Medical Expert Report

U.S. Department of Homeland Security

Office for Civil Rights and Civil Liberties

December 17-19, 2018

Buffalo Federal Detention Facility

Complaint Nos. 18-02-ICE-0050, 18-07-ICE-0245, 18-10-ICE-0482, 18-11-ICE-0569, 18-12-ICE-0648, and 18-12-ICE-0651

(b) (6) **MD, MBA, MPH, CCHP-P, CCHP-A**

December 2018

Executive Summary

During the three day period of December 17-19, 2018, I visited the Buffalo Federal Detention Facility (BFDF) in Batavia, NY, as a member of a CRCL team to assess the degree of compliance of BFDF medical unit with the standards of care for detainees housed in that facility. Additionally, I was asked to investigate several specific allegations regarding the medical care at BFDF. I visited several of the BFDF medical facilities including intake area, the main clinic that houses the close observation room consisting of two hospital beds, the two negative pressure isolation rooms that double as suicide prevention rooms, the Special Housing Unit (SHU), and several of the general population housing units. I also interviewed various BFDF custody and health care staff including the Health Services Administrator, the Program Manager who also serves as the Director of Quality Improvement, the medical director, and one of the Advance Practice Practitioners (APP). Additionally, I spoke to several detainees. I extend my most sincere thanks to all BFDF health care and custody leadership and front line staff for their hospitality and generosity with their time and resources. I would also like to thank BFDF health care and custody leadership and staff for their openness to my suggestions and critical appraisal of this facility's processes and activities. BFDF personnel were completely cooperative and helpful in this visit. I enjoyed full and unhindered access to all areas and staff.

The current BFDF health care personnel appear to be highly engaged and strongly committed and invested in caring for the detainees of this facility. The overall health care of the BFDF detainees appears to be in compliance with Performance-Based National Detention Standards 2011 (PBNDS 2011) and the National Commission on Correctional Health Care (NCCHC) standards. The BFDF detainees' health care experience starts at intake screening where, according to my audit of nearly 50 records, 100% of the detainees receive their intake screening within hours of arriving at the facility. Detainees identified as having a medical condition requiring continuation of medications are started on their medications within 24 hours of arrival regardless of the day of the week or the time of the day. I consider this a best in class achievement. Additionally, all detainees who are identified as having an acute or chronic medication condition are evaluated by a provider staff (physician or APP)

within a couple of days as part of their initial Health Assessment. All other detainees receive their initial Health Assessment evaluation by RN staff within 14 days of arrival to this facility. Detainees with chronic medical conditions are evaluated by the facility provider staff on a regular basis as part of the chronic care clinic process. Chart audits and detainee interviews indicated that medication continuity process is consistent and with very few misses. Dental care and sick call also appear to be functioning well with a couple of exceptions described below.

The facility dentist has been without a dental assistant since April 2018. As a result, the dental clinic productivity is near 50% of where it should be normally (currently between five to six patients per day instead of the normal 12 patients per day). Additionally, simple procedures such as dental extractions are currently being referred to community dental clinics at a high cost to the system. I was unable to assess the timeliness of the dental sick call due to lack of access to sick call requests. It was discovered during this visit that the dentist was inadvertently destroying dental sick calls after addressing them. This was corrected while I was on site.

The current sick call process consists of the nursing staff presenting a "sick call log" to each housing unit between the hours of 7 am to 9 am. Detainees are asked to put their names and their health issues on this sheet of paper. There are two significant issues with this approach. One is the obvious lack of privacy. Detainees are unable to confidentially express their health issues without other detainees and the custody staff having ready access to this information. Another issue is the restriction that this approach creates as detainees who may miss the opportunity to enroll in the daily sick call log are forced to wait until the following day unless the health care issue is of urgent nature.

Another example of a best in class process at BFDF is the disease prevention efforts that are currently in place with regard to intake screening for TB. 100% of all detainees at BFDF undergo a screening CXR within the first 3 days of arriving at this facility.

There were no areas of performance that could come close to potentially rising to the level of an unsafe environment of detention.

Report Organization

In addition to my review of the specific **medical allegations**, I will provide an overall assessment of the **performance of healthcare services** at BFDF based on Section II (Expected Outcomes) and Section V (Expected Practices) of the Performance-Based National Detention Standards 2011 (PBNDS 2011) (revised December 2016) and NCCHC 2018 Standards for Health Services in Jails. I will support my overall assessment of the performance of health care services at BFDF by providing a summary of several **chart review** investigations that stemmed from my personal interviews and interviews performed by other members of the CRCL team with detainees at BFDF, as well as a random chart audits based on various criteria including chronic disease, non-emergent health care request (sick call), ER referrals, specialty care services, etc.

My Credentials

(b) (6)

CRCL Allegations

Below, is my review and assessment of the following medical allegations at BFDF that were received by CRCL:

Detainee #1[1] alleged that he would kill himself or someone else because he has a mental disability and he has not received any medical attention.

Detainee #1 arrived at BFDF on June 15, 2018 and underwent an intake screening. He had normal vital signs and there was no reported or identified medical issues at that time and no reported history of chronic medications related to physical health issues. He underwent his initial health assessment three days later by the facility APP. Detainee was diagnosed with a behavioral health condition for which he was referred to BFDF behavioral health services. He was subsequently seen by facility MD for penile rash and had several labs ordered including HIV, RPR (for Syphilis), Hep C, GC (Gonorrhea and Chlamydia), and HSV (Herpes Simplex Virus). He was diagnosed with HSV infection and was treated accordingly.

Impression: this complaint with regard to not receiving any medical attention is unsubstantiated.

Detainee #2 alleged that since arriving at BFDF he contracted Hepatitis A, as well as liver and stomach issues. He claimed that he was sent to a doctor, but has not been provided with an explanation as to what is causing his pain, or what his status is. He also claimed that the treatment he is receiving from facility is making him feel depressed, and makes him want to do stupid stuff.

Detainee #2 arrived to BFDF on February 23, 2018 and underwent an initial health screening. He reported only a history of migraine and arthritis. He underwent his initial health assessment four days later. Detainee was evaluated by facility provider on March 2, 2018 for family history of diabetes. Blood work obtained at that time indicated Hepatitis which was later confirmed to be due to acute Hepatitis A. Detainee had formal referral and evaluation by Gastroenterology. He additionally underwent a hepatic ultrasound and a battery of blood tests to rule out other potential underlying causes. All other tests returned negative. Hepatitis later resolved based on follow up blood work. In all, this detainee had at least 32 nurse visits, three MD visits and 13 APP visits during this workup. Considering the above time line it is very likely (most likely) that detainee was exposed to Hepatitis A before entering BFDF. This is

[1] Please note that I have omitted from this report Personally Identifiable Information (PII) relating to the detainees discussed. Each detainee's name is included in Appendix A with the corresponding alien number so that the report can be freely shared, without the appendix, with those who have no need to know this PII.

further supported by the fact that Hepatitis A is a food borne pathogen and no one else in the facility developed this disease.

Impression: this complaint is unsubstantiated.

Detainee #3 alleged that he has severe internal issue which stems from him being stabbed four times in the stomach. Due to this incident, he has a lot of scar tissue in his stomach area and requires proper monitoring as it related to his internal system. According to the complaint, he has not received appropriate treatment, which caused bleeding and vomiting; he was rushed to the hospital and was advised by a doctor that if he had not continued to pursue care, his condition would have worsened and he would have needed surgery; and he has been denied medication for a skin condition, among other things.

Detainee #3 arrived at BFDF on June 25, 2015 and underwent an intake screening. During the intake screening he reported a history of asthma that was reportedly treated with Albuterol inhaler. CXR one day later showed surgical clips in his right upper lung. On June 13, 2018, detainee complained of new onset of nausea and vomiting and abdominal pain. He was transferred to the local hospital where he again reported new onset of his symptoms. He was diagnosed with small bowel obstruction most likely related to adhesion strictures that may have resulted from gunshot wound to his abdomen over 20 year ago. He was treated conservatively with suction and was transferred back to BFDF the following day. Intermittent bowel obstruction pursuant to internal abdominal injury/surgery is a common albeit unfortunate complication and completely unrelated to any care BFDF may have/could have provided.

Impression: this complaint is unsubstantiated.

Detainee #4 alleged calluses on his feet have become so large and painful that it has become difficult for him to walk. He also claimed that BFDF medical staff told him they would make a referral to a podiatrist, but it has yet to happen. He also reported that he has swelling in his left foot due to accident before entering ICE custody, and he was waiting to receive an MRI.

Detainee #4 arrived at BFDF on October 10, 2017 and underwent an intake screening. There was no reported or identified medical issues or history of chronic medications for physical health issues. He received his health assessment six days later and again there was no reported or identified medical issue. On October 21, 2017 detainee complained of left ankle pain due to old history of getting beaten by a baton. Detainee was referred to facility provider who ordered an x-ray of left foot and ankle that returned normal. Detainee was subsequently seen by facility APP on November 11, 2017 for callous on the bottom of both feet. Plain films and MRI of the feet returned normal on December 12, 2017. Detainee was referred to podiatry on December 29, 2017 and was seen the same day. Detainee was seen again by podiatry on April 5, 2018 for follow up and underwent debridement of callouses on both feet.

Impression: this complaint is unsubstantiated.

Detainee #5 alleged having periodic flares of rashes all over his body for five months and claimed that medical treatment provided was ineffective; he alleged he is currently experiencing swelling, itchiness, and difficulty eating and sleeping.

Detainee #5 arrived at BFDF on September 8, 2017 and underwent the intake screening during which there were no reported or identified chronic medical conditions or chronic medications. Detainee underwent his health assessment 10 days later which was also completely normal. On October 13, 2017, detainee reported new onset of a body rash which was treated by the nursing staff with Benadryl. On October 31, 2017 detainee again complained of rash for which he was referred to facility physician. Detainee was evaluated by the facility physician three days later and was diagnosed with tinea corporis (also known as ringworm). This diagnosis was confirmed one week later at the local hospital emergency room. Detainee has continued to have interval follow up.

Impression: this complaint is unsubstantiated.

Detainee #6 alleged that he has experienced a three-month delay for eyeglasses.

Detainee #6 arrived at BFDF on June 14, 2017 and underwent an intake screening. There were no reported or identified chronic medical conditions or chronic medications. Detainee underwent his health assessment one week later. Detainee submitted a sick call request for eye glasses to be brought in from home. He was issued a special needs form so that his glasses can

be brought in by his family. On February 21, 2018, detainee requested a referral to Optometry. Detainee was subsequently evaluated by Optometry on April 5, 2018. Detainee refused facility issued eye glasses and instead opted to have family members bring in a new pair of prescription eye glasses that may have caused the delay.

Impression: this complaint is unsubstantiated

Detainee #7 alleged that the facility provided him with inadequate medical care for a stroke and ruptured disk. He claimed that he experienced a stroke on August 7, 2018 and was unable to walk due to the effects of the stroke and ruptured disk. He further claimed that he has severe headaches and that one side of his body is not functioning, however, he was not treated for possible stroke and the facility medical staff did not follow hospital discharge care instructions among other things.

Detainee #7 underwent intake screening on May 21, 2018 and reported history of Sarcoidosis. He received his health assessment on May 22, 2108 by facility APP. He had a one week follow up with the facility APP where his CXR and lab results were reviewed. Detainee submitted sick call requests on May 30, June 13, June 29, July 31, and August 8. None of these related to his above allegation. He was evaluated for each of the above sick call requests. On August 10, 2018 detainee was evaluated for acute onset of loss of feeling to his right arm and right leg. He was transferred to the local hospital where multiple studies including CT of the brain and MRI/MRA of the brain ruled out stroke. He was evaluated by neurology while at the hospital that recommended outpatient neurology follow-up. Detainee left BFDF on August 25, 2018 prior to his scheduled outpatient neurology appointment.

Impression: this complaint is unsubstantiated

Detainee #8 alleged that BFDF staff have mentally and verbally abused her based on transgender status. She claimed that staff have made fun of her, disclosed her gender identity to other detainees to humiliate her, denied her hormone treatment, and ignored her transgender status. Detainee #8 alleged that staff have threatened to place her in segregation.

The overall medical record review does not support the above allegations. I investigated two specific medical complaints.

1. Detainee #8 reported suspected history of thyroid cancer. There is no evidence of this claim. The fine needle aspiration of the thyroid goiter on November 14, 2017 indicated a benign thyroid nodule.
2. Detainee #8 reported that the endocrinologist's recommendations from March 28, 2018 visit were ignored by the BFDF medical services. Review of the medical record indicates that the endocrinologist's recommendations from March 28, 2018 were transcribed verbatim into the electronic medical record and followed except for one medication. This exception is well explained in the medical record and complies with the acceptable standards of care.

Impression: this complaint is unsubstantiated

Detainee #9 alleged that he has received inadequate medical care for chronic left eye pain and double vision sustained after an assault by another detainee.

Detainee #9 was admitted to BFDF on February 6, 2018 and underwent intake screening during which he was identified as having asthma and chronic back pain due to old assault injury that he suffered in 2017. He underwent his health assessment by the facility PA on February 7, 2018. On August 3, 2018 he received injury to his left eye due to an assault by another detainee. He was evaluated at BFDF and referred to the local ED. He returned the following day with orders for only ice and ibuprofen. Detainee had a follow up visit with the facility PA two days later. On August 13, 2018 detainee was evaluated again in the sick call clinic for continued complaint of left eye pain and headache. He was evaluated by the facility APP on August 20, 2018 and was referred to Ophthalmology. Detainee's ophthalmology visit on September 27, 2018 was unremarkable.

Impression: The complaint is unsubstantiated.

Detainee #10 alleged that his blood was drawn, but he never received an explanation as to why.

Detainee #10was admitted to BFDF on September 7, 2018 with diagnosis of HIV. He was then seen for his initial health assessment three days later. Per protocol, he was ordered baseline HIV labs which were collected on September 12, 2018. The results of these labs were discussed with detainee at his initial chronic disease visit.

Impression: The complaint is unsubstantiated

Detainee #11 alleged he has received inadequate medical care for kidney stones, which causes urinary frequency and sleeplessness.

Detainee #11 was admitted to BFDF on December 8, 2017 and reported history of kidney stones that was asymptomatic at the time. On March 28, 2018, detainee had new onset of hematuria and pain. He reported that he may have "passed a stone." He was evaluated by the facility provider and received a KUB. He had a follow up with the facility provider on April 11, 2018 and voiced no complaints at that time. Detainee left BFDF and was re-admitted to BFDF on July 19, 2018 with the same history of kidney stones. Since his new admission, detainee has had six sick call visits none of which are regarding kidney stones.

Impression: The complaint is unsubstantiated

Detainee #12 alleged that he has received inadequate medical care for stomach, abdominal, and testicle pains. He claimed that Ibuprofen and Metamucil have been ineffective.

Detainee #12 was admitted to BFDF on June 26, 2018 with history of HTN, Epilepsy, and Asthma. He received his health assessment on the following day. On June 29, 2018, detainee submitted sick call request for right sided abdominal pain. This was evaluated and treated with pain medication. On July 4, 2018, detainee submitted another sick call request for intermittent right sided abdominal pain radiating to his groin and testicles. This was also evaluated and treated with pain medication. On August 14, 2018, detainee underwent a testicular ultrasound that was unremarkable. On September 1, 2018, detainee was evaluated for acute onset of abdominal pain as well as nausea and vomiting. He was transferred to the local hospital where CT of abdomen was read as normal except for mild thickening of the gastric wall. Since that time, detainee submitted sick calls on September 7, 19, 24, October 6, 25, November 9, 15 and December 4. None of these sick calls related to the above allegation.

Impression: The complaint is unsubstantiated

<u>**Performance of Health Care Services**</u>

As mentioned in the executive summary, I found several areas of care that

met PBNDS 2011 and NCCHC standards of care for detention facilities. Below, I will focus my findings to those PBNDS 2011 and/or NCCHC standards that were **not met** along with my recommendations for remediation.

PBNDS 2011, Std. 4.3.II.1. Detainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment.

PBNDS 2011, Std. 4.3.V.A.3: Every facility shall directly or contractually provide its detainee population with the following:... Comprehensive, routine and preventive health care, as medically indicated.

Findings:

BFDF has failed to provide comprehensive preventive care for the detainee population who quality for routine vaccination based on Centers for Disease Control and Prevention (CDC) guidelines. Specifically, all asthmatic detainee charts, all diabetic detainee charts, and one of three HIV positive detainee charts audited in this visit lacked documentation of Pneumovac vaccination. Representative cases include 26-33 and 36 in Appendix B.

Recommendation:

- BFDF must train and educate the staff to provide immunization according to national guidelines.

PBNDS 2011, Std. 4.3.II.4. Detainees shall be able to request health services on a daily basis and shall receive timely follow-up.

PBNDS 2011, Std. 4.3.V.S. Sick Call. Detainees must have "unrestricted opportunity to freely request health care services…"

NCCHC J-E-07: Inmates' non emerging health care needs are met.

Findings:

The PBNDS 2011 states that detainees must have "unrestricted opportunity to freely request health care services." BFDF detainees have the ability to submit sick call requests on a daily basis, but their ability is hindered by the way this process is designed. The current sick call process consists of the nursing staff presenting a "sick call log" to each housing unit between the hours of 7 am to 9 am. Detainees are asked to put their names and their medical condition on this sheet of paper. There are two significant issues with this approach. One is the obvious lack of privacy. Detainees are unable to confidentially express their health issues without other detainees and the custody staff having ready access to the information. Another issue is the restriction that this approach creates. Detainees who may miss the opportunity to enroll in the daily sick call log are forced to wait until the following day unless the health care issue is of an urgent nature. Additionally, the current design makes it extremely difficult to audit the sick call process for timeliness since there are no actual sick call requests entered into the detainee health record charts. The only option at this time to compare the daily sick call logs against the nursing sick call encounters.

Representative cases include 20, 21 and 23 in Appendix B.

Recommendations:

- BFDF should redesign the sick call process to allow for privacy and unrestricted access of detainees to non-urgent sick call requests.
- BFDF must create a system and an audit tool to allow for tracking of sick call requests to ensure that all sick call requests are addressed in a timely manner.

PBNDS 2011, Std. 4.3.V.R.1. Emergency dental treatment shall be provided for immediate relief of pain, trauma and acute oral infection.

PBNDS 2011, Std. 4.3.V.S. Sick Call. Detainees must have "unrestricted opportunity to freely request health care services…"

NCCHC J-E-07: Inmates' non-emerging health care needs are met.

Findings:

The facility dentist has been without a dental assistant since April 2018. As a result, the dental clinic productivity is near 50% of where it should be normally (currently between five to six patients per day instead of the normal 12 patients per day). Additionally, simple procedures such as dental extractions are currently being referred to community dental clinics at a high cost to the system. I was unable to assess the timeliness of the dental sick call due to lack of access to sick call requests. It was discovered during this visit that the dentist was inadvertently destroying dental sick calls after addressing them. This was corrected while I was on site.

Recommendations:

- BFDF should hire a dental assistant to improve dental clinic timeliness and efficiency (best practice).
- BFDF should maintain a copy of all dental sick call requests and create a monitoring tool to allow for assessment of the timeliness of dental sick call requests.

PBNDS 2011, Std. 4.3.II.6. A detainee who is determined to require health care beyond facility resources shall be transferred in a timely manner to an appropriate facility. A written list of referral sources, including emergency and routine care, shall be maintained and updated annually.

PBNDS 2011, Std. 4.3.V.A.5. Every facility shall directly or contractually provide its detainee population with the following:... Specialty health care.

NCCHC J-D-08. Hospitalization and specialty care are available to patients who need these services.

Findings:

Detainees have good access to emergency and specialty medical care. Their access to specialty care, however, is not timely. Several examples of detainees waiting for various specialty health care services for more than a month were observed during my

audit.

Representative cases include 11-13, 16, and 19 in Appendix B.

Recommendation:

- BFDF should ensure that detainees identified as needing specialty services receive an evaluation by a specialist in a timely manner and ideally within 30 days (best practice).

PBNDS 2011, Std. 4.3.II.12: Detainees with chronic conditions shall receive care and treatment, as needed, that includes monitoring of medications, diagnostic testing and chronic care clinics.

