to inform custody staff of any contraindications to use of force or restraint or other necessary precautions. Medical staff are also expected to perform an initial examination of the detainee for injury or adverse consequences from use of force or restraint and to periodically monitor the detainee's health and well-being while in restraint. *2008 Performance Based National Detention Standard (2008 PBNDS), Use of Force and Restraints, II. Expected Outcomes, #5.*

2. Only on those occasions when a detainee's mental health care requires restraint (medically ordered restraint) is a physician's order obtained. In these instances, the decision for medically ordered restraint must include documentation that less restrictive measures were considered and determined to be inappropriate. There must be documentation of an after incident review each time medically ordered restraint is used. The purpose of after-incident review is to consider what treatment alternatives will reduce use of restraint in the future and include these in the detainee's treatment plan. *2008 Performance Based National Detention Standard (2008 PBNDS), V. Expected Practices K. Mental health Program 6. Restraints.* Untimely and/or Unresponsive Sick Call Requests: there were several instances when the sick call requests were not addressed in a timely manner or they were not addressed at all. To ensure timeliness of care, every written request for care should be in the EMR. The request should be signed and dated indicating review, and an encounter with the detainee addressing the request documented in the EMR. Best practice: Track all health care results on a log which includes the date the complaint was written, the date it was received, the date the request was triaged, the nature of the complaint, when the detainee was seen in response to the complaint, and the outcome of the encounter (referred to a provider, treated by nursing protocol, educated or coached in self-care etc.). Audit the EMR to ensure that each encounter is documented in the medical record and monitor the log to ensure that it is current, that all requests are logged, and all requests are seen. *2008 Performance Based National Detention Standard (2008 PBNDS), V. Expected Practices N. Sick Call*

3. Treatment Refusals - There were instances where a detainee refused HIV testing; however, HIV testing was conducted after the refusal was obtained and documented. Per 2008 PBNDS, "medical treatment shall not be administered against a detainee's will". YCP

should review current practices and identify reasons HIV testing is completed when the detainee has refused. Additionally, YCP should develop and implement corrective action to ensure practices meet 2008 PBNDS for Informed Consent and Involuntary Treatment. *2008 Performance Based National Detention Standard (2008 PBNDS), V. Expected Practices T. Informed Consent and Involuntary Treatment.*

4. Language Access - YCP detainees, oftentimes, were used by medical staff to interpret the medical needs of non-English speaking detainees. Officers also provided interpretation services for health care providers. YCP should discontinue the practice of using detainees or officers as interpreters during medical or mental health encounters. YCP should provide interpretation/translation services to non-English speaking detainees and/or detainees who are deaf and/or hard at hearing. Best practice in medical settings is to document language assistance that was provided, including the identity of the interpreter[18]. Some facilities keep an updated log or alert in the medical record of detainees who need language assistance so these services can be arranged in advance of any health care encounter. *2008 Performance Based National Detention Standard (2008 PBNDS), V. Expected Practices I. Medical Screening of New Arrivals, last paragraph.*

Best Practices:

1. Clarify the expectation and document the LPNs communication with a RN when the focused nursing assessment indicates that the detainee's condition is deteriorating, not responding to therapy, or is unstable, as outlined in the state nurse practice act[19].
2. Modify Fist Aid and Suicide Prevention to include facility policy, procedure, and expected practices and more closely match the training needs of facility staff.
3. Train at least 80% of line correctional officers in basic mental health disorders, how to work effectively with mentally ill persons, therapeutic communication and mental health referral.
4. Review documentation expectations with officers responsible for constant observation.
5. Nursing protocols should direct nurses to put a detainee on blood pressure monitoring and if pressures over a two-week period exceed 140/90, refer to a provider for evaluation and possible initiation of hypertensive treatment. Alternatively, the protocol should direct the nurse to refer to a provider for follow up of high blood pressure readings and the provider can determine if further monitoring is necessary.
6. Implement all specialist's recommendations or document the rationale for not following a specialist's recommendation.
7. Obtain records of treatment that took place immediately prior to the detainee's intake to the facility.
8. Time provider appointments to coincide with requirements for medication renewals or orders are required. Detainees needing ongoing prescriptions for medications for treatment of chronic disease should have these continued without having to submit a sick call request.

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[18] Section 1557 of the Patient Protection and Affordable Care Act (2016). Accessed 8/19/2019 at https://www.hhs.gov.gov/civil-rights-for-individuals/section-1557/index.html

[19] Pennsylvania Code 21.145 (a) (1) (iii) accessed 8/4/2019 at https://www.pacode.com/secure/data/049/chapter21/s21.145.html

Appendix 1: Medical Records Reviewed

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APPENDIX A

Non-Priority/Best Practices Recommendations

York County Prison

Complaint Nos. 18-01-ICE-0744, 18-03-ICE-0743,
18-11-ICE-0608, 19-05-ICE-0298, 19-06-ICE-0296,
19-07-ICE-0295, and19-07-ICE-0297

Medical

1. As outlined in the State Nurse Practice Act[1], clarify the expectation and document that LPNs communicate with an RN when the focused nursing assessment indicates that a detainee's condition is deteriorating; that a detainee is not responding to therapy; or that a detainee is unstable.

2. Modify First Aid and Suicide Prevention to include facility policy, procedure, and expected practices and more closely match the training needs of facility staff.

3. Train at least 80% of line correctional officers in basic mental health disorders, how to work effectively with mentally ill persons, therapeutic communication, and mental health referral.

4. Review documentation expectations with officers responsible for constant observation.

5. Nursing protocols should direct nurses when to put a detainee on blood pressure monitoring and if pressures exceed 140/90 over a two-week period, refer to a provider for evaluation and possible initiation of hypertensive treatment. Alternatively, the protocol should direct the nurse to refer to a provider for follow up of high blood pressure readings and the provider can determine if further monitoring is necessary.

6. Implement all specialist's recommendations or document the rationale for not following a specialist's recommendation.

7. Obtain records of treatment that took place immediately prior to the detainee's intake at the facility.

8. Time provider appointments to coincide with requirements for prescription and order renewals. Detainees needing ongoing medication prescriptions for treatment of chronic diseases should have these continued without having to submit a sick call request.

[1] Pennsylvania Code 21.145 (a) (1) (iii) accessed 8/4/2019 at https://www.pacode.com/secure/data/049/chapter21/s21.145.html

Corrections

9. YCP is not maintaining all detailed records in a separate file for each detainee while the detainee is housed in the SMU, and these records are not forwarded to the detainee's permanent detention file. YCP should maintain all records in a separate file for each detainee while held in the SMU and forward all SMU records to the detainee's permanent detention file upon release from the SMU. (2008 PBNDS, SMU, Detention Files)

REPORT FOR THE U. S. DEPARTMENT OF HOMELAND SECURITY

OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES

CONDITIONS OF DETENTION EXPERT'S REPORT

July 29-31, 2019

Investigation regarding

YORK COUNTY PRISON

Complaints reviewed in this report include the following:

CRCL Complaint No.

18-01-ICE-0744, 18-03-ICE-0743, 18-11-ICE-0608, 19-07-ICE-0295,

19-06-ICE-0296, 19-07-ICE-0297, and 19-05-ICE-0298

Prepared by:

(b) (6)

MAS

Rocklin, CA

September 18, 2019

For Official Use Only

YORK COUNTY PRISON

I. SUMMARY OF INVESTIGATION

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) conducted a July 29-31, 2019 onsite investigation at the York County Prison (YCP) in York, Pennsylvania. The investigation was initiated due to complaints received alleging that U.S. Immigrations and Customs Enforcement (ICE) violated the civil rights and civil liberties of persons being detained at YCP. CRCL's investigation included allegations raised by detainees related to medical care and conditions of confinement. During this onsite investigation, I reviewed the conditions of confinement allegations, including law library and legal material access, correspondence and other mail, sexual assault and abuse prevention and intervention (SAAPI/PREA) and use of force. I also reviewed additional areas related to civil rights and civil liberties including, special management unit use and conditions, disciplinary system, detention files, the grievance system, retaliation, staff-detainee communication, language access, national detainee handbook, postings, intake processing, orientation, physical plant, barbering, environmental health and safety related to suicide cell cleanliness and torn mattresses.

To examine the allegations in the complaints, this investigation reviewed YCP's adherence to Performance Based National Detention Standards (PBNDS) 2011 Significant Self-Harm and Suicide Prevention and Intervention and Sexual Abuse and Assault Prevention Standards, and Intervention and PBNDS 2008 in all other areas. Allegations related to medical health care are addressed by another CRCL expert.

Through this review, I found operational deficiencies related to some of the allegations in the complaints. This report contains observations and limited 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).

II. PROFESSIONAL EXPERTISE

(b) (6)

III. RELEVANT STANDARDS

A. ICE Detention Standards

ICE's PBNDS 2008 currently apply to YCP. Additionally, YCP signed modification agreements to incorporate PBNDS 2011 Significant Self-Harm and Suicide Prevention and Intervention and Sexual Abuse and Assault Prevention and Intervention (SAAPI) into their Intergovernmental Service Agreements. The facility was covered by these standards during the entire period relevant to this investigation. Consequently, I relied on the PBNDS 2008 and PBNDS 2011 when looking at the specific allegations in the relevant standards regarding conditions at the facility. Additionally, I considered 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.

York County is currently negotiating with ICE on an Intergovernmental Service Agreement modification to move to the PBNDS 2011. The facility currently has several waivers from ICE regarding PBNDS Standards. Several of the waivers will no longer be applicable when the revised agreement is executed.

IV. FACILITY BACKGROUND AND POPULATION DEMOGRAPHICS

YCP is located in York, Pennsylvania and is operated and managed by the County of York. YCP houses county inmates and ICE detainee. YCP has the capacity to house 950 ICE male and female detainees. On July 29, 2019, 703 male detainees and 90 female detainees were housed at YCP.

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 YCP on July 29-31, 2019, along with CRCL staff; and interviewed ICE and YCP staff and detainees.

The staff at YCP was extremely helpful during our onsite investigation, and I appreciated their assistance. I 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 the April 2016 ICE National Detainee Handbook
- Reviewed relevant ICE PBNDS 2008 standards:
    - Environmental Health and Safety
    - Classification System
    - Facility Security and Control
    - Searches of Detainees
    - Use of Force and Restraints
    - Contraband
    - Grievance System
    - Detainee Handbook
    - Correspondence and Other Mail
    - Admission and Release
    - Law Libraries and Legal Materials
    - Group Presentations on Legal Rights
    - Recreation
    - Religious Practices
    - Staff-Detainee Communication
    - Special Management Units (Administrative and Disciplinary)
    - Detainee Classification System
    - Population Counts
    - Disciplinary System
    - SAAPI/PREA (PBNDS 2011)
    - Funds and Personal Property
    - Suicide Prevention and Intervention (PBNDS 2011)
    - Telephone Access
    - Detention Files
    - Visitation
- Reviewed the ICE ERO Compliance Review-October 2017
- Reviewed the ICE Uniform Correction Action Plan-March 2018
- Reviewed the ICE ERO Compliance Review-October 2018
- Reviewed the ICE Uniform Correction Action Plan-March 2019
- Reviewed relevant ACA correctional standards

While at the YCP on July 29-31, 2019, and post-visit, I did the following:

- Toured male housing units
- Toured female housing unit
- Interviewed housing officers
- Interviewed male detainees
- Interviewed female detainees
- Reviewed detainee housing rosters
- Reviewed detainee files
- Reviewed the YCP Detainee Handbook
- Inspected telephone pro bono number postings in housing units
- Tested telephone functionality
- Toured visiting room
- Inspected the main law library and Lexis-Nexis
- 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
- Reviewed specific detainee grievances and responses
- Reviewed detainee disciplinary reports
- Reviewed detainee requests made to ICE
- Reviewed the daily activity schedule
- Interviewed custody and program personnel regarding orientation, intake, 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, suicide prevention policies, language access, telephone access, and correspondence and other mail
- Met with various ICE and YCP staff during the review
- Reviewed YCP policies on:
    - Sexual Assault and Abuse Prevention and Intervention (PREA)
    - Admission and Release (Intake)
    - Classification System
    - Searches of Detainees
    - Detainee Housing
    - Orientation
    - Detention Files (Records)
    - Contraband
    - Visiting
    - Correspondence/Mail
    - Recreation
    - Housing
    - Use of Force
    - Grievance Procedures

- Disciplinary Policy
- Detainee Handbook
- Staff and Detainee Communication
- Law Library (Library & Legal Rights)
- Staff Training
- Property
- Telephone Access
- Mental Health Services
- Religious Practices
- Environmental Health and Safety
- Special Management Unit
- Disability Identification, Assessment and Accommodation

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.

VI. CONDITIONS OF DETENTION FINDINGS AND RECOMMENDATIONS

A. Use of Force, Facility Security and Control, Staff Misconduct, Retaliation, Staff Detainee Communication, Grievance System Access, Special Management Unit, Disciplinary Detention

YCP allowed CRCL full access to the documents and information requested. This un-impeded access facilitated CRCL's investigation. I was able to complete a thorough review of the allegations leading to this investigation based on this full access, the information the facility provided, and detainee interviews.

During this investigation, I interviewed over 48 male and female detainees in three different groups, plus conducted individual detainee interviews.

Use of Force, Searches, Classification, Facility Security and Control, and Physical Plant
On February 16, 2019, ERO Philadelphia reported use of force involving two detainees at YCP, Detainee #1 and Detainee #2[1]. According to the Daily Detainee Assault Reports (DDAR), on the same date the two detainees refused officer commands and became non-compliant during the search of the housing units. I reviewed YCP reported they used a hard take down[2] to gain control of both detainees. In reviewing the video for the use of force to gain compliance was justified; however, in reviewing the video regarding the search of the unit, the search was performed in a very unprofessional manner and in violation of 2008 PBNDS Searches of

[1] Complaint No. 19-05-ICE-0298 and Sen Number 2019SIR0006174

[2] Hard take down is the term YCP uses when force is used, and the detainee is taken to the ground in a use of force incident.

Detainees and Use of Force standard.[3] [4] [5]During the search detainees' personal items and bedding was searched and tossed on the floor without consideration of the destruction or damage to item as well as a the unit was left in a mess for the detainees to clean-up. This search was not done in conformance to any professional search standard. Contraband searches of housing units are at times necessary to preserve the safety and security of the facility, staff and detainees; however, conducting a housing unit contraband search in a professional manner is critical or incidents can occur because of the tension created by staff if the search of detainee property is done without care or regard to damaging the detainees' property, or the unit is searched in an unprofessional manner and left in a mess for the detainees to clean up.