Findings:

Almost all detainees with asthma whose charts were audited during this visit lacked peak flow meter measurements during their clinical encounters.

Representative cases include 26-29, 32, and 33 in Appendix B.

Recommendation:

- BFDF should ensure that detainees with asthma receive peak flow meter measurements during their clinical encounters at least during their initial intake and health assessment encounters and their interval chronic care clinic visits.

PBNDS 2011, Std. 4.3.II.30. This standard and the implementation of this standard will be subject to internal review and a quality assurance system in order to ensure the standard of care in all facilities is high.

PBNDS 2011, Std. 4.3.V.EE.1. Quarterly Administrative Meetings

PBNDS 2011, Std. 4.3.V.EE.2. Health Care Internal Review and Quality Assurance

NCCHC J-A-06: A continuous quality improvement (CQI) program monitors and improves health care delivered in the facility.

Findings:

BFDF's current Quality Improvement program was implemented in August 2018. QI meeting minutes for the past few meetings were reviewed. Attendance is relatively low at five to seven participants. Many of the topics were redundant and rather superficial. There were no trending or statistical information shared at the meetings (at least not according to the meeting minutes). Specifically, there is little evidence that any tracking/trending information is shared with the committee or that any action plans are developed/monitored.

Recommendations:

- BFDF must enhance its quality improvement committee to include leaders from health care and detention divisions.
- BFDF should ensure that the quality improvement committee identifies aspects of health care that are not meeting the minimum standards of care based on PBNDS, NCCHC, or evidence-based community best practices. The committee should then create action plans to address these issues and monitor the ongoing performance of the system.
- BFDF should ensure that the quality improvement committee completes at least one process and/or outcome quality improvement study each year.

PBNDS 2011, Std. 4.3.V.I. All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. Copies of the documents must be maintained on site and readily available for review. A restricted license does not meet this requirement.
NCCHC J-C-01: The credentialing verification process includes inquiry regarding sanctions or disciplinary actions of state boards and, for prescribers, the National Practitioner Data Bank (NPDB).

Findings:

Credentialing files for the facility physician and three APPs (Advance Practice Providers) were complete with the exception of the following:

- All files lacked a copy of picture ID verifying the identity of the provider.

- PA credentialing file lacked the National Practitioner Data Bank verification.
- PA license is set to expire at the end of this December 2018.

Recommendations:

- BFDF should include a copy of a government issued picture ID in every credentialing file.
- BFDF should obtain and include a NPDB verification form in the credentialing file of the PA.

PBNDS 2011, Std. 4.3.V.BB.1. Health Record File
NCCHC J-A-08: A confidential health record is created and maintained using a standardized format.

Findings:
As mentioned above, the current sick call process at BFDF eliminates confidentiality for the detainees who put their name and their medical condition for which they are seeking attention.

Recommendation:

- Please see the recommendations in my discussion of the sick call process.

Case/Chart Reviews

The discussion, findings, and recommendations contained in the Detainee Interviews, Significant Incident Reports, Specialty Care Chart Reviews, and Additional Chart Reviews sections below are drawn from my review of medical records related to the cases discussed. The name and alien number for each detainee is contained in Appendix B, and corresponds to the number associated with each discussion.

Detainee Interviews

1. Reported blood in stool that was not getting proper attention.

Review of records indicates that detainee was seen by nurse on December 7, 2018 for this complaint. Plan was to refer detainee to provider. No provider referral was found. Upon further investigation it was discovered that the corresponding provider referral for this sick call request was inadvertently deleted. A new provider referral was created when the issue was raised to address this issue.

Impression: this complaint is substantiated.

Recommendation:

- Please see the recommendation in my discussion of the specialty care.

2. Reported concerns for his health with "male bleeding," incontinence, facial twitching and overall "life threatening issues."

Review of records indicates that detainee has a chronic diagnosis of HTN, sarcoidosis, Chronic Kidney Disease stage III and high cholesterol. Detainee was evaluated on September 20, 2018 in a sick call visit for incontinence and hematuria. Detainee was referred to and was evaluated by Urology and had a normal CT scan and cystoscopy. Detainee was additionally evaluated on December 13, 2018 for episode of facial drooping and resolved spontaneously. He has been referred to neurology and has an MRI of brain scheduled for January 12, 2019. Detainee has future urology and nephrology follow up appointments.

Impression: this complaint is unsubstantiated.

3. Reported swollen knee that is not being treated.

Detainee arrived at BFDF on November 14, 2018 and denied all medical issues during intake screening. She submitted a sick call request on December 13, 2018 for new onset of right leg pain that was not related to any physical injuries. She was evaluated by nursing staff and was given ibuprofen for pain.

Impression: this complaint is unsubstantiated.

4. Reported swollen knee that is not being treated.

Detainee arrived at BFDF on June 29, 2018 and denied all medical issues. She underwent her health assessment on July 10 and again denied all medical issues. She submitted sick call requests on August 4, September 3, September 17, October 24 and November 17 for issues unrelated to the above complaint. She was evaluated for all of the above sick call requests. On December 10, 2018, detainee complained of acute onset of knee pain that was unrelated to injuries. Her examination, however, was normal. On December 16, 2018, detainee submitted another sick call request for worsening of left knee pain. On that day, her exam was remarkable for swelling, ecchymosis (bruising), and tenderness. Nursing staff referred this case to the facility APP who prescribed rest, ice, and pain medication and a follow up in a few days.

Impression: this complaint is unsubstantiated.

5. Reported swollen feet that are being ignored.

Detainee arrived at BFDF on October 18, 2018 with history of latent TB infection (LTBI) for which the detainee was already receiving treatment. LTBI treatment was continued. Detainee received a health assessment on October 19, 2018. On December 17, 2018 detainee submitted a sick call request for which she was evaluated, diagnosed with fungal foot infection, and is currently under treatment with a topical medication.

Impression: this complaint is unsubstantiated.

6. Alleged kidney stones are being ignored.

Detainee arrived at BFDF on July 19, 2018 with no medical history. He received his health assessment on July 28, 2018 which again was normal. Detainee submitted six sick call

requests between August 19 and October 22 for left knee pain and constipation. On October 29, 2018, detainee submitted a sick call request for "right kidney pain" and requested pain medication. Detainee submitted another sick call request on November 1, 2018 for the same issue. He was referred to the facility provider who diagnosed the detainee with new onset of diabetes based on the detainee's finger stick blood glucose and large glucose in his urine. At this point, there is no evidence of kidney stone.

Impression: this complaint is unsubstantiated.

7. Alleged that his foot was run over by a cart two days ago and he is experiencing pain in his toes.

Detainee submitted two sick call requests on December 17 and 18 neither of which were addressed by the nursing staff. Detainee has a provider appointment today (December 19).

Impression: this complaint is substantiated.

Recommendation:

Please see the recommendations in my discussion of the sick call process.

Significant Incident Reports

8. Detainee was transferred to local ED on November 13, 2017 for low blood oxygen level. Detainee received intake screening on April 20, 2017 with history of CAD and MI but on no medications. His screening CXR was normal. On July 8, 2017 a repeat CXR for acute onset of cough indicated early pneumonia for which he was treated with oral antibiotics. On November 13, 2017, detainee presented with new onset of shortness of breath for which he was transferred to local ED. He was admitted and treated for bronchitis and returned to BFDF on November 16, 2017

Impression: ED transfer was appropriate.

9. Detainee was transferred to local ED on February 15, 2018 for DKA.
Detainee received intake screening on December 1, 2017 with no medical history (only behavioral health issues). He was diagnosed with new onset of DM and DKA on February 15, 2018 based on presentation of nausea and vomiting, thirst and blurred vision.

Impression: ED transfer was appropriate.

10. Detainee was transferred to local ED on May 11, 2018 for active TB and pleural effusion. Detainee received intake screening on May 23, 2018 after he was diverted at initial presentation on May 11, 2018 due to history of recent diagnosis of pulmonary TB and left pleural effusion.

Impression: ED transfer was appropriate.

Specialty Care Chart Reviews

Chart Number	Specialty	Referral Date	Appointment Date	Wait Time
11	Urology	5/11/2018	6/22/2018	42
12	Endocrinology	6/27/2018	12/12/2018	168
13	Podiatry	10/29/2018	11/29/2018	31
14	Cardiology	11/8/2018	11/14/2018	6
15	ENT	11/13/2018	11/20/2018	7
16	Ophthalmology	10/9/2018	11/20/2018	42
17	Vascular	10/22/2018	11/13/2018	22
18	Nephrology	11/7/2018	11/8/2018	1
19	Ortho	3/28/2018	5/16/2018	49

Additional Chart Reviews

While at the facility I reviewed a number of charts. Below is my assessment of the charts reviewed. These reviews have been used as reference to the corresponding PBNDS 2011 and NCCHC standards that are unmet as indicated above.

20. Detainee was seen by dental on December 10, 2018 for sick call request. No sick call log found to correspond to this visit.
21. Detainee was seen by dental on December 10, 2018 for sick call request. No sick call log found to correspond to this visit.
22. Detainee was seen by dental on December 4, 2018 for sick call request. Was able to locate sick call log corresponding to this visit.
23. Detainee was seen by dental on November 27, 2018 for sick call request. No sick call log found to correspond to this visit.
24. Detainee was seen by dental on December 13, 2018 for sick call request. Was able to locate sick call log corresponding to this visit.
25. Detainee was seen by dental on December 4, 2018 for sick call request. Was able to locate sick call log corresponding to this visit.
26. Detainee received intake screening on January 13, 2017 (asthma and epilepsy). Health Assessment (HA) by APP on January 16, 2017. No peak flow measurement. No Pneumovac vaccination, no flu vaccination
27. Detainee received intake screening on October 10, 2017 (asthma, CAD, HTN, DM). HA by MD on October 10, 2017. No peak flow measurement. No Pneumovac vaccination, no flu vaccination
28. Detainee received intake screening on August 13, 2018 (asthma). HA by PA on August 14, 2018. No peak flow measurement. No Pneumovac vaccination, no flu vaccination
29. Detainee received intake screening on September 22, 2018 (asthma, HTN, DM, high cholesterol). HA by PA on September 24, 2018. No peak flow measurement. No Pneumovac vaccination, flu vaccination was given.
30. Detainee received intake screening on March 27, 2018 (DM, HTN, high cholesterol). HA by APP on March 28, 2018. No Pneumovac vaccination, flu vaccination was given.

31. Detainee received intake screening on August 2, 2018 (DM, HTN). HA by APP on August 2, 2018. No Pneumovac vaccination, flu vaccination was given.
32. Detainee received intake screening on August 12, 2015 (Asthma, HTN, high cholesterol). HA by PA on August 13, 2015. Was diagnosed with DM by routine HgbA1C on January 24, 2018. No Pneumovac vaccination, flu vaccination was given. No peak flow.
33. Detainee received intake screening on September 22, 2018 (DM, HTN, Asthma, high cholesterol). HA by PA on September 24, 2018. No Pneumovac vaccination, flu vaccination was given. No peak flow.
34. Detainee received intake screening on January 9, 2018 (HIV, HTN). HA by PA on January 10, 2018. Received Pneumovac and flu vaccination. First ID visit was carried out via e-consult within the first week of arrival at BFDF.
35. Detainee received intake screening on September 7, 2018 (HIV). HA by PA on September 10, 2018. Received Pneumovac and flu vaccination. First ID visit was carried out via e-consult within the first week of arrival at BFDF.
36. Detainee received intake screening on September 19, 2018 (HIV). HA by PA on September 20, 2018. Received flu vaccination. No evidence of Pneumovac vaccination. First ID visit was carried out via e-consult within the first week of arrival at BFDF.

Summary of Recommendations:

1. BFDF has failed to provide comprehensive preventive care for the detainee population who quality for routine vaccination based on Center for Disease Control and Prevention (CDC) guidelines. Specifically, all asthmatic detainee charts, all diabetic detainee charts, and one of three HIV positive detainee charts audited in this visit lacked documentation of Pneumovac vaccination. BFDF must train and educate the staff to provide immunization according to national guidelines.
2. BFDF detainees have the ability to submit sick call requests on a daily basis, but their ability is hindered by the way this process is designed. The current sick call process consists of the nursing staff presenting a "sick call log" to each housing unit between the hours of 7am to 9am. Detainees are asked to put their names and their medical condition on this sheet of paper. There are two significant issues with this approach. One is the obvious lack of privacy. Detainees are unable to confidentially express their health issues without other detainees and the custody staff having ready access to the information. Another issue is the restriction that this approach creates. Detainees who may miss the opportunity to enroll in the daily sick call log are forced to wait until the following day unless the health care issue is of urgent nature. Additionally, the current design makes it extremely difficult to audit the sick call process for timeliness since there are no actual sick call requests entered into the detainee health record charts. The only option at this time to compare the daily sick call logs against the nursing sick call encounters.
    - BFDF should redesign the sick call process to allow for privacy and unrestricted access of detainees to non-urgent sick call requests.
    - BFDF must create a system and an audit tool to allow for tracking of sick call requests to ensure that all sick call requests are addressed in a timely manner.
3. Detainees have good access to emergency and specialty medical care. Their access to specialty care, however, is not timely. Several examples of detainees waiting for various specialty health care services for more than a month were observed during my audit. BFDF should ensure that detainees identified as needing specialty services receive an evaluation by a specialist in a timely manner and ideally within

30 days (best practice).

4. Almost all detainees with asthma whose charts were audited during this visit lacked peak flow meter measurements during their clinical encounters. BFDF should ensure that detainees with asthma receive peak flow meter measurements during their clinical encounters at least during their initial intake and health assessment encounters and their interval chronic care clinic visits.

5. BFDF's current Quality Improvement program was implemented in August 2018. QI meeting minutes for the past few meetings were reviewed. Attendance is relatively low at five to seven participants. Many of the topics were redundant and rather superficial. There were no trending or statistical information shared at the meetings (at least not according to the meeting minutes). Specifically, there is little evidence that any tracking/trending information is shared with the committee or that any action plans are developed/monitored.

    - BFDF must enhance its quality improvement committee to include leaders from health care and detention divisions.
    - BFDF should ensure that the quality improvement committee identifies aspects of health care that are not meeting the minimum standards of care based on PBNDS, NCCHC, or evidence-based community best practices. The committee should then create action plans to address these issues and monitor the ongoing performance of the system.
    - BFDF should ensure that the quality improvement committee completes at least one process and/or outcome quality improvement study each year.

6. Credentialing files for the facility physician and three APPs (Advance Practice Providers) were complete with the exception of the following: all files lacked a copy of picture ID verifying the identity of the provider; PA credentialing file lacked the National Practitioner Data Bank verification; and PA license is set to expire at the end of this December 2018.

    - BFDF should include a copy of a government issued picture ID in every credentialing file.

- BFDF should obtain and include a NPDB verification form in the credentialing file of the PA.

7. BFDF has been without a dental assistant since April 2018. As a result, the dental clinic productivity is near 50% of where it should be normally and simple procedures such as dental extractions are currently being referred to community dental clinics at a high cost to the system.

    - BFDF should hire a dental assistant to improve dental clinic timeliness and efficiency (best practice).
    - BFDF should maintain a copy of all dental sick call requests and create a monitoring tool to allow for assessment of the timeliness of dental sick call requests.

Appendix A

Detainee No.	Name, Alien No.
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Appendix B

Case/Chart No. Name, Alien No.

Case/Chart No.	Name, Alien No.
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(b) (6) PH.D.
Atlanta, GA

CONFIDENTIAL

REPORT FOR THE
U.S. DEPARTMENT OF HOMELAND SECURITY
OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES
December 17-19, 2018

Investigation Regarding Buffalo Federal Detention Facility

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

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CRCL'S INVESTIGATION OF BFDF's MENTAL HEALTH DELIVERY SYSTEM

INTRODUCTION

Referral Issue

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation of complaints it received that included issues regarding the adequacy of Buffalo Federal Detention Facility's (BFDF) mental health delivery system for ICE detainees. I specifically reviewed the mental health care provided to the complainants. I also reviewed the care provided to other detainees by: interviewing staff and detainees; reviewing randomly selected medical records; and reviewing administrative documents. The medical records were selected from detainees who had been placed in the Medical Housing Unit (MHU) on suicide precautions, in the Special Housing Unit (SHU) on segregation and protective custody status, and in general population units for high and low security detainees. These interviews and record/document reviews were used to assess BFDF's mental health delivery system's compliance with Performance-Based National Detention Standards 2011 (PBNDS 2011) and other related professional standards, to include best practices.

Professional Qualifications

(b) (6)

forensic/correctional consultant since 1988.

Standards, Policies, Procedures, and Best Practices

- Performance-Based National Detention Standards 2011 (PBNDS 2011)
- IHSC Directives 07-02, 03-25, 03-04
- IHSC OM #16-002
- IHSC Behavioral Health Services Guide
- BFDF Mental Health Policy
- National Commission on Correctional Healthcare's Standards for Jails 2014, (NCCHC)
- Prison Rape Elimination Act (PREA) and Sexual Abuse and Assault Prevention and Intervention (SAAPI) policies
- Psychiatric Services in Jails & Prisons, 2000 (American Psychiatric Association, APA)

Sources of Information

- **Facility Tour**
- **Observations of Mental Health Delivery System in action**
- **Documents Reviewed**
  - IHSC Directive 07-02, Behavioral Health Service (Overview)
  - IHSC Behavioral Health Services Guide, Effective Date: 25 March 2016
  - IHSC Directive 03-25, Gender Dysphoria & Transgender Detainees
  - IHSC Directive 03-04, Clinical Practice Guidelines For Chronic Care Conditions
  - BFDF Mental Health Care Policy 4.5.7
  - IHSC OM 16-002 Significant Self-Harm and Suicide Prevention
  - Office of Detention Oversight Compliance Inspection, April 18-20, 2017
  - PBNDS Inspection Worksheet for BFDF, 1/14/2017 to 2/17/2017
  - CRCL Medical Expert Investigative Report, October 29, 2012
  - CRCL Correctional Expert Investigative Report, October 29, 2012
  - Behavioral Healthcare Records of 11 Detainees
  - Mental Health Staff Credentials Packet
  - BFDF's Suicide Prevention Training Verification (2018)
  - CQI Mental Health Process Study (2018)
  - Quarterly Health Care Administrative Meeting Minutes
  - Monthly Health Care Services Staff Meeting Minutes
  - Psychotropic Medication Utilization Report, December 2018
  - List of Detainees Receiving Mental Health Services, November 2018
  - List of Detainees on Suicide Watch in the past 12 months

- List of Detainees admitted to Columbia Regional Care Center (CRCC) in the past 12 months

➢ **Staff Interviewed**

1) (b)(6)
2)
3)
4)
5)
6)

➢ **Detainee Interviewed**

(Refer to Appendix I)

➢ **Medical Records Reviewed**

(Refer to Appendix II)

Description of Buffalo Federal Detention Facility (BFDF)

Buffalo Federal Detention Center (BFDF), in Batavia, New York, opened in March 1998. It is owned and operated by the US Immigration and Customs Enforcement (ICE) and Akima Global Services (AGS) provides security and other services under contract. The Office of Enforcement and Removal Operations (ERO) began housing detainees at BFDF in March 1998 as a Service Processing Center under the oversight of the ERO Field Office Director (FDO) in Buffalo, New York.

ERO has assigned ERO Deportation Officers and a Detention Services Manager (DSM) to the facility. An ICE Assistant Field Office Director (AFOD), (b) (6), (b) (7)(C) is responsible for oversight of daily facility operations and is supported by approximately 357 personnel. ICE Health Service Corps (IHSC) provides detainees medical and mental care. The facility holds accreditations with the American Correctional Association and the National Commission on Correctional Healthcare.

The facility has a reported capacity of approximately 636 detainees. The detainee count reportedly ranges from 600 to 620 with a count of 612 detainees on December 17, 2018, which consisted of (542 male (87%) and 80 female (13%) detainees. The length of stay usually ranged from eight to 10 weeks, with the average length of stay being 65 days. The females are housed in unit (b)(7) . The high-security males are housed in single cells on (b) (7)(E) . The low/medium security males (b) (7)(E)

During CRCL's investigation, among the ten detainees on disciplinary segregation, five were receiving mental health services and five were not receiving mental health services. Additionally, among the nine detainees in administrative segregation, five were receiving mental health services and four were not receiving mental health services. The medical unit has two negative airflow cells which are also used for suicide precautions (suicide watch, constant watch,

and mental health observation). No detainees were on suicide watch (SW), constant watch (CW), or mental health observation (MHO) during CRCL's investigation. Medical did not have any infirmary beds.