Detainee #1 was subsequently involved in an incident that resulted in him being placed in a restraint chair and having the emergency response team surround him while he was secured in the restraint chair. I watched the video of the incident. The detainee appeared to be compliant, but the emergency response CERT team by policy took pre-set positions surrounding the restrained, compliant detainee. It appeared that there were seven custody officers on the response team. One male officer began to cut the detainees clothes off with a pair of scissors which was described by interviewed staff as standard practice. Shortly after the officer began cutting the fabric of the leg of the pants that the detainee was wearing, the male officer handed the scissors over to the female officer who then proceeded to cut the male detainees clothes off. I viewed the video while onsite; however, I also asked for a copy of the video for further analysis, but to date I have not received it. When interviewing detainee #1 he asked if it was appropriate for a female staff to see him unclothed. A female staff should never conduct an unclothed search of a detainee unless exigent circumstances exist, and no other male officers are present or available. The video clearly shows that other male officers were present who could have conducted the unclothed strip search[6] [7]. The detainee was clearly compliant and

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[3] 2008 PBNDS, Searches of Detainees, Section II. 3.requires "Searches of detainees, housing and work areas will be conducted without unnecessary force and in ways that preserve the dignity of detainees."

[4] 2008 PBNDS Use of Force and Restraints, V. Expected Practices, A. Overview, "Use of force in detention facilities is never used as punishment, is minimized by staff attempts to first gain a detainee's cooperation, is executed only through approved techniques and devices, and involves only the degree necessary and reasonable to gain control of a detainee."

[5] 2008 PBNDS Use of Force and Restraints, V. Expected Practices, B. Principles Governing the Use of Force and Application of Restraints, 4. "Staff shall use only that amount of force necessary and reasonable to gain control of a detainee."

[6] 2008 PBNDS, Searches of Detainees, V. D. 2. Strip Search, a. Description "A strip search is a visual inspection of all body surfaces and body cavities. Staff shall not routinely require a detainee to remove clothing or require a detainee to expose private parts of his or her body to search for contraband. To the extent reasonably possible, the inspector refrains from touching the skin surface of the detainee; however, the inspector may request that the detainee move parts of the body to permit visual inspection. It is considered more intrusive than a pat search and shall be made in a manner designed to assure as much privacy to the detainee as practicable.

exigent circumstances did not exist that required the cutting off the detainees' clothes, nor did it require a female custody staff to cut the clothes off. I reviewed Detainee #1's record and he has a mental health condition. There is no justifiable correctional reason that required the detainee who had a mental health condition to have his clothes cut off by a female officer while he was compliant in a restraint chair. This is a barbaric practice and clearly violates 2008 PBNDS, Searches of Detainees Standard, 2.11 SAAPI Standard, 2008 PBNDS Searches of Detainees and Use of Force and Restraints, and basic principles of humanity.

On April 27, 2019 ERO Philadelphia reported the use of force on Detainee #3, a detainee at YCP. ERO reported that Detainee #3 refused officers' orders and he physically resisted attempts to move him to another cell.[8] YCP used hard techniques to gain control and placed him in an Emergency restraint chair. Detainee #3 is on a mental health caseload. While the use of force to gain control of Detainee #3 was justified by policy, the facility is using force to respond to situations involving detainees with mental health conditions who act out or fail to follow custody orders. Officers should be provided additional training on recognizing the signs and symptoms of mental health behaviors and trained on how to verbally de-escalate conflict situations and gain compliance without using force when dealing with detainees with mental health conditions. This should reduce the number of use of force incidents at this facility.

Classification

Classification and housing decisions can directly impact the number of incidents at a facility and can contribute to the number of use of force incidents. Detainees are allowed to be housed with County inmates at YCP. Detainees reported that this causes conflicts. Classification and housing decisions can contribute to incidents. Due to the limited time available a classification and housing review could not be conducted. The facility should conduct a review of all incident locations, individuals involved in the incident, contributing factors and whether a detainees' mental health condition contributed to the incident and subsequent use of force.

Facility Safety and Control and Physical Plant

The physical plant of F block unit endangers the safety of detainees due to a lack of adequate staffing.[9] F block is two level housing unit. The staffing consists of one officer who staff's a desk

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[7] 2008 PBNDS, Searches of Detainees, Section V. D. 2. Strip Search, b. Gender of Inspector, "Staff of the same gender as the detainee shall perform the search. Except in the case of an emergency, a staff member may not perform strip searches of detainees of the opposite gender. When members of the opposite gender perform a strip search, it is mandatory that two staff members must be present, and it should be done in private.

[8] Complaint No. 19-07-ICE-0295

[9] PBNDS 2008, Facility Security and Control, Section V. A. Security Staff- "Security staffing shall be sufficient and appropriate to maintain facility security and prevent or minimize events that pose a risk of harm to persons and property. The facility administrator shall determine security needs based on a comprehensive staffing analysis and staffing plan that is reviewed and updated at least annually. Essential posts and positions shall be consistently filled with qualified personnel."

at the entrance of the unit and one rover. There are numerous small living area dorms within the unit that are not visible to custody unless the rover is in the area. Showers for the unit are also in an area that custody does not have direct observation of. Physical and sexual assaults can easily occur in this housing unit area due to a lack of staffing and cameras. The Department of Corrections conducted staffing audit several years ago that resulted in an officer position being permanently removed from this housing unit. The lack of adequate custody coverage in this unit puts the detainees at great risk of physical and sexual harm. The high number of incidents also increases the use of force in response to incidents. The additional officer position should be added to the staffing in this unit. This will increase security and reduce the number of incidents/assaults. Additionally, a convex mirror should be added in the stairwell between the first and second floor to improve visual coverage of the areas. A facility camera and staffing review should be conducted to determine where cameras could be added to improve security coverage.

Grievance System

I reviewed the grievance system as part of this investigation. The 2008 PBNDS 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. All three groups of interviewed detainees reported YCP's grievance system is not effective or responsive. Male and female detainees reported during interviews that their grievances are not responded to timely. In some cases, detainees must put in multiple grievances to obtain a response and follow-up action to resolve their grievance did not always occur. The YCP Detainee Handbook page 9 states "You will normally receive a response within ten (10) business days from the date it was received." The 2008 PBNDS[10] requires that non-medical and non-emergency grievances are responded to within five days after a shift supervisor or other employee designated to receive grievances has attempted to meet with the detainee to attempt to resolve the grievance in a timely manner. A review of non-medical grievances substantiated that grievances were not being responded to timely and within the five-day requirement[11]. This was also a finding in the August 2017 Office of Enforcement and Removal audit.

YCP's current grievance process is for the detainee to request a grievance form from the officer and then they must return the completed form to the officer, who will then provide the form to the counselor. This current process is cumbersome and may be have a chilling effect to those

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[10] 2008 PBNDS, Grievance System, Section V.C. 3.2.f. refers to the person "acting on the grievance within 5 days,", this is after the shift supervisor receives the grievance, meets with the detainee, conducts research/investigation and is unable to ultimately resolve the grievance to the detainee's satisfaction.

[11] National Detainee Handbook, April 2016, page 17, 5. "The GO [Grievance Officer] will give you a written response within five days of receiving your grievance."

detainees who may want to file a grievance against an officer. YCP should ensure the grievance form is readily accessible within housing units and provide a separate box for the detainees to anonymously file a grievance. Detainees also reported that they must request grievance forms from the officer in the housing unit that may be the same officer they want to grieve, and they are fearful of retaliation. During my tour of the housing units, I found some units had grievance forms available on a table and in other housing units detainees had to request the grievance form from the officer or other staff person. Grievance forms were not available in Spanish and responses to grievances that were written in Spanish by LEP detainees were written in English. I will discuss this further in the Language Access section of this report.

The 2008 PBNDS 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. 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. 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. While detainees reported fear of retaliation for filing a grievance or reporting staff mistreatment, I did not find any examples of the retaliation during my investigation.

National Detainee Handbook

Many of the YCP detainees indicated that they did not receive the National Detainee Handbook, which provides a summary of rights and requirements during their time in ICE custody. During a review of detention files, I found some files did not contain a signed receipt that the detainee had received the National Detainee Handbook.

Staff Detainee Communication

Male and Female Detainees reported verbal disrespect by staff. Female detainees also reported verbal abuse by staff. Female detainees reported staff would verbally threaten them with being locked up in the segregation unit and "going to the hole" for behaviors that did not violate the rules and did not warrant isolation. Female detainees also reported that staff would tell them they cannot cry and are quick to put them on suicide watch just for crying. The detainees reported they were upset about being detained and away from their families. The detainees were not having suicide ideations. Female detainees also reported being reprimanded by some staff for laughing.

Male and female detainees reported that county inmates (ICE and County detainees can be housed together at YCP) are treated better by York staff than ICE detainees. Many detainees also reported that staff were overfamiliar with County detainees. Examples given by female detainees include that some staff and County inmates are Facebook friends and know each other from the area. The personal relationships result in better treatment for the County inmates.

Special Management Unit and, Disciplinary

I reviewed the segregation unit and disciplinary process while at YCP. Records in the SMU are

incomplete and do not comply with standards[12]. Daily activity logs are not accurately maintained. Detainees are not provided with immediate notice of the reason placed in SMU which is also mandated by the SMU standard. The SMU standard[13] requires that "ICE and the detainee shall be immediately provided a copy of the administrative segregation order describing the reasons for the detainee's placement in the SMU." The detainee is not receiving a copy of the administrative segregation placement order within 24 hours. A file of all records related to the detainees stay in segregation is supposed to be maintained while the detainee is in segregation and then all records are to be forwarded to the detainee's detention file.[14]

Findings:
YCP's policy of routinely cutting off detainee clothes while detainees are compliant and secured in a restraint chair is an excessive use of force and a violation of the 2008 PBNDS Searches of Detainees and Use of Force and Restraint standards is substantiated.

YCP custody staff violated 2008 PBNDS Searches of Detainees and 2011 PBNDS 2.11 SAAPI by allowing a female officer to cut the clothes off Detainee #1 when exigent circumstances did not exist, and male staff were available is substantiated.

YCP's staffing, cameras and convex mirrors in F block unit is inadequate and does not provide adequate security and control to safely protect detainees from abuse and assault is **substantiated.**

The YCP grievance system does not conform to 2008 PBNDS and the National Detainee Handbook is **substantiated.**

Detainees are not consistently receiving the National Detainee Handbook is **substantiated.**

Detainee #1 was subjected to use of force at YCP that did not conform to 2008 PBNDS is **substantiated.**

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[12] 2011 PBNDS, 2.12 Special Management Units, Section II. 20. "Detailed records shall be maintained on the circumstances related to a detainee's confinement to the SMU, through required permanent SMU logs and individual detainee records."

[13] 2008 PBNDS, Special Management Units, Section V. C. 2. "A written order shall be completed and approved by a security supervisor before a detainee is placed in Administrative Segregation, except when exigent circumstances make this impracticable. In such cases, an order shall be prepared as soon as possible. A copy of the order shall be given to the detainee within 24 hours, unless delivery would jeopardize the safety, security, or orderly operation of the facility.

[14] 2008 PBNDS, Special Management Units, V.E.3. d. "Upon a detainee's release from the SMU, the releasing officer shall attach the entire housing unit record related to that detainee to either the Administrative Segregation Order or Disciplinary Segregation Order and forward it to the chief of security for inclusion into the detainee's detention file."

YCP's use of force involving Detainee #3 was in conformance with 2008 PBNDS.

Some YCP officers verbally harass and treat detainees in a disrespectful manner is **substantiated.**

YCP is failing to provide detainees with due process by not providing a detainee who is removed from the general population and placed in administrative segregation with an order describing the reasons for placement in the SMU within 24 hours **is substantiated.**

YCP does not maintain all detailed records in a separate file for each detainee while the detainee is housed in the SMU and these records are not forwarded to the permanent detention file **is substantiated.**

Recommendations:

- YCP must train staff on 2008 PBNDS Searches of Detainees and provide adequate supervisory oversight to ensure "Searches of detainees, housing and work areas will be conducted without unnecessary force and in ways that preserve the dignity of detainees." (2008 PBNDS, Searches of Detainees) Level I
- YCP must train staff to ensure only the amount of force necessary is used to gain control of detainees. (2008 PBNDS, Use of Force and Restraints) Level I
- YCP practice of allowing female custody staff to cut the clothes off male detainees held in a restraint chair should cease immediately. YCP should provide training to officers and ensure compliance that female officers do not perform strip searches or cut a male detainee's clothes off and comply with the strip search gender requirements. (2008 PBNDS, Searches of Detainees, Section V. D. 2. B) Level I
- YCP must conduct a staffing, physical plant, camera, and convex mirror assessment in F block unit to determine what additional resources or physical modifications are necessary to conform to 2008 PBNDS requirement that security staffing shall be sufficient and appropriate to maintain facility security and prevent or minimize events that pose a risk of harm to persons and property." (2008 PBNDS Security Staffing and Control, Section V. A.) Level I
- YCP's lack of timely response to detainee grievances and failure to consistently respond to detainee grievances has resulted in a lack of confidence in the grievance system. YCP should respond to detainee grievances within five days as required and ensure proposed resolution actions are completed. (2008 PBNDS, Grievance System, Section V.C. 3.2.f., National Detainee Handbook) Level I
- YCP's practice of requiring that grievance be submitted to staff person is having a chilling effect on grievance submittals. YCP should provide a secure locked box for detainees to place their grievances in to ensure grievances are not destroyed and confidentiality can be maintained or the facility administrator, or designee, shall create a process that allows a detainee to submit a formal, written grievance to a single designated grievance officer or the facility's grievance committee. (2008 PBNDS, Grievance System, Section V.C.) Level I
- YCP detainees are not consistently provided a copy of the National Detainee

Handbook. YCP shall ensure that detainees are provided a copy of the National Detainee Handbook in English, Spanish or other languages deemed necessary by the Field Office Director. (2008 PBNDS Section Detainee Handbook, Section II.3) Level I

- YCP detainees are verbally disrespected, threatened and demeaned by some YCP officers. YCP should provide additional training and adequately investigate detainee complaints of mistreatment to comply with IC policy of treating all detainees with dignity and respect to keep the facility safe and secure. (2008 PBNDS Staff Detainee Communication, National Detainee Handbook) Level I
- YCP is violating detainees due process by not providing the detainee with a copy of the administrative segregation order that describes the reason for placement in segregation. YCP shall provide detainees within 24 hours of placement a copy of the administrative segregation order describing the reasons for the detainee's placement in the SMU. (2008 PBNDS, SMU) Level I
- YCP is not maintaining all detailed records in a separate file for each detainee while the detainee is housed in the SMU, and these records are not forwarded to the permanent detention file. YCP shall maintain all records in a separate file for each detainee while held in the SMU and forward all SMU records to the detainee's permanent detention file upon release from the SMU. (2008 PBNDS, SMU, Detention Files) Level II