The number of detainees receiving mental health services was fluid, changing daily. In response to a request for a list of detainees receiving mental health services, BFDF provided a document which identified 93 detainees receiving mental health services. In other words, 15.2% of the detainee population was receiving mental health services. Analysis of the names revealed that approximately 15 detainees were female and 78 were male. Analysis of the female and male populations revealed that 18.8% of all females and 14.4% of all males were receiving mental health services. In response to a request for a list of detainees receiving psychotropic medication (antipsychotic medication, antidepressant and anxiolytic medication, and mood stabilizers), the pharmacist produced a list of 42 detainees being treated with psychotropic medication. In other words, 45% of the mental health caseload was being treated with medication, 33% of them with antipsychotic medication and 67% with medication for anxiety and/or depression. No detainees were being treated with a mood stabilizers.

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

Protected by the Deliberative Process Privilege

EXECUTIVE SUMMARY

CRCL conducted two onsite investigations at BFDF, one in 2012 and the other in 2018. The focus of the 2012 CRCL investigation was on medical care and correctional conditions. (b)(6) (b)(6) was the medical subject matter expert and (b)(6) was the correctional subject matter expert. The 2012 results from the CRCL medical/mental health investigation were very good. In fact, (b)(6) concluded that "the medical care provided by IHSC at BFDF was excellent, meeting or exceeding expectations for care on more than 100 elements in a draft performance measurement tool."

ICE also conducted a PBNDS 2011 inspection of BFDF in 2017. Once again, medical and mental health care did very well, meeting all components from PBNDS 2011 Standard 4.3 (Medical Care) and Standard 4.6 (Significant Self-Harm and Suicide Prevention and Intervention).

The 2018 CRCL investigation was expanded to include mental health because detainees were filing complaints with the OIG about the allegedly inadequate provision of mental health services. To understand BFDF's mental health delivery system, staff and detainees were interviewed, medical records were reviewed, and administrative documents were reviewed to include the credentials of mental health care providers, continuous quality improvement studies, training logs, significant incident reports, a use of force report, and a pharmacy report.

The mental health staff consisted of one full-time psychologist, one full-time licensed clinical social worker, and three part-time psychiatrists (one psychiatrist onsite for approximately two hours every other week, one tele-psychiatrist for approximately three hours a week, and another tele-psychiatrist who worked when needed). Please note that two psychiatrists were briefly interviewed. They stated that their hours were flexible. In other words, they were available to work more hours if needed. The full-time psychologist was not interviewed because he was working in Texas on temporary duty (TDY). Mental health's staffing pattern also had one vacant licensed clinical social worker position. Being short staffed in general and especially during this investigation, the LCSW was very busy; however, she went out of her way to spend time with me all three days of the investigation. The Program Coordinator, the Assistant Health Administrator, and the Clinical Director also went out of their way to make themselves available as needed. The officers were also very helpful in coordinating detainee interviews.

Approximately 20% of the mental health caseload (20 detainees) was reviewed, either by individual face-to-face interviews and/or by medical record reviews. Detainees were selected because they either: filed a complaint about the delivery of mental health services with the OIG; were referred by members of CRCL's investigative team during the investigation; or were randomly selected from the SHU and general population dorms. Unfortunately, the sample only consisted of males. Females had been selected; however, they were not reviewed because of logistical problems.

The findings revealed a professional, knowledgeable, skilled, motivated, and committed staff.

They spoke candidly, sharing their accomplishments and challenges. Along with knowing the policies and procedures, they knew and respected the detainees. At no time did I observe staff being punitive or disrespectful toward the detainees. In fact, they demonstrated compassion while maintaining firm limits. The mental health staffing pattern was lean and their clinical and administrative demands were great (i.e., performing intake assessments, responding to referrals in a timely manner, making required rounds, taking "call after hours," providing treatment, consulting with other Departments, developing and updating treatment plans, documenting services delivered, and coordinating psychiatry schedules and tele-psychiatry). In order to meet these demands, they had to be efficient and hard working. Their psychological/psychiatric assessments and treatment documentation were generally very good and their relationships with the detainees were professional and therapeutic.

The findings also revealed a broad spectrum of mental illness, ranging from mild to moderate mood and adjustment disorders, to serious and chronic psychotic disorders, to high acuity disorders characterized by distress, suicidality, and unpredictability. In general, these mentally ill detainees appeared to be outliers on at least two dimensions. First, they were disproportionately represented in the SHU, making up 10 of the 19 detainees in the SHU (53%), while only making up 15% of the total detainee population. Second, the average length of stay (LOS) at BFDF for the 20 detainees who were reviewed was longer than for the overall general population's average length of stay, (eight months vs two to three months, respectively).

Most detainees receiving mental health services had mild to moderate mental health problems which were being adequately managed/treated by mental health and medical staff. Along with these mildly/moderately mentally ill detainees, there were detainees who were seriously mentally ill and/or acutely distressed. In contrast to the former detainees, many of the latter detainees were receiving care that was less than optimal.

Seriously mentally detainees are usually unable to live independently in the community. If they are not living in a residential facility, they are usually homeless. While in detention, if these detainees are not living in a structured, sheltered living unit, they are often in segregation or protective custody. If they are living in the general population, they are usually isolated. The reviews identified many detainees who, by default, were living in the SHU or isolated in general population.

The acutely distressed detainees also have difficulty living in any stressful environment because they are easily overwhelmed by changes in routine and by relatively minor stressors. Their coping strategies/defense mechanisms are usually maladaptive, making bad situations worse, resulting in transient psychotic episodes and/or self-injurious behavior. The reviews identified at least half a dozen detainees whose distress either did not come to the mental health staffs' attention or was minimized by mental health staff. Regardless of the reasons why they were "falling through the cracks," their distress was being exacerbated, increasing their risk of suicidal behavior.

Along with the above findings, a review of administrative documents revealed an active medical/mental health continuous quality improvement program, up-to-date staff suicide

prevention training logs, credentialing files which were well organized and contained all required documents, and minutes from quarterly medical/mental health administrative meetings. Additionally, reviewed medical records revealed timely and comprehensive mental health evaluations, a holistic and integrative medical/mental health treatment approach, and overall, appropriate mental health interventions. At no time were staff perceived as punitive.

There were two significant "big picture findings," namely, gaps in mental health's continuum of care and inadequate mental health staffing. One of the gaps in BFDF's continuum of care was the paucity of services for seriously mentally ill detainees who have become invisible in protective custody and general population. An "ideal fix" would be to create a small sheltered living unit with programming that keeps these detainees active and makes them feel safe. A "realistic fix" would be to increase the activities for these seriously mentally ill detainees, in their current units.

The other gap in BFDF's continuum of care was a dearth of services for distressed detainees who were teetering on the edge of becoming overwhelmed and self-injurious. Many of these detainees were relatively recent arrivals who were having problems adjusting to being detained at BFDF. However, some were detainees who had lived at BFDF for months and never adapted to it. Consequently, they continued to struggle with their distress which was occasionally minimized by overworked staff who tended to see their behavior as exaggerated or manipulative. A "realistic fix" would include being proactive, identifying relatively fragile detainees, and preventively providing them with psycho-educational and supportive services.

The second "big picture finding" was inadequate mental health staffing. Given the American Psychiatric Association's standard of care, psychiatry needs to be increased, allowing them to be active members of the treatment team, making big contributions to the care of the seriously mentally ill and acutely distressed detainees. Additionally, filling the vacant licensed clinical social worker position would go a long way in helping to close the gaps in BFDF's mental health continuum of care.

"Smaller picture," relatively "quick fix" findings included: enhancing the two suicide resistance cells in the Medical Housing Unit, making it more difficult for detainees to commit suicide; ensuring privacy while talking with detainees receiving mental health services in the SHU, especially those who are seriously mentally ill; increasing psychiatric follow-up with detainees being treated with psychotropic medication to at least every 30 days; ensuring that psychiatry schedules detainees who are being treated with psychotropic medication prior to their medications lapsing; and expanding mental health continuous quality improvement (CQI) studies, focusing on the delivery of acute care.

In conclusion, the overall delivery of mental health care was excellent, with the exception of services being provided to seriously mentally ill and subacute/acute detainees who were not receiving the appropriate level of mental health care. (b)(6) the psychologist who was on TDY, and (b)(6) are both skilled and conscientious clinicians, providing a wide array of mental health services; however, there is a limit to the services they can provide. Consequently, the major recommendation to close the gaps in mental health's continuum of care is going to

require an increase in mental health staffing.

REVIEW OF MENTAL HEALTH CARE PROVIDED TO 20 BFDF DETAINEES

➢ A REVIEW OF TWO MEDICAL / MENTAL HEALTH CARE COMPLAINANTS

Complaint No. 18-02-ICE-0050
Complaint No. 18-07-ICE-0245
Complaint No. 18-10-ICE-0482
Complaint No. 18-11-ICE-0569
Complaint No. 18-12-ICE-0648
Complaint No. 18-12-ICE-0651

There were six allegations dealing with Medical and Mental Health Care, one allegation dealing with the Care of Transgender Detainees, and six allegations dealing with Facility Operations. Three allegations that were applicable to Mental Health Care are presented below.

A. Detainee A (Refer to Appendix II)

1) Documents Reviewed

Case Summary Report C18-ICE-DET-33076
CRCL Medical Referral
IHSC Response (9/04/2018)
Detainee A's Medical Record

2) Detainees Interviewed

Not Applicable

3) Nature of the Complaint

Detainee A called the OIG hotline on 6/22/2018 to file a complaint because he was being held eight days more than his initial four-year sentence. He called the Guyana Embassy twice in June 2018 and was told that they had not received his travel documents. The complainant reportedly stated that he will hurt himself or someone else because he has a mental health disability and he has not received any medical attention.

4) IHSC Response (9/04/2018) to CRCL Medical Referral (7/19/2018)

IHSC noted that the complainant arrived at BFDF on 6/15/2018. His intake assessment, which was performed on the day of his arrival, revealed a reported history of self-harm and auditory hallucinations; however, the detainee denied current suicidal ideation or auditory hallucinations. His initial health assessment, performed on 6/18/2018 revealed that he reportedly had been diagnosed with a Bipolar Disorder, Depression, and Schizophrenia. The detainee said that he was not interested in being treated with

medication. He stated that he "just wants to get out of detention." His initial mental health evaluation on 6/21/2018 resulted in a diagnosis of an Adjustment Disorder. He was not interested in any mental health treatment and signed a treatment refusal form. IHSC added that the complainant was seen by mental health staff on 6/28/2018 after recently being placed in segregation. IHSC noted that the complainant continued to be followed by behavioral health regularly, per detention standards and community standards. As a result, they concluded that there was no evidence to support a finding of "negligence."

5) Medical Record Review

On 6/21/2018, (b)(6) performed an initial mental health evaluation. He noted that the detainee was a 27-year-old single male who was transferred to ICE custody after completing four years in NY DOC for criminal sale of a controlled substance. Detainee A denied any prior mental health history; however, he reported a history of suicidal ideation in 2009, 2010, and 2017. A review of his NY DOC discharge summary revealed a psychiatric hospitalization in 2009 for suicidal ideation. It also revealed that he received mental health services in NY DOC, was diagnosed with an Adjustment Disorder, and engaged in self-injurious behavior and suicidal gestures for secondary gain. (b)(6) diagnosed Detainee A with an Adjustment Disorder with Mixed Anxiety and Depressed Mood. My impression after reading these documents was that Detainee A appeared to be trying to portray himself to DOC staff as someone who was usually in control of his feelings and behavior, using them to manipulate others.

On 6/28/2018, (b)(6) met with Detainee A after he was placed in the Special Housing Unit (SHU) on segregation status for threatening an officer who told him that "it's unlikely you will be leaving BFDF in the next week."

Approximately 3 hours later (b)(6) returned to meet with Detainee A per custody's request, because he stated that he was "suicidal." Surprisingly, when she arrived, he was calm and denied being suicidal, saying that he made the statement "to try to get a reaction." She noted that "he is young, reactive, and impulsive." He said, "I just want to make them work" as he was smiling. She informed him that she would meet with him tomorrow; however, she added that if he did not feel safe or if he experienced agitation, he should seek out custody/medical.

On 6/29/2018, (b)(6) met with Detainee A again, addressing his impulsivity and need for attention. She provided support and encouraged continued prosocial behavior. He anticipated being in SHU for approximately another week and asked if she could "reach out again."

On 7/02/2018, (b)(6) met with Detainee A. They talked about his concerns of repatriating to Guyana. The detainee was provided support to help manage the remainder of his time in the SHU. He understood that he will have follow-up sessions during mental health segregation rounds, assuming he is still in the SHU when rounds

are conducted later in the week. He will seek out mental health as needed "PRN" via a sick call request after completion of SHU sanctions.

On 7/05/2018, (b)(6) met Detainee A during mental health segregation rounds. His mental status was stable. (b)(6) noted that he will be seen in one week during mental health rounds in the SHU.

On 7/18/2018, (b)(6) met with Detainee A and prescribed Remeron 45 MG, 1, orally, QHS 30 days, per the detainee's request, "because he was feeling stressed and depressed, unable to sleep."

On 7/26/2018, (b)(6) met with Detainee A to check his mental status, provide supportive psychotherapy, and assist him with discharge planning. She noted that he anticipated being released this week and that he felt frustrated with continuing to be detained at BFDF. He stated that he will "make them work if they don't release me." (b)(6) spent much of the 30-minute session helping him find prosocial ways to deal with his frustration and addressing cognitive distortions at length. She stated that she will follow up with him in 2 to 3 weeks unless he needs to be seen sooner per a sick call request.

On 7/27/2018 at 9:27 AM, (b)(6) noted that Detainee A was placed on suicide watch last evening after he reportedly made statements that he was suicidal and superficially cutting his forearm. Detainee A denied being suicidal, telling (b)(6) "I just want to get out of here." He noted that the incident leading to his actions stemmed from a verbal conflict with custody last night and his belief that they were "just putting him in SHU." He reminded her that when he was put in SHU, he was seeking attention and not intending to harm himself. (b)(6) consulted with Dr. (b)(6) on next steps. A decision was made to discharge Detainee A from the Medical Housing Unit (suicide watch) at 12:06 PM.

On 7/30/2018, (b)(6) met with Detainee A to perform a suicide risk assessment. Detainee A denied having any problems, saying that he was back in his general population unit and he was doing well; however, he continued to verbalize his frustration over his detention and over feelings that he was being lied to.

On 7/30/2018, approximately 10 hours after (b)(6) met with Detainee A, he was admitted to the MHU again and placed on constant watch by nursing. The Pod Officer called medical, stating that Detainee A needed to talk to mental health. The detainee was brought to medical where he stated, "I'm depressed. I need to speak to mental health. I can't take this place anymore. This place is worse than state jail. I feel like I am going to snap. I feel like I'm going to hurt somebody. I'm always locked in. I need to call my family. I need to call my mother."

On 7/31/2018 at 2:36 PM, (b)(6) met with Detainee A who denied wanting to harm himself. He stated "I don't want to go on mental health observation. I just want to go to my unit. I need to use the phone to call my family." Detainee A adamantly denied suicidal ideation. He admitted to feeling sad and wanting to reach out to his mother because he worried about her. He was discharged from the MHU at 3:16 PM.

On 8/02/2018, (b)(6) met with Detainee A during weekly mental health segregation rounds while the detainee was on protective custody status. His mental status was stable.

On 8/03/2018, (b)(6) discontinued the Remeron, per the detainee's request.

On 8/22/2018, Detainee A was transferred out of the facility.

6) Findings

Detainee A was a 27-year-old single, English speaking male from Guyana. He was detained at BFDF for nine weeks and five days, from 6/15/2018 to 8/22/2018 after being incarcerated in NY DOC for four years. He received mental health services on a regular basis while incarcerated in DOC. Treatment consisted primarily of counseling.

DOC's psychiatric discharge summary indicated that Detainee A's self-reports were often contradictory (i.e., denying a mental health history prior to incarceration while simultaneously reporting suicidal ideation during adolescence). DOC also reported that his records revealed a psychiatric hospitalization in 2009, when he was approximately 18-years-old, for suicidality.

While in DOC's SHU, Detainee A reportedly tried to cut himself and then hang himself until staff intervened. In October 2017 while incarcerated in NY DOC, he also became angry and suicidal after missing a visit from his daughter whom he had not seen for three years. Detainee A subsequently described these self-injurious events to be suicidal gestures, made for secondary gain. He continually minimized his self-injurious behavior and reports of suicidal ideation, saying that he was "joking."

During his initial mental health evaluation at BFDF, Detainee A was "superficially cooperative," focusing on his desire to return to his country "ASAP" and threatening to be disruptive if he wished. In other words, he implied that he was able to strategically control his emotions and behavior to threaten staff and create extra work for staff in order to obtain what he wanted. He repeatedly supported this portrayal by minimizing his suicidality which could be described as "out of control behavior" at both NY DOC and BFDF, describing it as a "joke," as an attempt "to get a reaction," and as an attempt "to get attention."

Detainee A's medical record revealed that he had a long history of emotional and behavioral instability, reportedly dating back to childhood and adolescence when he

was treated with Seroquel, Risperidone, and Adderall. His pre- and post-incarceration history indicated that he became easily overwhelmed, distressed, and agitated by stress. It also indicated that his problem-solving abilities and judgement were limited and his coping strategies (i.e., using cannabis and acting-out) were maladaptive. Consequently, he has had problems adapting/adjusting to life in most any environment (i.e., free world community, prison, detention).

7) Analysis

In summary, Detainee A was a 27-year-old male who became easily distressed and agitated, was unable to adaptively problem solve, and acted impulsively. He appeared to be emotionally shallow in that he would become emotionally overwhelmed for brief periods of time and then quickly return to baseline, being relatively calm. When he became overwhelmed, he would injure himself and need psychiatric stabilization placement. Despite these episodes of destabilization, he repeatedly presented himself as someone who was able to strategically control his emotions and behavior in order to manipulate his environment to obtain whatever secondary gain he desired.

It's easy for staff to focus on the word "manipulate" and dismiss the detainee's behavior; however, we have to ask "why is the detainee trying to manipulate the situation? How desperate is he, and how much will he up the ante?" Additionally, it's easy for staff to believe that detainees have more control over their emotions and behavior than they actually have, especially when staff's time is limited. Consequently, the severity of his mental illness, the acuity of his distress and the risk he posed of committing suicide tended to be minimized, resulting in sessions with the Detainee which were reactive (i.e., to evaluate suicide risk and to make mental health segregation rounds) rather than proactive and preventive, guided by a collaboratively constructed treatment plan.

Detainee A was seen 12 times by mental health clinicians during his nine-week detention at BFDF. In general, their clinical documentation of each session was good. An analysis of the "Reason for Appointment" revealed that sessions were initiated by: requests to evaluate Detainee A; a need to evaluate him in the SHU; a need to evaluate him in the MHU while he was on suicide watch; and a need to assess his mental status after being released from the SHU and MHU. In other words, sessions were driven by a need to assess him, not to treat him.

8) Clinical Observations and Recommendation(s)

There were two clinical observations and one recommendation. The first clinical observation was that mental health clinicians were responsive to Detainee A, meeting with him in the SHU, MHU, and general population (GP) at least 12 times during his nine-week detention at BFDF. The assessments and progress were well documented; however, they indicated that Detainee A became overwhelmed by relatively minor stressors, which lead to emotional dysregulation that impaired judgment and disinhibited behavior resulting in threats of a hunger strike, physical threats made

towards staff, suicide threats, and self-injurious behavior. Mental health staff appropriately responded to each incident with the same supportive counseling strategy which did not appear to be effective. It is unclear why other strategies were not considered and why relevant factors identified in OM 16-002 and PBNDS 2011, Standard 4.6 Component 4 (i.e., relevant history, psychological factors, environmental factors/antecedents, factors social).