B. Admission and Release, Orientation

I reviewed the Admission and Release functions as part of this investigation. The majority of the admission intake processing of detainees takes place in an open area. The Officer sits at a desk with a chair in front of the desk for the detainee to sit in. Behind the detainee is a table where up to five detainees sit while the detainee intake questioning occurs. Sexual victimization and prior predatory conduct questions are asked during this intake screening by the officer. The lack of privacy has a chilling effect on the detainee interview which poses the risk of false and inaccurate reporting which jeopardizes a safe housing decision. The officer conducting the screening uses the speaker phone if he uses language line (language line is not consistently used when needed), and the detainees sitting at the adjacent table can hear the entire conversation also jeopardizing the accuracy of the reporting, privacy of the detainee's information and potentially the detainee's safety.

Orientation

I viewed the existing YCP detainee orientation video. The existing video needs to be updated to address policy and practice that conform to the 2008 PBNDS. The current orientation video contains outdated information and the information skips during the presentation which results in incomplete orientation material being provided to the detainees. Additionally, the orientation video is only available in English which is a violation of detention standards and language access requirements.

Findings:

YCP's current admission intake screening process is conducted in an open setting with other detainees in close proximity fails to provide adequate privacy to ensure the confidentiality of detainee responses to intake questioning. The lack of privacy during intake questioning can

result in inaccurate intake information and can jeopardize the personal safety detainees at this facility **is substantiated.**

YCP's current orientation video malfunctions and is not available to LEP detainees is **substantiated.**

Recommendations:

- YCP current practice of admission intake screening in an open setting with other detainees in close proximity should cease to ensure detainees can share accurate personal and confidential responses to the intake questions which will result in accurate screening and housing decisions and protect the safety of detainees. (2008 PBNDS, Admission and Release) Level I
- YCP's current malfunctioning orientation video should be replaced with an orientation video that works properly and be translated into Spanish for LEP detainees. (2008 PBNDS, Admission and Release, ICE Language Access Plans) (Level I)

C. Language Access and Medical Confidentiality

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 three groups of detainees which included detainees who are limited English proficient (LEP), the detainees reported significant language access issues.[15] The facility is not providing appropriate language access to LEP detainees in a number of areas. During the intake process there is an assumption by staff that Spanish speaking detainees all speak the same dialect. This can result in inaccurate information being recorded during the intake process. YCP does not track what language is spoken by detainees. The forms used for are intake are only partially translated), grievances, Text Behind pamphlet (related to mail, text, photos), legal/special correspondence, inmate haircut, postings, detainee requests and other forms are only available in English despite a large population of Spanish speakers who spoke limited or no 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 being provided. 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 consistently provided. LEP detainees are required to sign 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. I-Speak posters are not posted in all the housing units.

Detainees also reported being teased, mocked, or called names by some deputies for being LEP. The language line was not consistently used. YCP detainees are used by custody, program and medical staff to interpret for other detainees. Security and HIPPA concerns are created by

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

utilizing detainees as interpreters. One female detainee reported that she consistently gets called by medical to be used as an interpreter for other female detainees who are LEP. The detainee felt it was wrong that she had to interpret and deliver medical diagnosis information to detainees. In the housing units officers are not allowed to use the language line.

YCP 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. Additionally, mandated postings of the various schedules, including law library, laundry, recreation, religious programing, DO schedules, menus, and other notices on bulletin boards (which should be posted in the housing units) are primarily only available in English and not translated into Spanish. Translated postings in Spanish are mandated and the postings in each unit should updated to include Spanish versions. YCP is required to provide meaningful language access for residents.

Findings:

YCP 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:

- YCP records indicate that language access resources are not consistently used to assist LEP detainees. YCP 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 I)
- YCP records indicate that language access resources are not consistently used to assist LEP detainees. Officers in the housing units are prohibited from using the language line. YCP 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)

- YCP records indicate that language access resources are not consistently 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 YCP 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, YCP should ensure the use of qualified interpreters or professionally translated informational postings and forms commonly used in intake, medical, commissary, programs, disciplinary proceedings, and segregation into Spanish at a minimum to ensure meaningful access for LEP detainees. (DHS and ICE Language Access Plans) Level I
- YCP should implement an improved system of determination of the dialect spoke by LEP detainees to improve the identification of the language spoken and the accuracy of information recorded during the intake process which can impact the safety of detainees. (DHS and ICE Language Access Plans) Level I
- YCP maintained very few records indicating when it provided language assistance to LEP detainees. Facility staff should notate on any document when interpretation is provided to LEP detainees when requiring detainees to sign documents written in English. (DHS and ICE Language Access Plans) Level I
- YCP does not post I-Speak posters in the housing units. To improve communication with detainees and correctly identify what language is spoken by LEP detainees, I-speak posters should be posted throughout the facility. (DHS and ICE Language Access Plans) Level I

D. Law Library Access, Correspondence and other Mail

Law Library

On December 14, 2017, CRCL received an OIG email referral concerning Detainee #4 alleging the computer in the law library was not working.[16] While onsite I inspected law library computer equipment, interviewed staff and detainees and found that the law library computer equipment is maintained on an ongoing basis in working order.

During interviews with detainees it was reported that YCP has established a detainee paid worker position in the law library to assist female detainees who are LEP with using the law library. The position is very helpful to the female detainees who are trying to work on their deportation cases; however, female detainees who are waiting to be assisted are not allowed to wait for their turn for assistance and are returned to the housing unit because they are not actively working on the computer as they are waiting for assistance from the detainee law library clerk. The detainee law library assistant confirmed that access is a problem. Without the assistance of the law library clerk detainees cannot utilize the Lexis-Nexis software. Additionally, female detainees reported being escorted to their law library time late which contributes to the lack of adequate law library time that meets mandated standard requirements.

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[16] Complaint No. 18-03-ICE-0743

Correspondence and Other Mail

On October 28, 2017, CRCL received an OIG referral regarding Detainee #5. In a phone call to the OIG on October 12, 2017, Detainee #5 alleged that the facility had been denying his legal mail which inhibited him from receiving the proper documents needed for his immigration case.[17] On December 14, 2017 Detainee #4 alleged the facility was opening his legal mail.[18] Both Detainee #3 and #4 a are no longer at the facility and therefore could not be interviewed regarding their specific complaints; however, I did interview staff regarding mail policies and practices. Staff reported there had been significant issues with legal and non-legal mail deliveries for an extended period. The mail delays were caused due to the facility staff trying to address the security issue of drugs being introduced into the facility via mail. The facility does not have any record of denying detainee #5 his mail and denies ever opening legal mail not in the presence of detainees. The facility now contracts for non-legal mail delivery services with an outside vendor that processes general mail to detainees within 24 hours.

Male and female detainees complained during my interviews that there had been issues with legal mail delays which contained documents that were needed for court. Attempting to reduce the drug contraband entering the facility via legal mail envelopes, the facility has changed its legal mail sorting and distribution process. This initially resulted in the delays of legal mail being distributed to the detainees. The facility has again revised its legal mail distribution process which now seems to have resolved the legal mail delays. The facility should monitor closely the legal mail delivery timeframes to ensure detainees receive the legal documents needed for court that arrive in the legal mail.

Findings:

Detainee #4's complaint regarding the law library computer equipment is not working is **not substantiated.**

Female detainees who are LEP do not have sufficient access to assistance in the law library to be able to utilize the Lexis-Nexis legal software and law library computer equipment is **substantiated.**

Detainee #4's complaint that his mail was denied which inhibited from receiving his legal mail is **not substantiated.**

Detainee #5's complaint that facility staff is opening his legal mail in his presence is **not substantiated.**

YCP delayed timely access to legal mail is **substantiated.**

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[17] Complaint No. 18-01-ICE-0744

[18] Complaint No. 18-03-ICE-0743

Recommendations:

- YCP is not providing female detainees who are LEP effective legal access to the law library and computer equipment. YCP should ensure that the law library schedule and access to the law library clerk are sufficient to accommodate female detainees and they are not returned to their housing unit without being able to utilize the Lexis-Nexis software and computer equipment. (2008 PBNDS, Law Libraries and Legal Materials, Section V. J)[19] Level I
- YCP's searching practices has impacted the timely receipt of legal mail and documents needed for immigration proceedings. YCP should closely monitor legal and non-legal mail deliveries to detainees to ensure they are receiving documents needed for immigrations proceedings within 24 hours (within one business day of receipt) as required by the standard[20]. (2008 PBNDS, Correspondence and Mail) Level I

E. Recreation Access

While onsite I reviewed recreation access at this facility. I interviewed detainees and inspected the recreational area. Recreation time is provided to detainees that meets the 2008 PBNDS requirements. Detainees did not have any complaints regarding recreational access.

Findings:

None

Recommendations:

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

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[19] 2008 PBNDS, V. J. Assistance to Illiterate, Non-English Speaking and Disabled Detainees, "Unrepresented illiterate or non-English speaking detainees who wish to pursue a legal claim related to their immigration proceedings or detention, and who indicate difficulty with the legal materials, must be provided with more than access to a set of English-language law books. To the extent practicable and consistent with the good order and security of the facility, all efforts will be made to assist disabled persons in using the law library. Facilities shall establish procedures to meet this requirement, such as: Helping the detainee obtain assistance in using the law library and drafting legal documents from detainees with appropriate language, reading and writing abilities;"

[20] 2008 PBNDS, Mail and Other Correspondence, V. D. Processing "Detainee correspondence and other mail shall be delivered to the detainee and to the postal service on regular schedules. Incoming correspondence shall be distributed to detainees within 24 hours (one business day) of receipt by the facility."

working order and adequately maintained. YCP's telephone rates are consistent with allowable amounts approved by ICE. During the tour of the facility I observed that telephone free number listings were not consistently located in the housing units.

Findings:

YCP's telephone free number listings are not consistently located in the housing units is **substantiated.**

Recommendations:

- YCP shall replace all missing telephone free number listings and ensure that the free number listings are posted in every detainee housing unit. (2008 PBNDS, Telephone Access) Level I

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

On March 28, 2019, ERO Philadelphia reported an alleged sexual assault at YCP involving Detainees #6 and #7[21]. On this same date Detainee #6 reported Detainee #7 had touched him inappropriately and harassed him for several days. On April 20, 2019 ERO Philadelphia reported an alleged sexual assault and abuse incident involving Detainee #8 and Detainee #9. ERO reported for the previous three weeks, Detainee # 9 had allegedly made inappropriate comments to and touched Detainee #8.[22] I reviewed YCP's SAAPI/PREA program during the onsite investigation of these complaints. I interviewed the onsite PSA Coordinator and inspected postings throughout the facility. I also reviewed the SAAPI/PREA policy. There were 12 SAPPI/PREA complaints in 2018, four involving staff and detainee and eight involving detainee on detainee. There were four SAAPI/PREA incidents recorded in 2019 (as of the date of this investigation) one involving staff and a detainee and three involving detainee on detainee. There was a recent full SAAPI/PREA audit. ICE and the facility were waiting for the formal report and results. The facility was very vague about any of the findings reported at the SAAP/PREA audit. The female detainees did not feel safe from sexual abuse and harassment at this facility specifically the detainee female shower stall in the H block was without shower curtains and was in plain view of any person walking in the hallway. Female detainees have been reporting their concerns for a significant period of time. The ability of anyone walking in the hallway to view the naked female detainees showering is a blatant violation of the female's privacy and the 2.11 SAAPI standard. YCP and ICE staff knew of this condition as the physical plant of this facility has not changed and did nothing to correct the violation. The blatant disregard for the female's privacy while showering indicates a culture of indifference which puts the women's safety at risk. If a concern as serious as this is not addressed, it leads one to question if detainees SAAPI concerns are treated seriously at this facility. There was a lack of privacy in the showers and toilets throughout the facility. They were no curtains or barriers provide for privacy while someone is using the restroom or showers.

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[21] CRCL Complaint No. 19-06-ICE-0296

[22] CRCL Complaint No. 19-07-ICE-0297

Another serious SAAPI concern is the incident previously described in detail in this report. A female member of the CERT (emergency response) team was near a male detainee's genitalia, as she was cutting his clothes off his body, while he was in restrained and compliant sitting in the Emergency Restraint Chair. Exigent circumstances did not exist as there were at least five other male officers present and the detainee was not resistive. This would be considered a cross gender strip search which is prohibited under the 2.11 Sexual Assault and Abuse Prevention and Intervention standard.
In one instance, it was observed that a female member of the CERT (emergency response) team was in close proximity to the male detainee's genitalia, as she was cutting his clothes off of his body, while he was in restrained and compliant sitting in the Emergency Restraint Chair. Exigent circumstances did not exist as there were at least five other male officers present and the detainee was not resistive. This would be considered a cross gender strip search which is prohibited under the 2.11 Sexual Assault and Abuse Prevention and Intervention standard.

Additional 2.11 SAAPI standard violations include blind spots in the kitchen. The existing YCP SAAPI policy does not conform to the 2.11 SAAPI standard and policy revisions are needed to become compliant. Staff in the facility were not consistently aware of what the zero-tolerance policy is. SAAPI training needs to be updated to be compliant with 2.11 SAAPI Standard.

Findings:

YCP took appropriate action in the SAAPI complaint involving Detainee #6 and #7 is **substantiated.**

YCP took appropriate action in the SAAPI complaint involving Detainee #8 and #9 is **substantiated.**

YCP does not comply with the 2.11 SAAPI (PREA) standard and which is putting detainees at risk of sexual harassment and abuse is **substantiated.**

Recommendations:

- ICE should require YCP to take immediate corrective action to remediate the numerous serious SAAPI PREA violations at this facility. These violations put detainees at risk of sexual harassment and abuse. (2011 PBNDS, 2.11 SAAPI) Level I
- YCP's kitchen currently has blind spots that puts the detainee's safety at risk. Convex mirrors must be installed in the kitchen area to eliminate the blind spots and ensure custody staff can adequately observe detainees for safety purposes and eliminate the risk of sexual assault. (2011 PBNDS, 2.11 SAAPI) Level I
- YCP's SAAPI policy does not conform with the 2.11 SAAPI standard. YCP must revise their current SAAPI policy to become compliant. (2011 PBNDS, 2.11 SAAPI) Level I
- YCP's current SAAPI training does not conform to the SAAPI training standard and should be updated to be compliant with the 2.11 SAAPI standard. (2011 PBNDS, 2.11 SAAPI) Level I

- When interviewed some of the YCP staff were unaware of the meaning of a zero-tolerance policy. YCP must provide additional training to staff to ensure they understand and comply with the SAAPI zero tolerance policy. (2011 PBNDS, 2.11 SAAPI) Level I

H. Environmental Health and Safety

During the tours of the housing units the detainees requested that I inspect the mattresses. The mattresses had an attached pillow. The mattresses were old and torn. Damaged mattresses are placing detainees at risk of infection, as they can no longer be properly cleaned and disinfected.