The second clinical observation was that the Clinical Director met with the detainee and both prescribed and discontinued Remeron rather than the psychiatrist. It is unclear why time was not taken to consult with one of BFDF's part-time psychiatrists.

The one recommendation is that detainees should not be discharged from suicide watch in the MHU in less than 24 hours, per OM 16-002 and PBNDS 2011 Standard 4.6. Detainee A was discharged from suicide watch twice within 18 hours during his nine-week detention at BFDF.

9) Conclusion

Detainee A had a serious mental illness and he was easily overwhelmed, becoming acutely distressed and agitated. This distress impaired his judgment and weakened his emotional and behavioral controls. Medical and mental health collaboratively did an excellent job reactively treating him. More proactive and preventive work with the treatment team, to include psychiatry, could have resulted in interventions which would have broken the cycle of repeatedly being admitted to, and discharged from the MHU.

B. Detainee B (Refer to Appendix II)

1) Documents Reviewed

Case Summary C18-ICE-BUF-33275
CRCL Medical Referral (July 19, 2018)
IHSC Response (8/23/2018)
Detainee's Medical Record

2) Detainees Interviewed

Not Applicable

3) Nature of Complaint

In a call to the OIG hotline on 6/25/2018, Detainee B alleged that since arriving at BFDF, he contracted Hepatitis A, as well as liver and stomach issues. He claimed that he was sent to a doctor but has not been provided with an explanation as to what was causing the pain, or what his status was. Detainee B also stated that facility staff were supposed to take photographs of him for his records; however, the facility erased the photographs that were taken. Additionally, he stated that facility staff had decided to ban his family from coming to see him. Detainee B stated that the treatment he was

receiving from facility staff was making him "feel depressed and wanting to do stupid stuff."

4) **IHSC's Response (8/23/2018) to CRCL Medical Referral (7/09/2018)**
Detainee B arrived at BFDF on 02/23/2018. His intake assessment was completed on 02/23/2018 and his initial health assessment was completed on 02/27/2018. The only medical complaint was that he had intermittent tooth pain. Subsequent routine blood work revealed elevated liver enzymes. A Hepatitis panel was ordered, performed and came back positive. The panel was repeated and came back normal. Additional testing was performed to rule out chronic liver disease and hepatic tuberculosis. The results were negative for liver disease and hepatic tuberculosis. Repeated lab work was recommended in three months.

5) **Medical Record Review**
The mental health screen on the Detainee's intake assessment was negative. Additionally, his mental health history on the initial health assessment was negative. On April 4, 2018, Detainee B was assessed by (b)(6) during mental health segregation rounds. His mental status was stable. He did not appear to be at risk for committing suicide and he did not have a DSM-5 diagnosis. No mental health referrals were made and there was no evidence suggesting a need for any mental health referrals.

6) **Findings**
On June 25, 2018, Detainee B reported that he was being treated poorly by facility staff, who were making him feel "depressed" and making him "want to do stupid stuff." There was no evidence of any mental health problems during the intake assessment, the initial health assessment, and the mental health segregation rounds assessment. There was also no evidence that would have warranted a referral to mental health for an evaluation.

7) **Analysis**
In conclusion, Detainee B did not have a diagnosable mental illness. IHSC medical and mental health staff provided adequate care regarding Detainee B's mental status.

➢ A REVIEW OF ONE COMPLAINT ON THE CARE PROVIDED TO TRANSGENDER DETAINEES

C. Detainee C (Refer to Appendix II)

1) **Documents Reviewed**
Letter of Complaint with Attachments to CRCL dated 11/15/2017
Medical Record at BFDF
Grievances
An Open Letter to Congressman Joe Kennedy, III
A Claim filed against the County of Genesee

2) Detainees Interviewed
Not Applicable

3) Nature of the Complaint
On November 27, 2017, CRCL received a complaint from Detainee C at BFDF, alleging that BFDF staff have "mentally and verbally abused her," based on her transgender status. She claimed that staff made fun of her, disclosed her gender identity to other detainees to humiliate her, denied her hormone treatment, and ignored her gender identity. She stated that her transgender status was recorded at intake at the facility, but has been ignored by staff. She alleged that staff have threatened to place her in segregation. She stated that these issues have been ongoing since February 2017. She alleged that correctional officers have called her "lady," "princess," "faggot," "weirdo," or "pervert" in front of other detainees.

4) Medical Record Review
Detainee C was a 55-year-old single male, born in Germany. Her reported developmental history was traumatic with a history of sexual abuse between five to nine years of age and emotional abuse from her mother. She reportedly received a PhD in Astrophysics from Max Planck University. In 1988, Detainee C emigrated to the United States at the age of 25, saying she left Germany because of the abusive treatment she was receiving from her family. She stated that the happiest time of her life was when she lived as a female in Seattle from 1991 to 1993. She worked in Los Angeles on "special effects," lived in Texas and travelled to Ireland where she attempted suicide and had a CVA in 2015. She was apprehended by ICE while crossing the Canadian-U.S. border after returning to the U.S. from Germany where she attended her mother's funeral. She was detained in BFDF for 15 months, from 02/03/2017 to April 2018.

Detainee C exhibited a lot of medical problems at BFDF, to include Diabetes Type II, Supra Ventricular Hypertension (SVH), Tachycardia, Meningitis Pneumonia, Encephalitis, Neuropathy, and Possible Cancer. She received a number of medical consultations to include Cardiology, Ophthalmology, Podiatry, Neurology, Orthopedics, and Physical Therapy. She had a medical and/or mental health appointment almost every day.

Detainee C's mental health screen from the intake assessment which was completed on 02/03/2017 was significant because she stated that she attempted suicide within the past month. She denied any current thoughts of killing or harming herself and/or others. She also stated that she was transgender. Her medical record indicated that "she identifies herself as male presently; however, she has always wanted to be female since a child." When questioned about trauma, she said that she was traumatized when her parents disowned her because they were told she wanted to be transgender.

Detainee C's initial health assessment was completed on 02/05/2017. Her reported mental health history was inconsistent with her mental health screen from 02/03/2017, with her denying any suicide attempts/gestures during the health assessment. A review of systems was negative for anxiety, depression, and suicidal/homicidal ideation. She also denied ever having been physically or sexually abused.

On 03/20/2017, PA (b) (6) noted that Detainee C was requesting mental health services for anxiety. She was seen on 03/22/2017 by (b)(6) who completed an initial mental health evaluation. (b)(6) noted that Detainee C identified as transgender, male to female. She was reportedly comfortable with her transgender identity; however, she was dysphoric due to her present detention and worried about the potential of deportation, afraid of once again being traumatized by the uncle who initially abused her sexually. She described her mood as depressed and anxious. She was not interested in a psychiatric referral but welcomed supportive counseling.

Over the next 14 months, Detainee C had 23 therapeutic contacts with (b)(6) 10 therapeutic contacts with (b)(6) LCSW, and at least eight psychiatric contacts. The Psychologist, Social Worker, Psychiatrists and the Clinical Director, (b)(6) worked together as a treatment team as evidenced in the progress notes and in my staff interviews. Detainee C clearly had a therapeutic relationship with the clinicians. She received supportive counseling and cognitive behavioral therapy to include work on both problem-solving and coping skills from (b)(6) She was psycho-pharmacologically treated with Zoloft and Remeron. From 12/22/2017 to 01/12/2018 she was psychiatrically hospitalized at Columbia Regional Care Center (CRCC) for depression and suicidal ideation. (Note, I was unable to locate a discharge summary from CRCC.) The mental health team also worked closely with medical to evaluate Detainee C for hormone treatment and to initiate that treatment.

5) Findings

The psychological dynamics underlying Detainee C's emotions (dysphoria, anxiety, frustration and anger) and behaviors (filing grievances, writing letters, filing complaints, and writing prose) were complex. The mental health / medical team worked well with her, keeping her relatively stable in a stressful environment.

6) Analysis / Clinical Observation and Recommendation

Detainee C had multiple diagnoses throughout her life to include the 14 months she was detained at BFDF. Time would have been well spent doing a comprehensive evaluation to make a differential diagnosis and then to develop a multidisciplinary treatment plan. A single diagnosis (i.e., an Adjustment Disorder) does not capture Detainee C's complexity and it does not help in the development of strategic interventions.

7) **Conclusion**
Detainee C was intelligent and psychologically complex. She likely had multiple psychiatric diagnoses. She had insight into her strengths and limitations. She was very aware of her environment and she assertively "stood up for herself" when she felt threatened, slighted, victimized, or criticized. She demanded a lot of support from medical and mental health. Given the complexity and severity of her problems, medical and mental health should be applauded for their collaborative work.

➢ A REVIEW OF MENTAL HEALTH CARE PROVIDED TO 17 BFDF DETAINEES

➢ Five Detainees Referred by CRCL Team During the Investigation

- **Detainee 1/D (Refer to Appendices I & II)**
  Detainee 1 was referred by CRCL's investigation team members, who noted that "Detainee 1 has a mental disorder." He was a 38-year-old male, born in Haiti. He was placed in BFDF on November 17, 2016.

  He was in his bed, under his blankets when the officer asked him if he would be willing to be interviewed in his dorm, B-2. He came out from under the blankets with ear buds in his ears. He agreed to be interviewed in the day room at a table.

  He was cooperative but guarded. He never initiated conversation and gave minimal responses to questions. He appeared suspicious and defensive. Rapport was superficial. He denied having any problems meeting with mental health. He knew the names of the mental healthcare providers and he knew how to access them. When questioned about his mental health history, he said that he was diagnosed with "Bipolar" and treated with "Haldol and Zyprexa." He also said that he was hospitalized three times in the last two years, twice at Columbia Regional Care Center (CRCC) and once at Krome. He noted that he was last discharged from the hospital and returned to BFDF in March 2018.

  Due to his discomfort and defensiveness, the interview was abbreviated. It ended cordially, and he was thanked for his participation. The original referral was forwarded to mental health.

  Impression: Detainee 1 was seriously mentally ill, socially withdrawn, and suspicious. Per the officer, he usually spent much of his time lying in bed, under his blankets, with ear buds in his ears.

- **Detainee 2 (Refer to Appendix I)**
  Detainee 2 was referred by CRCL's investigation team members, who noted "he said he was suicidal."

  Detainee 2 was a 33-year-old male, born in Nigeria. He was placed in BFDF 20 months ago, on May 5, 2017. He agreed to be interviewed, answering questions about BFDF's mental health delivery system. He was interviewed in his dorm, B-1. An interpreter was not needed because he spoke English well.

  He was cooperative, dysphoric, and mildly agitated during the interview. He talked about having been tortured in Nigeria (showing his scars) and said, "now I am locked in a cage,

18 hours a day for more than a year. I am locked up for overstaying my visa. I am not being treated fairly."

When questioned about being suicidal, he said "I don't know if I can control myself. I don't control my mood. Sometimes I get upset and ask myself if I should just end it all. I can't move in the cage. Freedom of movement helps so much. Once I hanged myself. I was lucky that security saved me." He stated that he was receiving mental health services and being treated with psychotropic medication. He did not know the name of his medication or his diagnosis; however, he said that he had an appointment with (b)(6) tonight.

The interview ended cordially, and he was thanked for his participation. The original referral was forwarded to mental health.

Impression: Detainee 2 was mildly to moderately distressed and easily overwhelmed. His behavior tended to be unpredictable and the intensity and expression of his emotions were poorly controlled.

- **Detainee 3 (Refer to Appendix I)**
  Detainee 3 was referred by CRCL's investigation team members, who noted that he said, "I jumped off the top tier, attempting suicide." He was placed in BFDF on November 15, 2018.

  He agreed to be interviewed, to answer questions about BFDF's mental health delivery system. He lived in dorm C-1; however, he was interviewed in visitation, with an interpreter on the phone, interpreting Punjabi. Unfortunately, there were problems connecting with the interpreter and communicating with the detainee. In summary, Detainee 3 denied ever attempting suicide. He said, "I was stressed. No one was taking care of me. My bond papers disappeared." He said that he wanted to go to his family in Canada. He talked about being under a lot of stress, saying "sometimes I am able to manage it and sometimes I can't."

  His medical record was also reviewed. He was a 29-year-old male, born on March 30, 1989 in Punjabi, India. He complained of stress during a health assessment and was referred to mental health and evaluated on 11/16/2018. On 11/19/2018, he was placed on suicide watch. A nurse practitioner documented that his thinking was disorganized and he admitted to attempting suicide. He also reported a history of racing thoughts and feeling both helpless and hopeless, especially over the past week. He was diagnosed with an Adjustment Disorder with Depressed and Anxious Mood.

  The interview ended cordially, and he was thanked for his time. The original referral was forwarded to mental health.

  Impression: Given our short time together, the apparent communication problems, and the contradictory messages/information, the best that can be said is that Detainee 3 was not

seriously mentally ill or acutely distressed during our interview; however, his emotional and behavioral stability were unclear.

- **Detainee 4 (Refer to Appendix I)**
Detainee 4 was referred by CRCL investigative team members, who noted "he's a sexual assault victim from a previous institution. He really wants to speak with mental health." He was receptive to being interviewed. His English was good; therefore, an interpreter was not needed. He was interviewed in his dorm, C-1.

Detainee 4 was a 29-year-old male, born in Columbia, South America. His voice was steady and the volume was appropriate; however, he spoke rapidly and the details of what he said were difficult to follow because he tended to contradict himself. For example, he became confused talking about the order in which he traveled to other countries (i.e., UK, Netherlands, Mexico) and the routes he took to run from others who reportedly wanted to hurt him. He said that he was trying to get to the United States from Columbia in order to seek asylum.

After arriving in the U.S., he talked about having been detained in Laredo, Texas and Albany, New York before being transferred to BFDF. He alleged being sexually assaulted and raped while traveling to the US and while being detained in Laredo and Albany. He said "guards and inmates worked together to confirm that I was gay. They assumed I was transsexual." He reported that drugs were placed in his food to make him vulnerable. He stated that detainees and guards from Albany told detainees and guards at BFDF that he was gay. He continued, saying "I don't feel safe. They want to destroy me. They want me to be deported. They want me to commit suicide, but I'm not committing suicide because I believe in God and hell. I'm afraid they might be assaulting me during the night. I don't know. I don't sleep well." He denied having suicidal thoughts, a suicidal plan, or suicidal intentions.

The interview ended cordially, and he was thanked for his time.

Impression: Detainee 4 was moderately distressed and confused. A differential diagnosis was indicated; therefore, the original referral was forwarded to mental health.

- **Detainee 5, (Refer to Appendix I)**
Detainee 5 was referred by CRCL investigative team members, who noted, "He's a 20-year-old detainee who is extremely fearful and really needs to speak with mental health." He was placed in BFDF on September 27, 2018.

He was located in medical, talking with a mid-level provider for an extended period of time. Due to time constraints, he was not interviewed; however, he was referred to mental health.

- **Impression of the five detainees referred by CRCL Investigative Team**

  CRCL's investigative team did a great job identifying distressed detainees. Three of the five detainees referred by the team had recently arrived at BFDF (within the past few months) and four of the five detainees were relatively young, in their 20s. They were anxious, distressed, and overwhelmed. Consequently, their emotional and behavioral controls were weak, and their judgment was compromised. They were all referred to mental health for follow-up appointments.

➢ **Six Detainees in the Special Housing Unit on Segregation / Protective Custody Status**

- **Detainee 7 (Refer to Appendix I)**
  Detainee 7 was a 27-year-old male, born in Pakistan. He was randomly selected to be reviewed. He agreed to be interviewed, answering questions about BFDF's mental health delivery system.

  He was well groomed. His eye contact was good. He engaged in conversation quickly. There was no evidence of distress. He spoke English well.

  Detainee 7 arrived at BFDF on July 17, 2017, 17 months ago and requested protective custody almost 10 months ago in April 2018. When asked why he requested PC, he said "I don't want to be around certain types of individuals. I am safe in here, in a single cell."

  When questioned about mental health services, he said "I can see mental health whenever I turn-in a sick call slip." He denied any problems with privacy, saying he meets mental healthcare providers in their offices. He also said that he talks with the psychiatrist every two to three months on "videoconferencing" (tele-psychiatry). He talked about having a history of taking "Remeron," an antidepressant medication and "Benadryl when I need help falling asleep."

  When asked how his life could be better, he said, "I'd like a pull up bar in here for exercising and I'd like a tablet."

  The interview ended cordially, and he was thanked for his time.

  Impression: Detainee 7 placed himself in protective custody, in order to feel safe. He appeared to have adapted well to PC; thus, his mental status was stable. There was no evidence of distress.

- **Detainee 8 (Refer to Appendix I)**
  Detainee 8 was a 61-year-old male, born in the Dominican Republic. He was randomly selected to be reviewed. He agreed to be interviewed, answering questions about BFDF's mental health delivery system.

He said, "After living in the United States for 53 years, I was detained in BFDF on April 20, 2018." He said that he "requested protective custody months ago because others were jealous of me and wanted to be beat me up." He said that he feels safe in protective custody and added that "officers treat me nice."

Detainee 8 was oriented and cooperative. He spoke English well. His hygiene was fair. His eye contact was poor. He was able to carry on a conversation. There was no evidence of any distress; however, his affect was flat. He said, "sometimes I get depressed thinking of my mother. I need to take care of her. She's in New York." He talked about a history of auditory hallucinations, saying "The voices started when I was young and I still hear them every day." He continued talking, saying "some days I think on God."

He said that he has been diagnosed with Schizophrenia for most of his life. He added, "I was psychiatrically hospitalized many times and I was getting an SSI check since I was young." He said that he has been treated with Haldol for a long time. During the interview, he was observed to have pronounced hand tremors, possibly due to his antipsychotic medication. He denied any lapses in medication. He said that he can access mental health through sick call. He denied any problems with privacy, saying that officers escort him without handcuffs to medical where he meets with mental healthcare providers in their offices. He also said that he talks with the psychiatrist, "on a computer."

Impression: Detainee 8 was chronically and seriously mentally ill. At the time of the interview, there was no evidence of distress. He appeared to be living in the SHU as a way to cope with the stressors of being detained.

- **Detainee 9 (Refer to Appendix I)**
  Detainee 9 was a 47-year-old male, born in Iran. He was randomly selected to be reviewed. He agreed to be interviewed, answering questions about BFDF's mental health delivery system.

  Detainee 9 spoke English well. He was oriented, cooperative, and deferential. His eye contact was good. He was easy to engage in conversation. There was no evidence of distress. He often initiated conversation, talking about having been a Muslim but became a Christian and converted five Iraqi men to Christianity while he was living in Germany.

  He arrived in BFDF on July 23, 2018. He requested protective custody in November 2018. He said that he did not "want to fight with other Muslims because I am a Christian." He denied having any problems in the protective custody unit. He talked about feeling bad whenever he asks officers for recreation, "because they're so busy. They don't have time for me." He said that he had access to recreation any time, "for about 3 hours a day." He also reported having access to a shower twice a day and to a microwave any time.

He said that he can access mental health by submitting a written request to go to mental health where he sees (b)(6) in her office." His medical record revealed that he was diagnosed with a Post-Traumatic Stress Disorder resulting from having been tortured in Iran. He had been treated with Xanax but said that he became "addicted" and now "refuses to take any medication," signing refusals. Within the past few months, he was placed in the Medical Housing Unit "because he was upset and threatened a hunger strike."

Impression: Detainee 9 was a trauma survivor, who was relatively fragile, protecting himself by continuing protective custody.

- **Detainee F, (Refer to Appendix II)**
Detainee F was a 30-year-old male, born in Trinidad. He was randomly selected to be reviewed. He declined to be interviewed; however, his medical record was reviewed.

Detainee F arrived at BFDF on March 9, 2018 and was placed in the Special Housing Unit in April 2018. In other words, he has lived in the SHU for 9 out of the 10 months he has been detained at BFDF. He was diagnosed with an Unspecified Psychotic Disorder and was being treated with Remeron. He had a history of disruptive behavior to include smearing food and feces on the walls. During his stay in the SHU, he continued to be seen at least weekly by a mental healthcare provider during rounds.

Impression: Detainee F appeared to be chronically and seriously mentally ill, living in the SHU as a way to cope with the stressors of his environment.