I inspected the suicide observation cells and found them to be filthy. Dried feces were splattered on the walls and the cells smelled of urine. The cells obviously were not routinely being cleaned and sanitized.

Findings:

YCP detainee's complaint of torn mattresses is **substantiated.**

YCP does not maintain clean and sanitary suicide observation cells is **substantiated.**

Recommendations:

- YCP's torn mattresses are placing the health and safety of the detainees at risk of infection. YCP should inspect all mattresses and replace any that are torn or cracked to protect detainees from the risk of infection and to facilitate compliance with the Personal Hygiene Standard which requires "each detainee shall have suitable clean bedding." (2008 PBNDS, Personal Hygiene, Section II.2 and V.A.; Environmental Health and Safety, Section II. 2., V. A) Level I
- YCP's suicide observation cells are not cleaned and sanitized putting the health and safety of detainees at risk. YCP should clean and sanitize the suicide observation cells after each use to comply with environmental health and safety standards, to protect the health and safety of detainees housed in these cells and comply with 2008 PBNDS. (2008 PBNDS, Environmental Health and Safety Section II.1, 2, V. A.) Level I

I. Barbering

During detainee interviews the detainees reported that they were being charged $16. per haircut. A review of the detainee handbook confirmed that by policy detainees were being charged $16 per haircut unless the detainee was indigent. Every 90 days detainees who are indigent can sign up for a free haircut. YCP contracts with a Barber from the community who performs the haircuts. The contract barber charges detainees $16. There is nothing in the 2008 PBNDS or the facility's contract that authorizes YCP to charge detainees for haircuts. The 2008 PBNDS requires that Detainees shall be provided hair care services in a manner and environment that promotes safety and sanitation.

Findings:

YCP detainee's complaint of being charged for $16. for haircuts is **substantiated.**

Recommendations:

- YCP must cease charging detainees $16. for haircuts which there is no authority to charge. YCP should establish an inmate barber position and provide the appropriate barbering tools and cleaning supplies or provide a staff or contractor to provide no cost haircuts regularly to detainees which will enable detainees to maintain personal hygiene. (2008 PBNDS, Personal Hygiene, Section V. F.; Environmental Health and Safety, Section II. 2., V. A) (Level l)

J. Postings

While touring the facility during the onsite investigation I observed that mandated postings which are required by ICE standards to be posted in the housing units were not. The postings were posted outside the housing unit located in enclosed bulletin boards. Detainees do not have direct access to the bulletin boards that contain the mandated postings, unless they are escorted outside their housing unit or are being escorted in the hallway to another location in the facility. Escorts outside the housing units to view the bulletin boards and posted information are not routinely available. The 2008 PBNDS, and 2.11 SAAPI require that specific postings be posted in the housing unit. The reason to mandate that postings are located in the housing units is to ensure the posted information will be accessible to detainees when the information is needed. Examples of these mandated postings include the law library schedule, visitation schedule, ICE Detention Officer schedule, recreation schedule, religious schedule, Office of the Inspector General hotline, Detainee Reporting Information line (DRIL), free telephone listing, etc. A prior ERO audit was performed and even though YCP was granted a waiver the Deputy Director Detention Management Division on January 5, 2017, the auditor still found YCP deficient as having direct access to the posted information is critical. YCP reported during the investigation they planned on conforming to the posting requirements when the facility moved to the 2011 PBNDS. The original exemption was requested by YCP due to the number of bulletin boards that would have to be procured, installed and updated regularly. The basis for the mandated posting requirement is to provide detainees direct access to critical information that is needed for legal access and their safety and security. YCP is currently not providing a reasonable alternative to the mandated requirements to ensure detainees can access the posted information, therefore, there is no legitimate basis for the exemption.

Findings:

YCP is not compliant with 2008 PBNDS and 2011 PBNDS 2.11 SAAPI mandated posting information requirements is **substantiated.**

Recommendations:

- YCP should install bulletin boards in each housing unit to ensure detainees have direct access to information that is mandated to be posted in the housing units to conform to standard requirements. (2008 PBNDS, Recreation, Law Library and Legal Materials,

Recreation, Religious Practices, Staff Detainee Communication, Telephone Access, Visitation, 2011 PBNDS 2.11 SAAPI) Level I

VII. SUMMARY OF YCP RECOMMENDATIONS

Regarding the specific deficiencies I found as part of my review of YCP, I make the following recommendations based on applicable 2008 PBNDS, and 2011 PBNDS SAAPI and Significant Self-Harm and Suicide Prevention Standards:

- YCP must train staff on 2008 PBNDS Searches of Detainees and provide adequate supervisory oversight to ensure "Searches of detainees, housing and work areas will be conducted without unnecessary force and in ways that preserve the dignity of detainees." (2008 PBNDS, Searches of Detainees) Level I
- YCP must train staff to ensure only the amount of force necessary is used to gain control of detainees. (2008 PBNDS, Use of Force and Restraints) Level I
- YCP practice of allowing female custody staff to cut the clothes off male detainees held in a restraint chair should cease immediately. YCP should provide training to officers and ensure compliance that female officers do not perform strip searches or cut a male detainee's clothes off and comply with the strip search gender requirements. (2008 PBNDS, Searches of Detainees, Section V. D. 2. B) Level I
- YCP must conduct a staffing, physical plant, camera, and convex mirror assessment in F block unit to determine what additional resources or physical modifications are necessary to conform to 2008 PBNDS requirement that security staffing shall be sufficient and appropriate to maintain facility security and prevent or minimize events that pose a risk of harm to persons and property." (2008 PBNDS Security Staffing and Control, Section V. A.) Level I
- YCP's lack of timely response to detainee grievances and failure to consistently respond to detainee grievances has resulted in a lack of confidence in the grievance system. YCP should respond to detainee grievances within five days as required and ensure proposed resolution actions are completed. (2008 PBNDS, Grievance System, Section V.C. 3.2.f., National Detainee Handbook) Level I
- YCP's practice of requiring that grievance be submitted to staff person is having a chilling effect on grievance submittals. YCP should provide a secure locked box for detainees to place their grievances in to ensure grievances are not destroyed and confidentiality can be maintained or the facility administrator, or designee, shall create a process that allows a detainee to submit a formal, written grievance to a single designated grievance officer or the facility's grievance committee. (2008 PBNDS, Grievance System, Section V.C.) Level I
- YCP detainees are not consistently provided a copy of the National Detainee Handbook. YCP shall ensure that detainees are provided a copy of the National Detainee Handbook in English, Spanish or other languages deemed necessary by the Field Office Director. (2008 PBNDS Section Detainee Handbook, Section II.3) Level I
- YCP detainees are verbally disrespected, threatened and demeaned by some YCP officers. YCP should provide additional training and adequately investigate detainee complaints of mistreatment to comply with IC policy of treating all detainees with

dignity and respect to keep the facility safe and secure. (2008 PBNDS Staff Detainee Communication, National Detainee Handbook) Level I