- **Detainee G, (Refer to Appendix II)**
Detainee G was a 34-year-old male, born in Jamaica. He was randomly selected to be reviewed. He declined to be interviewed; however, his medical record was reviewed.

He arrived at BFDF on April 22, 2016. His medical record revealed that he was referred to mental health because of problems sleeping. A quick review of his medical record revealed that his initial mental health assessment occurred on July 1, 2016. He had a relatively long mental health history, characterized by multiple diagnoses. He was currently diagnosed with a Major Depressive Disorder with Psychotic Features. He was regularly seen by mental health staff to include psychiatry who was treating him with Olanzapine 5mg, an antipsychotic psychotropic medication. His informed consent paperwork had been signed and his the results of his last AIMS was on October 20, 2018. He appeared to have a long history of moving back and forth between the SHU and general population. Staff reported that he had difficulty living in general population.

Impression: Detainee G appeared to be chronically and seriously mentally ill. He appeared to have been placed in the SHU as a way to help keep him safe.

- **Detainee H, (Refer to Appendix II)**

Detainee H was a 32-year-old male, born in Haiti. He was randomly selected to be reviewed. He declined to be interviewed; however, his medical record was reviewed.

He arrived at BFDF on June 29, 2018 and was initially placed in the SHU on segregation status in August. A quick review of his medical record revealed that he was diagnosed with Schizophrenia, Paranoid Type and had a history of being treated with Haldol Decanoate. He has attempted to move back into general population but always returned to the SHU within 48 hours.

Impression: Detainee H, who appeared to be chronically and seriously mentally ill, appeared to be adapting to BFDF by living in the SHU.

- **Impression of the six detainees in SHU**

  The six mentally ill SHU detainees had a 16-month average length of stay at BFDF which was significantly longer than the mentally ill detainees in the general population. Their median age (mid-30s) was also significantly older than the detainees referred by the CRCL investigative team. All six detainees had significant mental health problems which were being managed by living in the SHU. In many ways, the SHU was being used as a structured, sheltered living unit for detainees with serious mental illness.

➢ **Five Randomly Selected Detainees Classified High Security, Living in General population Single Man Cells**

- **Detainee 6 (Refer to Appendix I)**
  Detainee 6 was randomly selected to be interviewed. He was a 35-year-old male, born in Chad, who arrived at BFDF on April 22, 2018. He agreed to be individually interviewed in a private office, in his dorm, B-1. Since he spoke English well, an interpreter was not needed.

  He had been detained at BFDF for approximately six months when he was interviewed by CRCL investigators on December 18, 2018. He was distressed and agitated, talking about being moved out of a dorm where he felt safe and supported last Friday to a dorm where he said, "I can't connect with anyone." He was crying, and talking about past traumas, previous suicide attempts, and current suicidal ideation.

  A review of his medical record revealed a history of multiple suicide attempts resulting in three Medical Housing Unit (MHU) placements and two hospitalizations at the Erie County Medical Center (ECMC) for psychiatric reasons. His medical record also revealed that he was seriously mentally ill, diagnosed with a Major Depressive Disorder and a Post-Traumatic Stress Disorder. Additionally, there was evidence that he was easily overwhelmed by relatively minor stressors, resulting in flashbacks (dissociation) and self-injurious behavior.

On August 20, 2018, Detainee 6 reportedly received "bad news from court," resulting in a suicide attempt via hanging and a transfer to ECMC for psychiatric reasons. Later that day, he was returned to BFDF and placed on mental health observation status which was increased to "constant watch status" after Dr. (b) (6) performed a suicide risk assessment.

On August 21, (b)(6) met with him again and continued the constant watch. That evening, Detainee 6 once again attempted to hang himself. A review of documents (i.e., progress notes in the detainee's medical record and eight officers' statements in a "Use of Force Report"), revealed that Detainee 6 genuinely attempted to kill himself in the MHU. The statements indicated that he attempted to hang himself in the MHU on August 21 at approximately 10:35 PM. He was reportedly "out of the line of sight, standing near the toilet in the corner," where he began wrapping an ACE bandage around his neck. It's unclear if and how the ligature was anchored. Statements indicated that he attached the ACE bandage on either a clothing hook or the shower head. The suicide attempt was observed by using a "search mirror" since he was "out of the line of sight." Officers entered the cell, interrupting his attempted suicide. Detainee 6's clothing and all of his property were removed from the cell. He was offered a suicide resistant gown, but refused to wear it, "running his head into the outside wall of the shower." Officers once again enter the cell, regained control of the situation, and placed him in a restraint chair for approximately 30 minutes. He was removed from the chair on August 22 at 12:30 AM. (b)(6) wrote an order for suicide watch status.

On August 23, the suicide watch was reduced to constant watch, and on August 24, the constant watch was discontinued and he was discharged from the Medical Housing Unit.

In approximately 2 ½ weeks, on September 10, he received a disciplinary report, which resulted in suicidal threats and head banging. Consequently, he was sent to the ECMC at 7:05 PM and returned to BFDF on September 11 at 3:05 AM, and placed in the MHU.

On September 12, (b)(6) met with Detainee 6 and explored his Post-Traumatic Stress Disorder, concluding that he had flashbacks when he was touched.

Approximately one week later, on September 19, Detainee 6 was moved from the SHU to the MHU and placed on constant watch because he was once again banging his head. He remained on constant watch until he was discharged from the MHU on September 21. Dr. Belde met him within 72 hours for a follow-up appointment on September 24.

For the next couple months, Detainee 6 appeared to have been relatively stable, until he was moved to another dorm on December 14. By the time he was interviewed on December 18, he had become distressed and agitated. Consequently, he was referred to mental health and (b)(6) met with him in a few hours after receiving the referral.

- **Analysis**

  When Detainee 6 was placed on constant watch on August 20, he was able to keep his regular clothing. Unfortunately, he attempted to hang himself. The decision made on August 20 to place Detainee 6 on "constant watch" rather than on the more restrictive "suicide watch" was a clinical decision, based on information obtained from an evaluation performed by an upper level provider. The fact that BFDF's clinicians used gradations of restrictive interventions indicated that they were individualizing treatment in the MHU for stabilization purposes. Their use these individualized interventions was a "best practice," rather than using a "one size fits all approach," placing everybody in the MHU on the most restrictive intervention, suicide watch.

  To better understand how suicidal behavior in general was managed in the MHU, suicide watch data from November 2017 through October 2018 was reviewed. The review revealed that three of 18 watches were discontinued in approximately 48 hours and 15 were discontinued in approximately 24 hours. It's unclear why 83% of the watches were discontinued so quickly. Record reviews revealed that decisions to discontinue suicide watch, constant watch and mental health observation were based solely on a suicide risk assessment with minimal to no evidence that pre-existing stressors or outcomes from any treatment interventions were considered.

  Operations Memorandum 16-002 to IHSC PHS Commissioned Corps Officers, indicates that this practice needs to be expanded. It stated that, "The BHP must develop a treatment plan based on the evaluation and assessment of the detainee……. The treatment plan must address the relevant factors that contribute to the detainee's suicidal ideation (e.g., environmental, historical, biological, psychological and social) and must be updated, as necessary…. A detainee placed on suicide watch must remain on suicide watch for a minimum of 24 hours before suicide watch can be discontinued, by a primary care physician and/or psychiatrist." Note that six of the 18 suicide watches were discontinued in less than 24 hours, on the same day they were initiated (please refer to Appendix III).

  The Operations Memorandum also stated, "The BHP (or on-site primary care physician, if a BHP is unavailable) must assess the detainee for the presence of mental health symptoms, including persisting suicidal ideations within 72 hours after the detainee is discharged from suicide or constant watch." A review of six suicide watches revealed that all six complied with the 72-hour evaluation requirement.

  Further review of the medical records from Detainee C and Detainee 6 revealed an absence of discharge summaries from ECMC and CRCC. Needless to say, these summaries are critical for continuity of care.

  There was one recommendation and two clinical observations which were generated by reviewing Detainee 6 and the suicide watch data. The recommendation is to perform a CQI study on the implementation of the Operations Memorandum 16-002 to ensure that clinicians are complying with this critical directive.

The first clinical observation is that clinicians can benefit from performing a behavioral analysis on unexpected clinical outcomes by reviewing the chain of antecedents/precipitants and consequences. The second clinical observation is that BFDF's medical/mental health staff should already be receiving discharge summaries from CRCC and ECMC which should be integrated into the detainee's treatment plan.

Impression: Detainee 6 appeared to have a Major Depressive Disorder and a severe Post-Traumatic Stress Disorder; consequently, his abilities to adapt to change, to modulate affect, and to control impulses were overwhelmed, placing him at risk for self-injurious behavior.

- **Detainee 10 (Refer to Appendix I)**
  Detainee 10 was a 42-year-old male, born in Trinidad, and was randomly selected to be interviewed. He agreed to be individually interviewed in his dorm, B-1. Since he spoke English well; an interpreter was not needed.

  Detainee 10 was placed in BFDF on August 3, 2017, approximately 17 months ago. When asked about "life at BFDF," he said "I had a roommate once. It didn't go good. We didn't get along. Now I have a single cell." Within a relatively short period of time, he began speaking rapidly and his thinking became mildly disorganized. Occasionally, his responses were unrelated to the questions being asked. Additionally, he began to contradict himself. His moderately disorganized thinking was best illustrated by examining his responses after being asked to describe his relationships with other detainees. He initially said, "I talk to voices," appearing to refer to auditory hallucinations. After making that comment, he focused on the word "relationship" and began talking about his relationship with a girlfriend. He said that she lived with him, in an apartment, and she didn't contribute to paying the rent or buying food because he paid for all expenses after reportedly "working on the streets all day, taking risks by selling drugs." When he returned to his apartment after work, he told her that he expected the apartment to be clean. After repeated requests, he said "I had to kick her out of the apartment." She reportedly went to the police and accused him of having a gun and physically abusing her. Detainee 10 concluded his story by saying, "that's how I got here, they arrested me."

  Detainee 10 said, "mental health here is not bad. I get to see (b)(6) every month and the psychiatrist, (b)(6) every two months. She gives me Haldol. I was taking Depakote and Cogentin too. They help, but I still hear voices every day." He said that his symptoms began when he was 24 years old. In the last 18 years, he said that he was psychiatrically hospitalized seven times.

  Impression: Detainee 10 was seriously mentally ill. He was coping with stress by "keeping to himself" and living in a single cell.

- **Detainee 11/I (Refer to Appendices I & II)**
  Detainee 11/I was a 26-year-old male who was born in Nepal. He was randomly selected to be interviewed. He agreed to be individually interviewed, in his dorm, A-2. Since he spoke English well, an interpreter was not needed.

  Detainee 11/I was placed in BFDF on August 7, 2018, approximately 5 months ago. On August 10, 2018, (b)(6) conducted an initial mental health assessment. He noted that Detainee 11/I had a history of mental health treatment since 2009, when he was diagnosed with a Bipolar Disorder at 6 years of age. He was subsequently diagnosed with Alcohol and Cannabis Use Disorders. He said that he had been psychiatrically hospitalized and placed in a group home for 16 months. He was reportedly treated with Zyprexa prior to being detained and has continued to be treated with the same medication. He was able to carry on a conversation. He denied having any problems with sick call. He was able to identify the mental health clinicians. He also knew the name of his diagnosis and medication.

  I cordially ended the interview, thanking him for his time.

  Impression: Detainee 11/I had a serious mentally illness and was compensating for his deficits by taking his prescribed antipsychotic medication and by living in a single cell.

- **Detainee 12 (Refer to Appendix I)**
  Detainee 12 was 46-year-old male, who was born in Pakistan. He was randomly selected to be individually interviewed. He agreed to be individually interviewed, in an office located in medical. Since he spoke English well, an interpreter was not needed.

  Detainee 12 was placed in BFDF on August 31, 2018, approximately 3 ½ months ago. He talked about having been kidnapped, raped, and tortured in Pakistan prior to 1991, when he came to the United States. He also talked about working for 2 years as an interpreter for the Department of Homeland Security. He said that he was married in 2007 and received 2 DWIs in 2014 which resulted in his current detention.

  He denied having any problems with accessing mental health services or with privacy during the delivery of those services. He said that he was diagnosed of a Post-Traumatic Stress Disorder and was being treated with Remeron. He added that he liked Seroquel "because it calmed me down." His mental status appeared relatively stable. There was no evidence of distress.

  I ended the interview cordially, thanking him for his time.

  Impression: Detainee 12 was a trauma survivor who was moderately mentally ill. With the help of mental health treatment, he has acquired skills to manage his symptoms and adapt to his environment.

- **Detainee 13/J (Refer to Appendices I & II)**
  Detainee 13 was a 54-year-old male who was born in Iraq. He was randomly selected to be individually be interviewed. He agreed to be individually interviewed in his dorm, A-2. An interpreter was not needed since he spoke English well.

  He arrived at BFDF on August 8, 2017, approximately 17 months ago. He expressed frustration with his detention. When questioned about mental health services, he said, "Yea, yea, yea, the food is good. The medical care and the mental health care are good." He denied having any problems accessing mental health services. He also knew the mental health clinicians' names and his diagnosis.

  He initiated conversation, talking about losing his family in Iraq "when George Bush came to Iraq." He expressed frustration with being detained for the past 17 months. He also complained about living with a roommate, repeatedly saying "I have to smell his shit everyday." His voice became louder and louder each time he repeated that phrase. He was told that his concerns will be noted and I cordially ended the interview, thanking him for his time.

  Impression: Detainee 13/J was a trauma survivor and was mildly to moderately distressed. He appeared to have acquired skills to help him manage his symptoms and adapt to his environment.

- **Impression of the five high security detainees, living in general population**

  The five high-security, general population detainees had serious mental illnesses. Three of them were relatively stable with the help of psychotropic medication and acquired skills. The other two were significantly impaired. One needed stabilization services and the other needed of a structured living unit.

➢ **One Randomly Selected Detainee Classified Low Security, Living in a General Population Open Dorm**

- **Detainee 14 (Refer to Appendix I)**
  Detainee 14 was a 42-year-old male who was born in Grenada. He agreed to be interviewed, answering questions about BFDF's mental health delivery system. An interpreter was not needed because his English was very good.

  He was placed at BFDF on December 13, 2017, approximately one year ago. He said that he has been receiving mental health services to help him deal with stress caused by being "unable to be myself." He self-identified as being transgender, male to female. He said that he is at peace with his decision; however, he conceals it at BFDF because he was concerned about being harassed by detainees and staff. He said that he has a detainee friend in whom he can confide. He laughed and said, "this friend is beginning to call me (b)(6) "

He said that he is not being treated with psychotropic medication, although he indicated that the stress has been bad "because my 14-year-old son, who was in special education, was missing twice in the past few months. They found him and everything is okay." He denied having any problems accessing mental health services. He was able to recall the names of his mental health care providers and the ways in which they have helped him.

Detainee 14's mental status was stable. There was no evidence of distress. He talked about being optimistic, hopeful that he will be approved for hormones soon. I ended the interview cordially and thanked him for his time.

Impression: Detainee 14 was a complex detainee who appeared to have adaptive coping skills and he was willing to seek help when he needed it.

- **Impression of the one low security detainee, living in general population**

  Detainee 14 was adaptively coping with significant stressors. He appeared to have insight, knowing his abilities and limitations. He also understood the stressors in his current environment.

SUMMARY OF BFDF'S MENTAL HEALTH DELIVERY SYSTEM

I reviewed the findings of two investigations/audits that were performed at BFDF before this review. In 2012, CRCL conducted an earlier onsite investigation, and in 2017, ICE conducted a PBNDS 2011 audit.

In 2012, CRCL requested a review of medical care provided to detainees and a review of allegations concerning conditions of confinement at Buffalo Federal Detention Facility. The medical subject matter expert was (b)(6) and the correctional subject matter expert was (b)(6) Neither (b)(6) nor (b)(6) focused on the delivery of mental health services; however, their work peripherally touched on the mental health delivery system.

During (b)(6) s review, he discovered six findings related to BFDF's mental health care. First, his review revealed that the suicide screening questionnaire for incoming detainees was an acceptable tool. Second, the suicide screen in seven of seven records had been timely. Third, medication continuity of care was also timely. Fourth, Valproic Acid levels and Lithium toxicity were being monitored. Fifth, the monitoring for metabolic syndrome in patients being treated with antipsychotic medication was mixed. Two of six records reviewed had weights documented within the past three months, and only one of four records had documentation of body mass index within the past three months. And sixth, mental health treatment planning was documented and updated in 10 of 10 reviewed records. (b)(6) concluded that "medical care provided by IHSC at BFDF was excellent, meeting or exceeding expectations for care on more than 100 elements in a draft performance measurement tool."

(b)(6) s report, which focused on conditions of confinement, also addressed a mental health area of concern; namely, suicide hazards. First, he recommended that BFDF replace the cages protecting fire alarms in suicide resistant cells with a secure screen or other means of protection in order to prevent the detainee from hanging, while not compromising the proper functioning of the alarm. And second, he recommended that if BFDF's restraint beds were no longer needed for their original, intended purpose, then they should be removed and replaced with the same type of beds used in the other cells in the special management unit.

In 2017, ICE conducted a PBNDS 2011 Inspection using the worksheet for facilities housing detainees over 72 hours. Their review of BFDF included two medical/mental health standards (Standard 4.3: Medical Care, and Standard 4.6: Significant Self-Harm and Suicide Prevention and Intervention). All components in Standard 4.3 which were applicable to mental health care, were "Met." In addition, all components in Standard 4.6, which were applicable to mental health, were also "Met."

In 2018, CRCL once again conducted an onsite investigation of BFDF, expanding the scope of the 2012 investigation by adding a review of the mental health delivery system to the medical services review and the conditions of confinement review. The reason for the inclusion of this

additional investigation was because the number of complaints dealing with mental health care increased. The overall results of the 2018 inspection were good, consistent with (b)(6) s conclusion that the care provided by IHSC was "excellent."

The findings from the current inspection of BFDF's mental health delivery system were similar to (b)(6) s 2012 findings. The intake assessment's suicide screening continued to be acceptable and it was administered in a timely manner. Once again, medication continuity of care was timely and informed consents were signed. The measurement of Valproic Acid levels and Lithium toxicity did not appear applicable because I could not find any detainees who were being treated with these medications; however, 14 detainees were being treated with antipsychotic medication. Record reviews of detainees being treated with antipsychotic medication revealed that psychiatry was reviewing and reporting lab results and AIMS scores in progress notes. When interviewed, (b)(6) indicated that he was regularly reviewing and reporting lab results and AIMS scores, adjusting doses accordingly. A review of treatment plans also indicated that seven of seven plans were updated and current.

(b)(6) s 2012 findings and recommendations on suicide hazards were also similar to current findings and recommendations. In the MHU, the fire alarm continues to be covered with a cage which could easily be used as an anchor for a ligature and the bed frames in those MHU cells have holes in the base which could be used to anchor a ligature. It's recommended that both the cages and the bed frames be replaced.

Findings from the 2017 PBNDS 2011 audit for the relevant mental health standards (Standards 4.3 and 4.6) were excellent. Once again, the PBNDS 2011 findings from the current CRCL investigation were excellent; however, a few components were not met. More specifically, two components from Standard 4.3 and three components from Standard 4.6 were not fully met.
Standard 4.3, Component 17 states that "mental health interviews be conducted in settings that respect detainee's privacy." In general, BFDF did an excellent job, ensuring privacy while working with detainees; however, privacy was reportedly compromised in the SHU while working with detainees on segregation status in that mental health rounds (brief evaluations, suicide risk assessments, counseling) often occur at cell front. Given the restrictions and the severity of mental illness in segregation, it's recommended that detainees be assessed weekly in a setting that ensures privacy.
Standard 4.3, Component 27 states that "if at any time during the screening process, there is an indication of the need for mental health services, the HSA must be notified within 24 hours. The clinical medical authority, HSA, or other qualified licensed healthcare provider shall ensure a full mental health evaluation if indicated." Out of all the records reviewed this component was met at BFDF; however, there was one exception. Detainee C reported during his intake assessment on February 3, 2018 that he attempted suicide within 30 days of arriving at BFDF. Consequently, he was to be referred to mental health immediately to ensure his safety.
Standard 4.6, Component 37 states that "any detainee prescribed psychiatric medication must be regularly evaluated by a duly licensed and appropriate medical professional at least once a month to ensure proper treatment and dosage." (b)(6) and (b)(6) do an excellent job coordinating psychiatry's schedule. Out of all the records reviewed, detainees on psychotropic

medication were consistently re-evaluated within 60 days, unless they were acutely unstable, in which case they were re-evaluated within 30 days. Per this high standard, all detainees being treated with psychotropic medication are to be re-evaluated within 30 days.
Standard 4.6, Component 4 states that "an evaluation by a mental health provider of detainees who are identified as being 'at risk' for significant self-harm or suicide will be documented in the medical record and include: relevant history; environmental factors; lethality of suicide plan; psychological factors; a determination of level of suicide risk; level of supervision needed; referral/transfer or inpatient care (if needed); instructions to medical staff for care; and reassessment time frames." Once again, the bar set by PBNDS is high and very specific. Out of all the records reviewed, most evaluations, to include the suicide risk assessments were excellent and contained most of the items listed in component 4; however, there were exceptions, especially with detainees who repeatedly threatened self-harm. It's always good practice to place the current situation into a historical context, documenting relevant antecedents and significant environmental factors. A reassessment of the detainee's suicide plan and intentionality is also good practice, since they can change from day to day. These reassessments appear to be implicitly taking place and used to decide which type of watch to order (suicide watch, constant watch, mental health observation). It's recommended that these implicit assessments be made explicit in the progress notes, which would help continuity of care.
Standard 4.6, component 6 states that "suicidal detainees should be closely supervised in a setting that minimizes opportunities for self-harm. The isolation room designed for evaluation and treatment must be free of objects or structural elements that could facilitate a suicide attempt and security staff shall ensure that the area for suicide observations is initially inspected so that there are no objects that pose a threat to the detainee's safety." As stated above, potential anchors for a ligature should be removed from the two cells in the medical housing unit. Additionally, problems with the line of sight should also be addressed.

The 2018 investigation began with a review of the mental health care delivered to three complainants. Those reviews were followed by reviews of mental health care delivered to: five detainees who were identified by the CRCL investigative team members during the investigation and referred for further examination; six detainees who were placed in the SHU on segregation / protective custody status; five detainees who were classified as high security, living in single-man cells; and one detainee classified as low security, living in open dorms.

A review of the mental health complaints revealed that two of the three complainants were having problems managing stress and frustration resulting from their detention at BFDF. One of them complained that the treatment he was receiving from facility staff was making him "feel depressed and wanting to do stupid stuff." The other one complained that he was being held eight days more than his initial four-year prison sentence, resulting in threats that he would "hurt himself or someone else because he has a mental health disability and has not received any medical attention." Both detainees received intake assessments within 12 hours of their arrival and initial health assessments within 14 days of arrival. Initial mental health evaluation were conducted within 24 to 48 hours of receipt of a referral. Additionally, brief mental health assessments were performed during SHU rounds. The information obtained from the mental health evaluations was substantive because the clinicians included well written narratives in the EMR's text boxes.

Both complainants received appropriate mental health care. The assessments performed on one of them (Detainee B), indicated that he did not need mental health services. The assessments on the other one (Detainee A) identified his distress, impulsivity, and "at-risk behavior." Medical and mental health staff worked collaboratively, identifying this at-risk behavior early and they treated it appropriately by placing him in the MHU and sending him to an outside hospital (ECMC) when he needed a higher level of psychiatric care. The details of this case, Detainee A, are presented above. Overall, the mental health care delivered to Detainee A was adequate. He was seen 12 times by mental health clinicians during his nine-week detention at BFDF. Specific clinical observations were made above.

There were two significant findings. The first finding was that Detainee A was never referred to psychiatry. Instead of psychiatry evaluating Detainee A, the Clinical Director, (b)(6) evaluated him, prescribed Remeron and then discontinued it three weeks later with minimal justification for the prescription or discontinuation. The second finding was that clinicians appeared to minimize the severity of the detainee's mental illness, the acuity of his distress, and the risk he posed of committing suicide. Consequently, his sessions with mental health staff tended to be reactive in that the clinicians were either evaluating suicide risk, makimg mental health segregation rounds, or conducting follow-up brief evaluations after being released from the MHU or SHU. In other words, sessions were reactive rather than being proactive and preventive, guided by a collaboratively constructed treatment plan. These findings appeared to be the result of mental health clinicians who had very large caseloads. With the addition of more psychiatry time and another LCSW, these findings should be corrected.

Detainee C was detained at BFDF for 15 months. During that time, he engaged custody by filing many grievances, medical by having daily appointments because of his health problems, and mental health by having over 40 appointments with psychology, social work, and psychiatry because of emotional distress related to his transgender status. BFDF's medical and mental health staff were responsive to his needs, providing timely and holistic-integrative care, which included a two to three-week hospitalization at CRCC. The details of Detainee C's case are presented above along with clinical observations. The only significant finding was that he was not referred to mental health for an evaluation after the intake assessment when he reported attempting suicide within 30 days prior to being detained.

Five detainees were referred to me by members of the CRCL investigative team because of team members' observations made while being interviewed by the team. I interviewed four of them and referred all of them to mental health. Four of the five were distressed, exhibiting at-risk behavior, and at least one was seriously mentally ill. Four of these detainees were living in low security, open dorms, and one detainee was living in high security, a single person cell. Two of the four detainees interviewed were at-risk of harming themselves. One was psychotic and isolating himself by lying in bed, under the blankets with ear buds in his ears. And the other detainee was distressed and appeared confused, struggling with a potential PREA issues. The major finding was that these unstable / at-risk detainees and a seriously mentally ill detainee who was coping by isolating himself, were identified by CRCL investigative team members before they engaged the BFDF's

mental health delivery system.

Six SHU detainees, who were receiving mental health services, were interviewed and some records were reviewed. Four of them were seriously mentally ill and two were mildly to moderately mentally ill, feeling unsafe in general population and thus placing themselves in the SHU on protective custody status. Once again, mental health care tended to be very good, to include weekly rounds and excellent documentation. That said, the primary take-aways from these interviews and record reviews were that the SHU was being used to house seriously mentally ill detainees who had a difficulty living in general population and detainees in segregation usually talked with mental health care providers at their door during MH SHU rounds, violating the privacy standard. Specific clinical observations of these case were noted above.

Six detainees living in general population dorms, five classified as high security and the other one classified as low security were interviewed.

Two of the high security detainees were seriously mentally ill, two others were moderately mentally ill, diagnosed with PTSD, and the sixth one was acutely distressed. The four high security detainees who were seriously and moderately mentally ill were adapting to their environment by taking their psychotropic medication, by staying away from other detainees, and by using coping strategies acquired during counseling sessions. The high security detainee who was acutely distressed had a history of being on suicide watch, (three times in the August and September, for a total of 11 days). He appeared to have been relatively stable from the end of September until early December when he was moved out of a dorm where he felt safe and into a dorm where he felt unsafe. After interviewing him, he was referred to mental health, seen within a few hours, and arrangements were made to move him to another unit.

The one low security detainee was dealing with being a transgender detainee living in a male ICE detention facility. He was mildly to moderately distressed about receiving hormones, being released from detention, and taking care of his son who had recently been missing. His mental status was stable. He was insightful and acquired adaptive coping strategies. Additionally, he worked well with mental health and medical staff, reaching out to them when he needed them.

The major take-away from the reviews of these six general population detainees was that detainees with mild to moderate mental health problems receive excellent care; however, those with severe and acute mental health problems adapt to less than optimal care and were often not identified in a timely manner. Additionally, Detainee 6 who had a history of suicide watch, appeared to have been released from the MHU without well-developed treatment plans focused on stressors and risk factors/antecedents.

The administrative documents which were reviewed met PBNDS 2011 standards, The credentialing files for (b)(6) and (b)(6) were organized, current, and all the required documents were present, (i.e., license, CPR Certification, peer review, and a current curriculum vita). Two detailed CQI studies were reviewed and recommendations for future studies are made below. Suicide Prevention Training Logs were organized with the name of the class, the

names of the trainers, the names of the attendees, and the dates of the classes for calendar year 2018. Significant incident reports and one use of force report were reviewed on detainees receiving mental health services. In every case, they provided valuable information that could be used by clinicians to develop effective treatment plans. The pharmacy report provided valuable information that could be used by mental health leadership to help oversee and manage their mental health program (i.e., provider prescription practices, psychiatry scheduling, required laboratory test). Finally, the quarterly medical administrative meeting minutes were quickly reviewed. Their agendas were in-compliance with standards. They were current and mental health was a participant.

Recommendations For BFDF's Mental Health Delivery System

Recommendation #1: Mental Health Continuum of Care

- **Recommendation #1: BFDF should fill the gaps in the continuum of mental health care with additional programming.**

Standards:

- **Standard: PBNDS 2011 4.3 V. B,** All facilities shall provide medical staff and sufficient support personnel to meet these standards. A staffing plan will be reviewed at least annually which identifies the positions needed to perform the required services.
- **Standard: NCCHC 2008 J-C-07 (important),** A sufficient number of health staff of varying types provide inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care.
- **APA 2000, 2nd Edition Part I Section III,** …the Task Force does not seek to promote any one rigid staffing formula for all jails and prisons, nonetheless, it is important to note that some consensus has been reached among correctional mental health experts, as well as in prison and jail litigation, as to caseloads of psychiatrists of patients receiving psychotropic medications…… It is suggested that in jails, for every 75-100 inmates with serious mental illness who are receiving psychotropic medication, there will be one full-time psychiatrist or equivalent.

Rationales:

- On the first day of CRCL's investigation, BFDF's detainee capacity was 636. It usually ranged from 600 to 620 with a count of 612 on December 17, 2018. Five hundred forty-two (542) detainees were male (87%) and 80 were female (13%). The length of stay usually ranged from eight to ten weeks, with the average length of stay being 65 days. The number of detainees receiving mental health services usually ranged from 80 to 90 with a count of 84 on the first day of the investigation. Pharmacy's "Drug Utilization Report" was reviewed for the past week, with a focus on psychotropic medications. The review revealed that 42 detainees or 50% of those receiving mental health services were being treated with psychotropic medication, primarily antipsychotic and/or antidepressant/antianxiety medications. Fourteen detainees were being treated with antipsychotic medication (i.e., Haldol, Zyprexa, and Risperidone) and 28 were being treated with antidepressant medication (i.e., Paxil, Zoloft, Remeron). Additionally, the medical records from a sample of mentally ill detainees were reviewed and a sample of this population was interviewed. The record reviews and the interviews revealed a broad spectrum of mental illness, ranging from detainees who were mildly / moderately mental ill (i.e., adjustment disorders with depressed and/or anxious mood), to detainees who were chronically and seriously mental ill (i.e., actively hallucinating with disorganized thinking), to detainees who were acutely mental ill (i.e., crying and reporting suicidal ideation).

The mild to moderately mentally ill detainees were receiving good mental health services (i.e., regularly scheduled supportive counseling and/or psychotropic medication management) and the acutely mentally ill detainees who were identified, received good mental care as evidenced in 2018 by 18 detainees having been placed on suicide watch for stabilization, five having been sent to Columbia Regional Care Center, and a few were sent to local hospitals (i.e., Erie County Medical Center) for a higher level of care.

In contrast to the mild and moderately mentally ill detainees, the chronic severely mentally ill detainees were being treated primarily with antipsychotic medication. (Note, NCCHC states "Mental health treatment is more than prescribing psychotropic medications.") That said, these detainees' mental status was checked either "as needed" or "every 30 to 90 days" by a psychiatrist who provided medication management. Progress notes were good, demonstrating empathy and an understanding of the detainees' mental status. Treatment sessions were adequate; however, seriously mentally ill detainees needed more services than just regularly scheduled sessions. They also needed sheltered living units and/or structured programming to include community meetings, therapeutic groups, and recreational activities. Without this level of care, these detainees adapted to this stressful environment by: requesting protective custody, getting in trouble and being placed in either segregation or a single cell in A-2 or B-1, and/or withdrawing from others (i.e., lying in bed all day with their heads under the covers and ear-buds in their ears).

For the chronically psychotic detainees, a separate small 20 to 30 bed supportive living unit with structured activities would be ideal. This unit would go a long way in helping to reduce their psychotic symptoms. However, achieving the ideal is unlikely given the limited space and limited staff. Consequently, weekly groups and/or individual psychoeducational and recreational activities are recommended. Too much unstructured time often results in a deterioration of their mental status. Activities for this population are strongly encouraged to include tablets. (Note, it might take a while to get some of them involved in any activity, until they begin to feel safe with the clinician.)

- The acutely mentally ill who were identified by BFDF, received excellent evaluations and appropriate stabilization services by being seen daily, and/or being placed on suicide watch, or being transferred to a hospital. Those who were not identified or considered subacute tended to seek support from other detainees or made pleas for help by telling CRCL team members that their sick call requests were being ignored, that they were frightened for their safety, and that they were suicidal. Their pleas illustrated a significant level of distress which was not being addressed by mental health. This situation became especially troubling when a review of some of their medical records revealed significant psychiatric histories. Consequently, a number of them were referred to mental health for evaluations.

For the acute and subacute mentally ill detainees, early identification and continued supportive counseling is strongly recommended. Risk factors which can be used for early identification of acute distress include a history of trauma, gang activity, and problems managing stress, modulating affect, and adapting to the environment. Early signs of rising acuity include reports of persecutory ideation, suicidal ideation, self-injurious behavior, and suicide attempts. Often, these detainees do not feel safe, afraid of what others might do and afraid of what they might do to themselves. Once they're identified, weekly support groups in a corner of each unit would go a long way in making them feel safe and reducing their stress.

Recommendation #2: Mental Health Staffing Pattern

- **Recommendation #2: In order to fill the gaps in the continuum of care and to enhance the quality and the quantity of mental health services delivered to detainees, BFDF must fill the vacant social worker position and psychiatry hours need to be increased to 10 hours per week, with at least four or five of those hours being filled by a psychiatrist who is physically present at BFDF.**

Standards:

- **Standard: PBNDS 2011 4.3 V. B,** All facilities shall provide medical staff and sufficient support personnel to meet these standards. A staffing plan will be reviewed at least annually which identifies the positions needed to perform the required services.
- **Standard: NCCHC 2008 J-C-07 (important),** A sufficient number of health staff of varying types provide inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care.
- **APA 2000, 2nd Edition Part I Section III,** …the Task Force does not seek to promote any one rigid staffing formula for all jails and prisons, nonetheless, it is important to note that some consensus has been reached among correctional mental health experts, as well as in prison and jail litigation, as to caseloads of psychiatrists of patients receiving psychotropic medications…… It is suggested that in jails, for every 75-100 inmates with serious mental illness who are receiving psychotropic medication, there will be one full-time psychiatrist or equivalent.

Rationales:

- As of the date of this investigation, mental health's staffing pattern consisted of one full time psychologist (b)(6) one full time licensed clinical social worker (Ms. (b)(6), one part-time onsite psychiatrist (b)(6) one part-time tele-psychiatrist (b)(6) and one part-time backup tele-psychiatrist (b)(6) (b)(6). Mental health also had one vacant licensed clinical social worker position. Organizationally, mental health was integrated into health services; consequently, medical nurses, nurse practitioners, a physician assistant, and a physician (b)(6)

M.D.) worked closely with mental health. Their collaboration was observed in the progress notes and during interviews with both medical and mental health staff.

Core mental health duties were performed by the psychologist, social worker, and psychiatrist. These duties consisted of: evaluating detainees (i.e., initial mental health screens, mental health evaluations, brief mental health evaluations, initial psychiatric evaluations, suicide risk assessments, evaluations for segregation, and PREA evaluations); responding to different types of referrals; rendering diagnoses; making rounds on detainees who were in segregation and in the Medical Housing Unit; developing treatment plans; and implementing those plans. Overall, they were doing an excellent job; however, in order to continue doing that job, they had to "cut corners." For example, the electronic medical records' "check box progress notes" and brief evaluations often looked alike for individual detainees over time and between detainees, especially when minimal information was added in the text boxes. Two other corners that were being cut included the provision of an appropriate level of care to the seriously mentally ill detainees and to detainees whose acuity level was often considered subacute (i.e., those who are struggling with distress but falling beneath a suicide watch threshold). In order to provide an appropriate level of care to those detainees who were falling through the gaps in mental health's continuum of care, the vacant "licensed clinical social worker position" must be filled at a minimum.

- For psychiatry, the acceptable standard for staffing jails, detention centers, and prisons was one full time equivalent for every 150 to 200 patients being treated with psychotropic medication. BFDF averaged at least 50 detainees being treated with psychotropic medication; consequently, they needed 10 hours a week of psychiatry time. The psychiatrists interviewed during the investigation reported that their hours were flexible, based on the facility need. When asked for the average number of weekly hours worked in the past couple months, (b)(6) said that he averaged two hours in the evening, every two weeks and (b)(6) reported that she averaged three hours a week. Consequently, BFDF was receiving an average of four hours of psychiatry a week instead of the recommended ten hours a week. It's hard to imagine that there was not at least 10 hours of work per week for psychiatry, especially when you consider the required 30-day medication reviews and the number of referrals generated during the intake process (i.e., detainees entering BFDF on psychotropic medication). It would also be helpful if the mental health staff used some of psychiatry's time consulting on treatment plans for difficult patients (i.e., the chronically subacute population and the chronically seriously mentally ill population).

Recommendation #3: Mental Health Privacy & Services in the SHU

- **Recommendation: Given the number of mentally ill detainees in the special management unit, the severity of their mental illness, and the fact that many of them are being treated with psychotropic medication, BFDF should ensure that mental**

health clinicians (to include psychiatry) are able to meet privately with those detainees in segregation. Additionally, BFDF needs to perform rounds more frequently on detainees who are actively psychotic (i.e., experiencing auditory hallucinations) and/or who are being treated with antipsychotic medication.

Standards:

- **Standard: PBNDS 2011 4.3 V L1.** Adequate space and equipment shall be furnished in all facilities so that all detainees may be provided basic health examinations and treatment in private while ensuring safety.
- **Standard: PBNDS 2011 4.3 II 27.** Detainees in Special Management Units (SMUs) shall have access to the same or equivalent health care services as detainees in the general population, as specified in standard "2.12 Special Management Units."
- **Standard: NCCHC 2008, J-A-09.** Discussion of patient information and clinical encounters are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of health services.
- **Standard: NCCHC 2008, J-E-9.** Inmates with serious mental disorders often experience an exacerbation of their underlying illnesses when segregated. The health rounds on patients with serious mental illness in segregation should take place at the beginning, middle, and end of each week to decrease the likelihood problems during weekend hours.
- **Standard: APA 2000, 2nd Edition Part I Section VII.** In all situations, the rights of the patient privacy and confidentiality must be weighed against the needs of other inmates as well as the institutional needs of safety and security.

Rationales:

- **Findings:** Both access to mental health services and sound privacy were generally not a problem at BFDF, except for detainees in segregation.

- BFDF's Special Housing Unit (SHU) has 20 single bed cells, with half of them used for disciplinary segregation and the other half used for protective custody (PC). On December 17, 2018 the SHU count was 19, with 9 in PC and 10 in Segregation. Ten of these 19 detainees (53%) were receiving mental health services. At least five of them were diagnosed with a serious mental illness (a psychotic disorder) and five were being treated with psychotropic medication. Sampling six of these 10 mental health detainees revealed that their stay at BFDF ranged from five to 18 months with their average length of stay being 7.9 months. Their most recent consecutive time in the SHU ranged from one to nine months with their average length of stay being 4.7 months. The amount of their BFDF time spent in the SHU was 59%. These numbers were significant because they revealed that detainees receiving mental health services were disproportionately represented in the SHU and they were spending the majority of their BFDF time in PC or segregation, primarily as a way to manage their mental illness.

- A number of these detainees were interviewed by CRCL investigators and their records were reviewed. There was evidence of active psychosis; however, there was no evidence that their mental status was deteriorating or that they were distressed / suicidal. Those in PC stated that they had access to meeting with their mental health clinicians privately in their provider's office. Weekly rounds were performed by medical / mental health staff, usually by a nurse practitioner. The psychologist and social worker also made rounds and/or did brief mental health evaluations. I did not observe any documentation indicating that psychiatry made rounds or met with detainees in PC or segregation.