- YCP is violating detainees due process by not providing the detainee with a copy of the administrative segregation order that describes the reason for placement in segregation. YCP shall provide detainees within 24 hours of placement a copy of the administrative segregation order describing the reasons for the detainee's placement in the SMU. (2008 PBNDS, SMU) Level I
- YCP is not maintaining all detailed records in a separate file for each detainee while the detainee is housed in the SMU, and these records are not forwarded to the permanent detention file. YCP shall maintain all records in a separate file for each detainee while held in the SMU and forward all SMU records to the detainee's permanent detention file upon release from the SMU. (2008 PBNDS, SMU, Detention Files) Level II
- YCP current practice of admission intake screening in an open setting with other detainees in close proximity should cease to ensure detainees can share accurate personal and confidential responses to the intake questions which will result in accurate screening and housing decisions and protect the safety of detainees. (2008 PBNDS, Admission and Release) Level I
- YCP's current malfunctioning orientation video should be replaced with an orientation video that works properly and be translated into Spanish for LEP detainees. (2008 PBNDS, Admission and Release, ICE Language Access Plans) (Level I)
- YCP records indicate that language access resources are not consistently 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 YCP 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, YCP should ensure the use of qualified interpreters or professionally translated informational postings and forms commonly used in intake, medical, commissary, programs, disciplinary proceedings, and segregation into Spanish at a minimum to ensure meaningful access for LEP detainees. (DHS and ICE Language Access Plans) Level I
- YCP should implement an improved system of determination of the dialect spoke by LEP detainees to improve the identification of the language spoken and the accuracy of information recorded during the intake process which can impact the safety of detainees. (DHS and ICE Language Access Plans) Level I
- YCP maintained very few records indicating when it provided language assistance to LEP detainees. Facility staff should notate on any document when interpretation is provided to LEP detainees when requiring detainees to sign documents written in English. (DHS and ICE Language Access Plans) Level I
- YCP does not post I-Speak posters in the housing units. To improve communication with detainees and correctly identify what language is spoken by LEP detainees, I-speak posters should be posted throughout the facility. (DHS and ICE Language Access Plans) Level I
- YCP is not providing female detainees who are LEP effective legal access to the law library and computer equipment. YCP should ensure that the law library schedule and access to the law library clerk are sufficient to accommodate female detainees and they

are not returned to their housing unit without being able to utilize the Lexis-Nexis software and computer equipment. (2008 PBNDS, Law Libraries and Legal Materials, Section V. J)[23] Level I

- YCP's searching practices has impacted the timely receipt of legal mail and documents needed for immigration proceedings. YCP should closely monitor legal and non-legal mail deliveries to detainees to ensure they are receiving documents needed for immigrations proceedings within 24 hours (within one business day of receipt) as required by the standard[24]. (2008 PBNDS, Correspondence and Mail) Level I
- YCP shall replace all missing telephone free number listings and ensure that the free number listings are posted in every detainee housing unit. (2008 PBNDS, Telephone Access) Level I
- ICE should require YCP to take immediate corrective action to remediate the numerous serious SAAPI PREA violations at this facility. These violations put detainees at risk of sexual harassment and abuse. (2011 PBNDS, 2.11 SAAPI) Level I
- YCP's kitchen currently has blind spots that puts the detainee's safety at risk. Convex mirrors must be installed in the kitchen area to eliminate the blind spots and ensure custody staff can adequately observe detainees for safety purposes and eliminate the risk of sexual assault. (2011 PBNDS, 2.11 SAAPI) Level I
- YCP's SAAPI policy does not conform with the 2.11 SAAPI standard. YCP must revise their current SAAPI policy to become compliant. (2011 PBNDS, 2.11 SAAPI) Level I
- YCP's current SAAPI training does not conform to the SAAPI training standard and should be updated to be compliant with the 2.11 SAAPI standard. (2011 PBNDS, 2.11 SAAPI) Level I
- When interviewed some of the YCP staff were unaware of the meaning of a zero-tolerance policy. YCP must provide additional training to staff to ensure they understand and comply with the SAAPI zero tolerance policy. (2011 PBNDS, 2.11 SAAPI) Level I

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[23] 2008 PBNDS, V. J. Assistance to Illiterate, Non-English Speaking and Disabled Detainees, "Unrepresented illiterate or non-English speaking detainees who wish to pursue a legal claim related to their immigration proceedings or detention, and who indicate difficulty with the legal materials, must be provided with more than access to a set of English-language law books. To the extent practicable and consistent with the good order and security of the facility, all efforts will be made to assist disabled persons in using the law library. Facilities shall establish procedures to meet this requirement, such as: Helping the detainee obtain assistance in using the law library and drafting legal documents from detainees with appropriate language, reading and writing abilities;"

[24] 2008 PBNDS, Mail and Other Correspondence, V. D. Processing "Detainee correspondence and other mail shall be delivered to the detainee and to the postal service on regular schedules. Incoming correspondence shall be distributed to detainees within 24 hours (one business day) of receipt by the facility."

- YCP's torn mattresses are placing the health and safety of the detainees at risk of infection. YCP should inspect all mattresses and replace any that are torn or cracked to protect detainees from the risk of infection and to facilitate compliance with the Personal Hygiene Standard which requires "each detainee shall have suitable clean bedding." (2008 PBNDS, Personal Hygiene, Section II.2 and V.A.; Environmental Health and Safety, Section II. 2., V. A) Level I
- YCP's suicide observation cells are not cleaned and sanitized putting the health and safety of detainees at risk. YCP should clean and sanitize the suicide observation cells after each use to comply with environmental health and safety standards, to protect the health and safety of detainees housed in these cells and comply with 2008 PBNDS. (2008 PBNDS, Environmental Health and Safety Section II.1, 2, V. A.) Level I
- YCP must cease charging detainees $16. for haircuts which there is no authority to charge. YCP should establish an inmate barber position and provide the appropriate barbering tools and cleaning supplies or provide a staff or contractor to provide no cost haircuts regularly to detainees which will enable detainees to maintain personal hygiene. (2008 PBNDS, Personal Hygiene, Section V. F.; Environmental Health and Safety, Section II. 2., V. A) (Level I)
- YCP should install bulletin boards in each housing unit to ensure detainees have direct access to information that is mandated to be posted in the housing units to conform to standard requirements. (2008 PBNDS, Recreation, Law Library and Legal Materials, Recreation, Religious Practices, Staff Detainee Communication, Telephone Access, Visitation, 2011 PBNDS 2.11 SAAPI) Level I

CRCL COMPLAINT NOS. 18-01-ICE-0744, 18-03-ICE-0743,

18-11-ICE-0608, 19-05-ICE-0295,

19-06-ICE-0296, 19-07-ICE-0297, and 19-07-ICE-0298

APPENDIX A

Detainee Name and Booking Numbers

	(b)(6)
Detainee #1:	
Detainee #2:	
Detainee #3:	
Detainee #4:	
Detainee #5:	
Detainee #6:	
Detainee #7:	
Detainee #8:	
Detainee #9	