- In contrast to the mentally ill detainees living in PC, access to mental health for those living in segregation was more restrictive. In fact, when they met with medical/mental health clinicians, they would usually meet at the cell front and talk through the door. Consequently, privacy was a problem, limiting the meaningfulness of evaluations and treatment.

Recommendation #4: Suicide Resistant Housing

- **Recommendation: To provide stabilization services: detainees in the medical housing unit: the two cells need to be made suicide resistant by eliminating blind spots and anchor points (i.e., a cage on the wall adjacent to the social workers office, the holes in the bed frame, the ventilation holes, and the shower head).**

Standards:

- **Standard: PBNDS 2011 4.6 V. F.** The isolation room must be suicide resistant, which requires that it be free of objects and structural elements that could facilitate a suicide attempt.
- **Standard: NCCHC 2014 J-G-05.** All cells or rooms housing suicidal inmates are as suicide resistant as possible (e.g., without protrusions of any kind that would enable hanging).

Rationales:

- An inspection of the cells revealed that detainees would have difficulty trying to hang themselves because most of the anchors that could have been used to fasten a ligature had been removed. However, there were a few areas in the cells that needed to be addressed. First, line of sight in both cells was obstructed by the shape of the cell. To compensate for this problem, a mirror was used. The effectiveness of this "work around" is questionable. A few other findings included the presence of a cage on the wall protecting a fire alarm, in one of the cells, which could be used to fasten a ligature. Suicide resistant bed frames traditionally do not have holes in their platform because these holes can be used to fasten a ligature. Also, the holes in the vent on the wall are too large, making it possible to threat a ligature through the vent holes. Finally, the shower head could also be used as an anchor. In fact, in the past year a detainee almost successfully hung himself with a ligature fastened to the shower head. The shower head should be recessed with no exposed faucets.

Recommendation #5: Suicide Treatment and Monitoring

- **Recommendation: BFDF should ensure that detainees' average length of stay on suicide precautions exceeds 24 hours during which time they should receive meaningful treatment that is guided by a treatment plan which is critical for continuity of care upon being discharged from the stabilization unit.**

Standards:

- **Suicide Prevention Program Guidelines, Operations Memorandum 16-002 version 2), Effective Date; 28 MAR 2016.** Reference sections (f) Treatment and (h) Discharge

Rationales:

- BFDF has two medical housing unit cells that were used for detainees in need of a negative air-flow cell and for detainees in need of a suicide resistant cell. As of December 17, the cells were used 18 times in 2018 for stabilization / observation of detainees who were high suicide risks. Average lengths of stay were usually less than 48 hours. Detainees were seen daily by medical and mental health. Placement / treatment was individualized, based on the detainees' needs. Consequently, detainees were either placed on observation or constant watch status and given property, or they were placed on suicide watch status, in which case property was removed except for a suicide resistant gown, mattress and blanket.

- Detainees on suicide precautions should remain on precautions at least 24 hours, during which time they should receive meaningful mental health interventions. Their response to these interventions, along with suicide risk assessments, should be used as valuable information in the determination of when to discharge them the MHU and what interventions to use upon discharge.

Recommendation #6: Pharmaceutical Management (Follow-up Appointments)

- **Recommendation: To comply with PBNDS 2011, BFDF should ensure that psychiatry meets with detainees being treated with psychotropic medication every 30 days to ensure proper treatment and dosage. Until proper staffing is in place, psychiatry needs to base the length of their orders on the stability, compliance and diagnosis of the detainees. They should meet with the meeting with the unstable, noncompliant and seriously mentally ill detainees at least monthly.**

Standards:

- **Standard: PBNDS 2011 4.3 V. O. 4.** Any detainee prescribed psychiatric medications must be regularly evaluated by a duly licensed and appropriate medical professional, at least once a month, to ensure proper treatment and dosage.

Rationales:

- A record review revealed that psychotropic medication orders were usually written for 60 or 90 days. Thirty-day orders were written for high acuity psychiatric detainees. For these detainees, their mental status and dosage were usually checked by the psychiatrist within 30 days of the medications being renewed.

- The PBNDS 2011 standard is higher than the general practice which is to base the length of the order / the medication reassessment, on the detainees' psychiatric stability, diagnostic severity and medication compliance over the past 90 days. If detainees have been stable, medication compliant, and not diagnosed with a psychotic disorder, then 60 to 90-day orders are usually acceptable. However, if they have a history of being psychiatrically unstable, being psychiatrically noncompliant, starting a new psychotropic medication, and/or being diagnosed with a psychotic disorder, then the psychiatrist should reassess the detainee every 30 days.

Recommendation #7: Pharmaceutical Management (Renewals)

- **Recommendation: BFDF should ensure that psychiatry or a supervised psychiatric nurse practitioner always schedules a follow-up session with a detainee being treated with psychotropic medication before renewing or discontinuing that medication.**

Standards:

- **Standard: PBNDS 2011 4.3 V. G. 3.** Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include prescription practices, including requirements that medications are prescribed only when clinically indicated and that prescriptions are reviewed before being renewed.

Rationales:

- A review of medical records revealed that a detainee who was being treated with Zoloft reported feeling better and said that he only wanted supportive therapy from the psychologist. Consequently, the medication was continued; however, a psychiatric appointment was not scheduled. Instead of scheduling another appointment, the detainee was informed that he should request to meet with the psychiatrist on as needed basis.

- Based entirely on the documentation, it's unclear if this detainee's order for Zoloft was ever renewed or discontinued without reassessing the detainee. The psychiatric progress note did not clearly indicate what was going to happen when the order expired.

Recommendation #8: Continuous Quality Improvement (Mental Health)

- **Recommendation: BFDF's Health Services should perform a 2019 CQI outcome study on one of five problem-prone areas (1. continuity of mental health care after returning from hospitalization or suicide watch; 2. compliance with Operations**

Memorandum 16-002 reference length of stay on suicide precautions and the treatment plan guiding discharge and continuity of care; 3. medication compliance outcomes; 4. medication noncompliance counseling outcomes; or 5. responsiveness / quality of mental health care delivered to the subacute and severely mentally ill detainees in all units, but especially those who are locked up most of the day in a Suicide Watch cell, Segregation, Protective Custody, Unit A-2, and/or Unit B-1) .

Standards:

- **Standard: NCCHC 2008 J-A-06 (essential).** A continuous quality improvement (CQI) program monitors and improves mental healthcare delivery in the facility.

Rationales:

- Two outcome CQI studies were submitted to the IHSC QI Coordinator on 05 April 2018. One of the studies focused on Physical Health outcomes (Elevated Blood Pressure at Intake) and the other study focused on Behavioral Health outcomes (Alcohol Screening). Both studies were very well done, closely following the 11 CQI Study Steps. The Behavioral Health study was an area identified per a Corrective Action Plan from FY 2017. The event studied was a High-Risk, Low-Volume event. It was studied by a retrospective review of three months during the first quarter of FY 2018 and then repeated in the third quarter of FY 2018. The sample size was 20 intakes per month. The threshold was 100%. Thresholds were met during both quarters.

- An effective CQI program monitors high-risk and high-volume events, or problem-prone aspects of patient clinical outcomes. Five problem-prone areas identified by the CRCL team are: continuity of mental health care (i.e., detainees returning from hospitalization and detainees returning from suicide watch in the MHU to either general population or the SHU); compliance with Operations Memorandum 16-002; medication compliance outcomes; medication non-compliance counseling outcomes; and responsiveness / quality of mental health care delivered to subacute mentally ill detainees and chronic severely mentally ill detainees.

A SUMMARY OF RECOMMENDATIONS

Recommendation 1. BFDF should fill the gaps in the continuum of mental health care with additional programming.

Recommendation 2. In order to fill the gaps in the continuum of care and to enhance the quality and the quantity of mental health services delivered to detainees, BFDF must fill the vacant social worker position and psychiatry hours need to be increased to 10 hours per week, with at least four or five of those hours being filled by a psychiatrist who is physically present at BFDF.

Recommendation 3. Given the number of mentally ill detainees in the special management unit, the severity of their mental illness, and the fact that many of them are being treated with psychotropic medication, BFDF should ensure that mental health clinicians (to include psychiatry) are able to meet privately with those in segregation. Additionally, BFDF needs to perform rounds more frequently on detainees who are actively psychotic (i.e., experiencing auditory hallucinations) and who are being treated with antipsychotic medication.

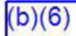
Recommendation 4. BFDF should enhance the suicide resistance of the medical housing unit cells by working with engineering to eliminate blind spots and anchor points (i.e., a cage on the wall adjacent to the social workers office, the holes in the bed frame, the ventilation holes, and the shower head).

Recommendation 5: BFDF should ensure that Detainees' average length of stay on suicide precautions exceeds 24 hours during which time they should receive meaningful treatment that is guided by a treatment plan which is critical for continuity of care upon being discharged from the stabilization unit.

Recommendation 6: To be in compliance with PBNDS 2011, BFDF should ensure that psychiatry meets with detainees being treated with psychotropic medication every 30 days to ensure proper treatment and dosage. Until proper staffing is in place, psychiatry needs to base the length of their orders on stability, compliance, and diagnosis, meeting with the unstable, noncompliant, and seriously mentally ill monthly.

Recommendation 7: BFDF should ensure that psychiatry or a supervised psychiatric nurse practitioner always schedules a session with a detainee being treated with psychotropic medication before renewing or discontinuing that medication.

Recommendation 8: BFDF's Health Services should perform a 2019 CQI outcome study on one of five problem-prone areas (1. continuity of mental health care after returning from hospitalization or suicide watch; 2. compliance with Operations Memorandum 16-002 reference length of stay on suicide precautions and the treatment plan guiding discharge and continuity of care; 3. medication compliance outcomes; 4. medication noncompliance counseling outcomes; or 5. responsiveness / quality of mental health care delivered to the subacute and severely mentally ill detainees in all units, but especially those who are locked up most of the day in a Suicide Watch cell, Segregation, Protective Custody, Unit A-2, and/or Unit B-1) .



Clinical Director, MHM
Georgia Department of Corrections

APPENDICES

APPENDIX I

Detainees Interviewed

- **Medical / Mental Health Complainants**
  (Not Applicable)*

- **An Allegation on the Care of Transgender Detainees**
  (Not Applicable)

- **Detainees Referred by CRCL Team During Investigation**
  1) (b) (6)
  2)
  3)
  4)
  5)

- **Detainees Admitted to Suicide Watch (SW) & Columbia Regional Care (CRCC)**
  6) (b) (6)

- **Detainees in Special Housing Unit on Segregation / Protective Custody**
  7) (b) (6)
  8)
  9)

- **Detainees on High Security in Single Cells & Low Security in Open Dorms**
  10) (b) (6)
  11)
  12)
  13)
  14)

*( ) denotes detainees who fall into multiple categories and are not being double counted

APPENDIX II

Records Reviewed

- **Medical / Mental Health Complainants**
  A) (b) (6)
  B)

- **An Allegation on the Care of Transgender Detainees**
  C) (b) (6)

- **Detainees Referred by CRCL Team During Investigation**
  D) (b) (6)

- **Detainees Admitted to Suicide Watch / Columbia Regional Care Center (CRCC)**
  E) (b) (6)

- **Detainees in Special Housing Unit on Segregation Status / Protective Custody Status**
  F) (b) (6)
  G)
  H)

- **Detainees on High Security in Single Cells & Low Security in Open Dorms**
  I) (b) (6)
  J)

*( ) denotes detainees who fall into multiple categories and are not being double counted

Appendix III

Detainees on Suicide Watch by Dates Initiated and Discontinued

- (b) (6)
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-
-
-
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REPORT FOR THE U. S. DEPARTMENT OF HOMELAND SECURITY

OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES

CONDITIONS OF DETENTION EXPERT'S REPORT

December 17-19, 2018

Investigation regarding

BUFFALO FEDERAL DETENTION FACILITY

Complaints reviewed in this report include the following:

CRCL Complaint Nos.

18-02-ICE-0050, 18-07-ICE-0245, 18-10-ICE-0482, 18-11-ICE-0569,

18-12-ICE-0648, and 18-12-ICE-0651

Prepared by:

(b) (6)

MAS

Rocklin, CA

February 2019

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BUFFALO FEDERAL DETENTION FACILITY

I. SUMMARY OF INVESTIGATION

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) conducted an onsite investigation at the Buffalo Federal Detention Facility (BFDF) in Batavia, New York on December 17-19, 2018. 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 the BFDF. CRCL's investigation included allegations raised by detainees related to medical care, mental health care, and conditions of detention. During this onsite investigation, I reviewed the conditions of detention allegations including care and treatment of transgender detainees, the grievance system, retaliation, religious access and accommodation, law library and legal material access, special management unit use and conditions, the disciplinary system, and treatment of detainees with disabilities. I also reviewed additional areas related to civil rights and civil liberties including sexual assault and abuse prevention and intervention (SAAPI/PREA), use of force, staff-detainee communication, language access and telephone access.

To examine the allegations in the complaints, this investigation reviewed BFDF's adherence to the Performance Based National Detention Standards (PBNDS) 2011 in the relevant areas. Allegations related to medical care and mental health care are addressed by other CRCL experts.

Through this review, I found operational deficiencies related to some of the allegations in the complaints. BFDF staff should be commended for their responsiveness to the volume of documents provided to the investigation team prior to the onsite. The timely response to the document request improved the quality of the investigation of complaints and conditions of detention at this facility.

This report contains observations and recommendations to address deficiencies identified that are based on PBNDS 2011. Additionally, I made recommendations based on my correctional experience, best correctional practices, and recognized correctional standards including those published by the American Correctional Association (ACA).

II. PROFESSIONAL EXPERTISE

(b) (6)

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(b) (6)

III. RELEVANT STANDARDS

A. ICE Detention Standards

ICE's PBNDS 2011 currently apply to BFDF. The facility was covered by these standards during the entire period relevant to this investigation. Consequently, I relied on the PBNDS 2011 when looking at the specific allegations 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.

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DHS-00039-0633

IV. FACILITY BACKGROUND AND POPULATION DEMOGRAPHICS

BFDF is located in Batavia, New York, and is operated and managed by ICE. BFDF has the capacity to house 636[1] ICE detainees, 544 male detainees and 80[2] female detainees. BFDF is currently accredited by the American Correctional Association and the National Commission on Correctional Health Care.

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 BFDF on December 17-19, 2018, along with CRCL staff; and interviewed ICE and BFDF staff and detainees.

The staff at BFDF 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 multiple detainee complaints
- Reviewed the April 2016 ICE National Detainee Handbook
- Reviewed relevant ICE PBNDS 2011 standards:
  - Contraband
  - Grievance Procedures
  - Detainee Handbook
  - Correspondence and Other Mail
  - Admission and Release
  - Access to Legal Material
  - Group Presentations on Legal Rights
  - Recreation
  - Religious Practices
  - Staff-Detainee Communication
  - Special Management Units (Administrative and Disciplinary)
  - Detainee Classification System
  - Population Counts
  - Disciplinary Policy
  - SAAPI/PREA
  - Funds and Personal Property

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[1] BFDF 636 bed capacity was reported by the Facility Administrator. ICE Facility capacity is reported as 650 beds on the Detention Review Summary Form G-324A dated March 2017.

[2] BFDF has limited the 92 bed unit capacity to 80 to accommodate housing female detainees.

- Suicide Prevention and Intervention
    - Telephone Access
    - Detention Files
    - Visitation
- Reviewed the ICE ERO Compliance Review-February 2017
- Reviewed the ICE Uniform Correction Action Plan-March 2017
- Reviewed the Nakamoto Annual Detention Inspection Report-March 2016
- Reviewed relevant ACA correctional standards

While at the BFDF on December 17-19, 2018, 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 BFDF Detainee Handbook
- Inspected telephone pro bono number postings in housing units
- Tested telephone functionality
- Toured visiting room
- Inspected the main law library and satellite Lexis-Nexis sites
- Reviewed the facility schedule for the law library
- Inspected the recreation yards
- Reviewed the recreation schedule
- Reviewed the religious service area
- Reviewed detainee grievance logs for January - November 2018
- 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, transgender, suicide prevention policies, language access, telephone access, and mail
- Met with various ICE and BFDF staff during the course of the review
- Reviewed BFDF policies on:
    - Sexual Assault and Abuse Prevention and Intervention (PREA)
    - Admission and Release (Intake)
    - Classification System
    - Detainee Housing
    - Orientation
    - Detention Files (Records)

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- 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
- 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, Staff Misconduct, Retaliation, Staff-Detainee Communication, Grievance System Access, Disability Accommodation, Special Management Unit, Disciplinary Detention and Medical Confidentiality

BFDF allowed CRCL full access to the documents and information requested. This unimpeded access facilitated CRCL's investigation. Based on this full access, the information the facility provided, and detainee interviews, I was able to complete a thorough review of the allegations contained in the complaints CRCL received.

During this investigation, I was able to review incident reports involving detainees during the period of January 2018 – October 2018. I interviewed over 31 detainees in three different groups. Group one consisted of male detainees housed in unit A-2. Group 2 consisted of female detainees housed in unit A-1. Group three consisted of male detainees housed in unit C-1. I also interviewed, individually, two detainees, who were housed in Administrative Segregation and one detainee housed in Disciplinary Segregation and two detainees using the language line. Overall, the detainees reported that the BFDF staff treated them with respect. However, during the detainee interviews, several detainees reported one particular staff member often called the detainees derogatory names and treated them with disrespect. The detainees did not

report any excessive use of force and I did not find any evidence of excessive use of force at this facility.

Grievance System

I reviewed the grievance system as part of this investigation. The PBNDS 2011 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 or concerns can be resolved timely and at the lowest level possible. All three groups of interviewed detainees reported that BFDF's grievance system does not work. The detainees stated the grievance system is not effective or responsive. Detainees report that their grievances are routinely screened out as non-responsive, the comments do not resolve the grievance or issue and, in some instances, the grievance response can be rude. For example, a detainee was grieving that the housing unit officer was not opening the recreation yard in accordance with the posted schedule time. The Grievance Lieutenant's response was "The rec yards will open when the officers are ready to open them, not when you say they should be open." The detainee was simply requesting that the officer follow the schedule. The Grievance Lieutenant then categorized this grievance as formally resolved, which it was not.

The PBNDS 2011 requires that each facility will maintain a detainee grievance log. Documentation in the log must include a grievance number, the receipt date of the grievance, and the date and disposition (outcome) of the grievance. BFDF's grievance log complies with these PBNDS 2011 requirements; however, the screening system and categorizing of appeals as informal or formal is deficient. Additionally, the resolution is based on the Grievance Lieutenant's opinion not whether the grievance was actually resolved. In the example provided above, the detainee was grieving that the recreation yard was not opening in accordance with the schedule and the Lieutenant's response, because he said the recreation yards will open when the officers are ready, is not a resolution to the issue. In reviewing the formal grievance log, for 2018, there were six grievances categorized as a formal grievance and 600 filed as informal grievances. Per PBNDS 2011, when the detainee files a written grievance, it should be counted as a formal grievance. Additionally, the Grievance Lieutenant routinely screens out grievances as the issue cannot be grieved.

For example, Detainee #5's formal complaint was that he shipped from the facility a pair of tennis shoes that he received from a vendor that had been purchased by his brother. The package, although it was logged out, was never received and the log did not contain tracking numbers. The issue was resolved by a relative and the facility calling the vendor and replacement tennis shoes were sent to the detainee. The Grievance Lieutenant categorized this missing property grievance as not a grievable issue, but missing property or a missing package is grievable. The grievance may be denied based on the circumstances, but it cannot be rejected by the Grievance Lieutenant simply because he says it is not a grievable issue.

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

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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.

Disability Accommodation

Detainee #6's formal complaint alleged that an officer did not accommodate his disability properly while he was performing his job sweeping and mopping the facility. I interviewed the detainee and conferred with the CRCL medical expert onsite during this investigation. We concluded that the detainee had been appropriately accommodated. While Detainee #6 was using a wheelchair, the detainee's medical condition did not necessitate the detainee's need to use a wheelchair. He simply preferred to use it.

The suicide observation cells in the facility's medical unit could not reasonably accommodate physical impairments and will require physical plant modifications to accommodate physical disabilities. The facility does use disability screening forms as part of their intake process.

Medical Confidentiality Breach and Safety Risk

During detainee interviews in the housing units, detainees reported they were required to sign up for medical sick call on a log that was posted at the housing unit officer's desk, in open view. The detainees had to record their name, number and medical complaint. The log remained in open view until it was provided to medical. This process exposed detainee's confidential, sensitive medical information to all detainees, staff, and others who visited the housing units. In addition to a medical privacy violation, exposing the detainee's medical condition to other detainees creates a safety concern. Any detainee could use another detainee's medical condition as leverage against another detainee. This poses a safety risk for detainees and potential security issues for custody staff. While touring the housing units, I observed the medical sign up logs in clear view, as reported by the detainees.

Special Management Unit

I inspected the Special Management Unit (SMU) at this facility. BFDF's SMU houses detainees on administrative and disciplinary segregation status. The unit is clean, quiet, and well maintained. I interviewed detainees in the SMU, who reported that staff are professional and treat detainees with respect. Detainees in administrative segregation also reported being provided access to mandated programs and services. Detainees in disciplinary segregation status were also provided with access to mandated programs and service. I interviewed Detainee #2 regarding his formal complaint that he was being denied extra hours in the law library. There is a computer in the SMU with access to Lexis-Nexis. I reviewed the unit log, Detainee #2's grievances regarding law library access and his segregation record. The records clearly indicate that Detainee #2 is provided additional law library hours with access to the Lexis-Nexis computer, while he is housed in the SMU. SMU staff had offered Detainee #2 additional hours, but he was refusing the offered additional morning hours. Detainees are not guaranteed a specific time slot for extra hours. Staff were accommodating Detainee #2's request for additional hours as the SMU schedule permitted. The detainee was choosing not to accept the morning additional hours when the SMU Lexis-Nexis computer was available.

and staff's schedule would permit.

One of the most serious findings at BFDF is the lack of adequate mental health treatment in the SMU. Over 50% of the SMU population has a serious mental health diagnosis. Mental health clinicians currently conduct interviews with detainees at the cell front though the open food port. The mental health expert on this investigation team will provide specific recommendations regarding the appropriate mental health treatment; however, detainees in SMU are significantly at risk of decompensating and potential risk of self-harm. Out of cell, private setting face-to-face clinical interactions are critical to establish effective mental health treatment in an SMU setting. There is an available private room in the SMU that mental health clinicians should utilize for their private clinical interactions with detainees who have a mental health diagnosis.

Disciplinary

Detainee #6's formal complaint alleged that an officer fabricated a story about his misuse of a razor so that he would be placed in disciplinary segregation in the SMU. I interviewed the detainee, reviewed the incident report and the officer did not fabricate the allegations. According to the incident report, detainee #6 got into an argument with another detainee which led to his disciplinary action. During the detainee group interview in the unit where this detainee was housed, Detainee #6 became verbally abusive and belligerent with one of the other detainees and almost created an incident in the unit.

Detainee #8's formal complaint alleged that he was placed in administrative segregation and remained there although he was found not guilty though the disciplinary hearing and appeal process. I reviewed the disciplinary documentation and it indicated that Detainee #8 was placed in segregation on March 3, 2018 and charged and initially found guilty of fighting with another detainee. I also reviewed Detainee #8's grievances related to this incident. After the disciplinary investigation was completed on March 5, 2018, he was released from disciplinary segregation related to the fighting charge, but then was placed in administrative segregation status until he was released from the facility on March 12, 2018. The facility had safety concerns and chose to keep him in administrative segregation until release. BFDF's actions were consistent PBNDS 2011.

Findings:

Detainee #5's complaint that his tennis shoes were lost by the BFDF **is not substantiated** due to the detainee receiving replacement shoes and he was wearing the shoes when he was interviewed as part of this investigation.

The BFDF grievance system screening and categorizing of informal and formal appeals practice do not conform to the PBNDS 2011 is **substantiated.**

Detainee claims that they suffer retaliation, verbal harassment, and disrespectful treatment by some BFDF staff is **not substantiated** due to a lack of evidence.

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BFDF does not provide sufficient disability accommodation in medical observation cells is **substantiated.**

Detainee #2's formal complaint of being denied extra law library hours is **not substantiated.**

Detainee #6's formal complaint of lack of disability accommodation and allegation of fabricated disciplinary charges are **not substantiated.**

BFDF does not adequately protect confidential detainee medical information is **substantiated.**

Detainee #8's allegation of inappropriate segregation placement is **not substantiated.**

The PBNDS 2011, along with additional applicable guidelines, support the following recommendations:

Recommendations:

- BFDF screens out grievances that should be responded to, categorizes some grievance issues inaccurately as non-grievable issues, and categorizes the vast majority of grievances as informal when many are formal grievances. BFDF also provides responses to detainees that grievance are formally resolved when they are not resolved. BFDF should revise their grievance screening and categorizing process to ensure appropriate grievances are not inaccurately screened out of the grievance process and ensure formal grievances are accurately recorded as formal. (Grievance System, § IV. (6); V. (3)) (Level I)
- BFDF should record grievances as denied instead of formally resolved when there is not a formal resolution. (Grievance System, § IV. (6); V. (3)) (Level I)
- BFDF practice of requiring detainees to sign up for medical call on a sheet in open view of staff and other detainees violates detainee privacy and jeopardizes the safety and well-being of detainees and the security of the facility. BFDF should create a secure medical drop box for detainees to place medical requests into which will maintain confidentiality, ensure protection of privacy, and eliminate detainee safety and facility security risks. (PBNDS 2011, Medical Care, § II(23)) (Level I)

B. Language Access

I reviewed the language access at this facility as part of this investigation. There were no open language access complaints at the time of investigation; however, during interviews of three groups of detainees which included detainees who are limited English proficient (LEP), the detainees reported significant language access issues.[3] At the time of this investigation, there were detainees housed at this facility from 95 different countries. The facility is not providing appropriate language access to LEP detainees in several areas.

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

The forms used for intake are only partially translated. The forms for the detainee requests, the detainee disciplinary process, grievances, ICE case management worksheets, law library requests, property, handbook, sick call sign up and other critical areas were only available in English despite what seemed like a large population of Spanish speakers who spoke limited or no English, in addition to the large number of detainees who spoke various languages from the 95 countries. Additionally, there were also no forms translated in Spanish) in any of the detention files reviewed. If the forms exist in Spanish, none were available in the housing units. Beyond Spanish, there were also detainees who spoke less common languages (e.g., Hindi, Mandarin, Romanian, Russian, French, Arabic, Punjabi, etc.) and who spoke little or no English. Detainees also reported being teased, mocked, or called names by some officers for being limited English proficient.

Although the language line appeared to be used regularly in medical, effective communication was not being provided in numerous areas. LEP detainees reported being required to sign documents in a language they did not understand. All of the forms in the files I reviewed were completed in English. A review of detainee files indicated that detainees who were or appeared to be Spanish speakers based on requests they had written in Spanish had signed forms written in English, with no indication of interpretation or translation assistance. Detainees I interviewed reported that LEP detainees were required to sign documents that were written in English and that language line interpretation assistance was not consistently provided.

BFDF 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, recreation, religious programing, Deportation Officer schedules, and menus, 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. BFDF is required to provide meaningful language access for detainees.

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BFDF staff do not consistently provide oral interpretation through Language Line or translate official documents from English to other languages for LEP detainees. LEP detainees are required to sign 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. Using the language line, I interviewed Detainee #1 who is from the Congo. He speaks Kinyarwanda. He has been at the BFDF for 30 months. Detainee #1 is LEP. He received a disciplinary report, was found guilty and was sentenced to 14 days in disciplinary segregation. The disciplinary report, the incident report, the review of segregation report, and the Assistant Officer in Charge's disciplinary appeal denial response were all written in English with no notation of any translation of the documents for the detainee. It is clear from the disciplinary appeal that the detainee is LEP. This detainee was not afforded his due process rights from the beginning of the disciplinary process to the end of the appeal process due to the lack of effective communication. This detainee is scared and would like to ask questions but is unable to due to language barriers. Friends had to help with sick call requests, which is privacy violation, but he believes he does not have a choice if he wants to be seen by the medical staff. He also reported being scared due to his inability to communicate with staff.

Detainee #4 is a Chinese language speaker. She was interviewed using a telephone interpreter. She stated that friends had to help her sign up for sick call which breeched medical privacy, but she did not have a choice. If she wanted to sign up for sick call, someone had to help her. She also reported being scared due to her inability to communicate with staff.

Findings:

BFDF 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:

- BFDF records indicate that language access resources are not consistently used to assist LEP detainees. BFDF 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) BFDF records indicate that language access resources are not consistently used to assist LEP detainees. BFDF 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)
- BFDF 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 BFDF 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, BFDF 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)

- BFDF 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)

C. Legal Access and Handbook

Law Library

As part of this investigation, I reviewed the law libraries and the detainees' access to legal material. I inspected the law library and Lexis-Nexis satellite sites in the housing units, interviewed detainees regarding use of the Lexis-Nexis computers, reviewed the law library schedule posted in each housing unit, and interviewed detainees regarding law library access. There is a sufficient number of computers in the law library locations, all of which has the Lexis-Nexis software installed. The Lexis-Nexis software updates are routinely completed. Detainees who are LEP cannot use the system which is only available in English. There is a male detainee clerk in the law library who provides assistance and training on the Lexis-Nexis software to male detainees in the law library. Female detainees are not provided with any assistance during their time to use the law library. The law library is housed adjacent to the recreational library. The computers and printer in the law library were all working at the time of this investigation. However, the legal computer in housing unit C-1 had been broken for over two weeks. The facility staff must call in a computer repair to an offsite location and is dependent on the central repair to dispatch a work order to the ICE computer repair technician who services multiple facilities. The computer repair work order request had been received by the repair technician within the last three days; however, the computer remained in non-working order during this time. Detainees were provided access to the law library and additional hours when requested. Detainee #2's formal complaint reported that he was not being provided additional hours use of the legal computer in disciplinary segregation. I reviewed his grievances and also the log book for the legal computer use in the segregation unit. The records reflect detainee #2 is regularly provided additional legal computer access. The issue is the detainee does not want to use the legal computer in the morning when the staff have time to escort the detainee to the legal computer room. Detainee #2 does not want the additional time in the morning. BFDF is not required to provide additional hours at the specific time slot requested by the detainee.

BFDF's Detainee Handbook states on page 5 "Detainees housed in the SHU must make a written request to the AFOD or designee for access to the law library or law library materials." This statement is not consistent with the facility's practice or the PBNDS 2011 Law Library and Legal Materials. The SMU has a dedicated room and Lexis-Nexis computer in the SMU to provide legal access for detainees housed in the SMU. BFDF's Handbook on page 4 does not notify detainees that Indigent detainees can request a free legal call.

Findings:

Detainee #2's complaint is **unfounded.**
Sufficient computers and printers are available in the law library and the Lexis-Nexis software is regularly updated; however, female detainees do not have equal access to support or training available to them on how to use the Lexis-Nexis software.

Delays to repairing legal computer equipment is **substantiated.** The Lexis-Nexis system is only available in English and accommodations for LEP detainee's use of the software are not made. Effective legal access to the law library is not provided is **substantiated.**

BFDF's Detainee Handbook related to Law Library access for SMU detainees is not consistent with their practice and the PBNDS 2011 is **substantiated**.

BFDF's Detainee Handbook does not advise indigent detainees that legal free calls can be requested is **substantiated.**

The PBNDS 2011, along with additional applicable guidelines, support the following recommendations:

Recommendations:

- BFDF should provide staff assistance to female detainees that is equivalent to male detainees to support detainee use of the Lexis-Nexis software and ensure legal access. (PBNDS 2011, Law Libraries and Legal Material, § II. 8) (Level I)
- BFDF should ensure timely repairs to computer equipment with Lexis-Nexis software so there is no impediment to legal access. (PBNDS 2011, Law Libraries and Legal Material, § V. E. a) (Level I)
- BFDF should provide assistance to illiterate and LEP detainees as mandated by the PBNDS 2011. (PBNDS 2011, Law Libraries and Legal Material, § V. I. 3) (Level I)
- BFDF's Detainee Handbook related to Legal Access for Inmates in the SMU Unit is inconsistent with the practice. The Detainee Handbook should be revised to reflect that legal access to Lexis-Nexis will be provided in the SMU. (PBNDS 2011, Law Libraries and Legal Material, § 2. 9, Detainee Handbook) (Level I)
- BFDF's Detainee Handbook should be revised to notify detainees that indigent detainees can request free legal calls. ((PBNDS 2011, Detainee Handbook, Telephone Access, § V. E.) (Level I)

D. Recreation Access

While onsite I reviewed recreation access at this facility. I interviewed detainees and inspected the recreational area. Recreation time provided to detainees exceeds the PBNDS 2011 requirements. Detainees had no complaints regarding recreational access, other than they would like more out of cell time in the celled units.

Findings:

- None

E. Telephone Access

During the group detainee interviews, detainees reported adequate telephone access. Detainee #2's formal complaint reported that he had issues with getting legal telephone access because the calls were not free. I reviewed this detainee's grievances and also a computer-generated report of the free legal calls that this detainee had been provided. The report confirms that BFDF does provide Detainee #2 with regular free telephone call access. Detainees complained of the high cost of the telephone rates, but the telephone equipment was in working order and adequately maintained. BFDF telephone rates are consistent with allowable amounts approved by ICE. Telephone free number listings were not consistently located near the telephones.

Findings:

Detainee #2's complaint that he is not being provided access to free legal calls is **unfounded**.

Recommendations:

- None

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

I reviewed BFDF's SAAPI/PREA program during the onsite investigation. I interviewed the onsite PSA Coordinator and inspected postings throughout the facility. I also reviewed the SAAPI/PREA policy. The detainees interviewed at this facility felt safe from sexual abuse or assault. The BFDF Handbook provided adequate SAAPI/PREA information; zero tolerance posters were posted throughout the facility. There were no reported SAAPI/PREA incidents during the year. There was one assault incident reported but it was not a sexual assault incident. The incident occurred when Detainee #3 approached another detainee to ask that he not speak about his sexuality. The detainee who Detainee #3 approached punched him in the face. The incident was investigated and determined appropriately to be an assault but not a SAAPI/PREA assault.

Findings:

None

Recommendations:

- None

G. Religious Access

Detainee #9's formal complaint alleges the facility is discriminating against Muslin detainees by not permitting them to congregate for worship during Ramadan prior to sunset, not allowing Muslim EId-Ul-Fitr prayer and not having an Imam. I interviewed the Chaplain and reviewed the Ramadan schedule. Detainees were allowed to congregate for worship and also detailed the

time for the Muslim Eld-Ul-Fitr prayer. The facility currently has a detainee acting as a volunteer Imam. The facility is also recruiting for an Imam from the community but currently has not identified a volunteer. The facility plans to continue to use a volunteer detainee to act as the Imam until a community Imam can be identified. This is a reasonable approach.

During interviews with the Chaplain it was determined that detainees are given a test when requesting a Kosher or Halal diet. There is no provision in the PBNDS 2011 to test for religious tenets to validate a religious diet request. Staff can monitor detainee's religious preference but cannot test on the tenets to prove the religious preference. This practice of testing detainees on religious faith tenets before approval of a religious diet request should cease.

Findings:

Detainee #9's complaint that the facility is discriminating detainees is **not substantiated.**

BFDF is violating the PBNDS 2011 Religious Practices by testing Muslim and Jewish detainees who request Halal and Kosher diets on tenets of their religions before approving their requests is **substantiated.**

Recommendations:

- BFDF's testing of Muslim and Jewish detainees on tenets of their religions before approving religious diets (Halal and Kosher) violates PBNDS Religious Practices. BFDF should cease testing detainees on religious tenets before approving Halal and Kosher diet requests. (PBNDS 2011, Religious Practice, § V. B.) (Level l)

OTHER OBSERVATIONS

In late 2017, BFDF began housing female detainees. The facility should ensure the programs and services offered to the female detainees are equivalent to those offered to male detainees. The male detainees currently have access to computer tablets in the housing unit. The female detainees do not. The facility has advised that computer tablets for the female detainees are on order and should arrive shortly. I therefore will not make a formal recommendation on this observation.

BFDF provides one floor officer for each celled housing unit. The detainees major complaint in the celled housing units is BFDF will only allow one tier out of their cells at a time. This results in half of the celled units being locked in their cell during day programming hours. The out of cell time limitation due to staffing creates tension in the unit. Detainees are being afforded the amount of out of cell and recreation time as required by the PBNDS 2011; however, it is recommended that BFDF staff evaluate resources to determine if there are available posts that could augment the housing unit officer to increase the out of cell time. As the facility is currently complying with PBNDS 2011 recreation time, this is an observation not a formal recommendation.

VII. SUMMARY OF BFDF RECOMMENDATIONS

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

- BFDF screens out grievances that should be responded to, categorizes some grievance issues inaccurately as non-grievable issues, and categorizes the vast majority of grievances as informal when many are formal grievances. BFDF also provides responses to detainees that grievance are formally resolved when they are not resolved. BFDF should revise their grievance screening and categorizing process to ensure appropriate grievances are not inaccurately screened out of the grievance process and ensure formal grievances are accurately recorded as formal. (Grievance System, § IV. (6); V. (3)) (Level I)
- BFDF should record grievances as denied instead of formally resolved when there is not a formal resolution. (Grievance System, § IV. (6); V. (3)) (Level I)
- BFDF's practice of requiring detainees to sign up for medical call on a sheet in open view of staff and other detainees violates detainee privacy and jeopardizes the safety and well-being of detainees and the security the facility. BFDF should create a secure medical drop box for detainees to place medical requests into which will maintain confidentiality, ensure protection of privacy, and eliminate detainee safety and facility security risks. (PBNDS 2011, Medical Care, § II(23)) (Level I)
- BFDF records indicate that language access resources are not consistently used to assist LEP detainees. BFDF 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)
- BFDF records indicate that language access resources are not consistently used to assist LEP detainees. BFDF 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)
- BFDF 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 BFDF 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, BFDF 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)
- BFDF 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)

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- BFDF should provide staff assistance to female detainees that is equivalent to male detainees to support detainee use of the Lexis-Nexis software and ensure legal access. (PBNDS 2011, Law Libraries and Legal Material, § II. 8) (Level I)
- BFDF should ensure timely repairs to computer equipment with the Lexis-Nexis software so there is no impediment to legal access. (PBNDS 2011, Law Libraries and Legal Material, § V. E. a) (Level I)
- BFDF should provide assistance to illiterate and LEP detainees as mandated by the PBNDS 2011. (PBNDS 2011, Law Libraries and Legal Material, § V. I. 3) (Level I)
- BFDF's Detainee Handbook related to Legal Access for Inmates in the SMU Unit is inconsistent with the practice. The Detainee Handbook should be revised to reflect that legal access to Lexis-Nexis will be provided in the SMU. (PBNDS 2011, Law Libraries and Legal Material, § 2. 9, Detainee Handbook) (Level I)
- BFDF's Detainee Handbook should be revised to notify detainees that indigent detainees can request free legal calls. ((PBNDS 2011, Detainee Handbook, Telephone Access, § V. E.) (Level I)
- BFDF's testing of Muslim and Jewish detainees on tenets of their religions before approving religious diets (Halal and Kosher) violates PBNDS Religious Practices. BFDF should cease testing detainees on religious tenets before approving Halal and Kosher diet requests. (PBNDS 2011, Religious Practice, § V. B.) (Level l)

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CRCL COMPLAINT NOS. 18-02-ICE-0050, 18-07-ICE-0245,

18-10-ICE-0482, 18-11-ICE-0569, 18-12-ICE-0648, and 18-12-ICE-0651

APPENDIX A

Detainee Name and Booking Numbers

Detainee #1: (b) (6)

Detainee #2:

Detainee #3:

Detainee #4:

Detainee #5:

Detainee #6:

Detainee #7:

Detainee #8:

Detainee #9

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