Medical Expert Report

U.S. Department of Homeland Security

Office of Civil Rights and Civil Liberties

August 14-16, 2018

Aurora Detention Facility also known as the Denver Contract Detention Facility

Complaint No. 17-12-ICE-0463

Complaint No. 18-06-ICE-0155

Complaint No. 18-03-ICE-0036

Complaint No. 18-09-ICE-0352

(b) (6)

MD, MBA, MPH, CCHP-P, CCHP-A

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EXECUTIVE SUMMARY

During the August 14-16, 2018, I visited the Aurora Detention Facility (ADF), also known as the Denver Contract Detention Facility (DCDF), in Aurora, Colorado as a member of a the Department of Homeland Security Office for Civil Rights and Civil Liberties (CRCL) team to assess the degree of compliance of ADF medical unit with the standards of care for detainees housed in that facility. Additionally, I was asked to investigate four specific complaints regarding the medical care at ADF. I visited several of the ADF medical facilities including intake, close observation unit, the main clinic and several male and female housing units including the Special Housing Unit (SHU). I also interviewed various ADF custody and health care staff including the Health Services Administrator, the Regional Administrative Director and the Corporate Executive Vice President for medical services. Additionally, I spoke to several detainees. I extend my most sincere thanks to all ADF health care and custody leadership and front line staff for their hospitality and generosity with their time and resources. I additionally thank ADF health care and custody leadership and staff for their openness to my suggestions and critical appraisal of this facility's processes and activities. ADF personnel were completely cooperative and helpful in this visit. I enjoyed full and unhindered access to all areas and staff.

The current ADF health care personnel appear to be highly engaged and strongly committed and invested in caring for the detainees of this facility. This is particularly exemplified in the current Health Services Administrator. I witnessed several examples of good/great performance. One example of a best in class process at ADF is the disease prevention efforts that have been implemented in this facility in recent months. Additionally, intake screening stands out as another high performing area. The initial health screening (medical and mental health screening) occur within hours of admission to ADF and no detainee is permitted into the general population until and unless they are screened for Tuberculosis (TB) and are found to be free of TB disease. This was observed in 100% of charts that were reviewed during our visit.

Unfortunately, I also discovered serval areas of poor performance some of which rise to the level of an unsafe environment of detention; and care that puts the health and wellbeing of ADF detainees at risk. Specifically, I discovered several examples of medical diagnosis that were either unacknowledged or untreated. One detainee was found to be human immunodeficiency virus (HIV) positive but was not told about the diagnosis. Other examples include detainees who were found to be hypothyroid or diabetic who did not receive care or received inadequate care.

One female detainee was documented to have persistent hematuria since January 2018 without a proper investigation into the etiology of her condition. She was still at ADF at the time of our visit. Any of these findings alone can be considered an "Immediate Jeopardy" according to the Center for Medicare & Medicaid Services (CMS) and can lead to the closure of large health systems. It is therefore of utmost importance that immediate corrective actions are implemented to ensure the health and wellbeing of detainees at ADF.

While there is a great deal of planning and work that need to get done, none is perhaps most urgent or crucial than the creation and implementation of a comprehensive Quality Assurance/ Process Improvement (QA/PI) plan to set goals, create expectation and accountability and to inform the ADF health care leadership and staff about the effectiveness and reliability of the existing processes. This includes every aspect of care from operational matters starting at intake screening and extending to the initial health assessment, enrollment and follow up in the chronic disease clinic, sick call process, medication continuity, referral to specialty services and discharge planning. While leadership staff is highly knowledgeable about the existing Performance Based National Detention Standards (PBNDS) 2011 and National Commission on Correctional Health Care (NCCHC) standards, they know very little about the performance of their current system. This is probably best exemplified in the sick call process where there seems to be very little data about the timeliness or effectiveness of this process. The same can be said about nearly all patient care processes. CRCL medical and mental health experts reviewed the "Quality Improvement (QI) reports" that were submitted by ADF prior to our arrival on site. These reports were completed by a contract registered health information administrator. The reports are dated January 15, 2018, April 7, 2018, April 28, 2018, April 30, 2018, May 27, 2018 and May 29, 2018. These reports are comprised of chart check evaluations and are strictly aimed at confirming the presence or absence of documentation that could support adherence to some of the PBNDS medical care standards. In nearly all areas of deficiency, the action plan is to "provide education and training to staff". The reports, however, fails to establish a timeline for the expected improvement or to identify the person(s) who is accountable to provide the additional training or ensuring that improvement is in fact achieved. These reports additionally fail to provide a graphic representation of the information so that performance over time can be easily tracked to indicate success/failure of implemented action plans.

Another significant issue is the apparent complete absence of physician leadership. Chart after chart indicate that nursing staff have basically been delivering nearly all patient care either in isolation or via telephone orders from the previous medical director. Time and again, there was evidence of multiple non-emergency sick call requests that were addressed by nursing staff without definitive treatment or more in depth investigation into the underlying cause of a presenting sign and symptom. The recent death in custody of a detainee with history of opiate abuse and withdrawal whose condition gradually worsened over two weeks without ever having a face to face physician evaluation is a glaring example of how the systemic deficiencies in ADF's provision of medical care and treatment resulted in significant harm.

In addition to the deficient practices identified above, there were significant operational and organizational deficiencies in the provision of medical care and treatment at ADF that must be addressed. These include:

- Lack of an overall leadership, direction, and accountability
- Lack of electronic medical record (ADF continues to use paper charting)
- Lack of a centralized, dependable tracking tool for all health care services and functions
- Lack of adequate and dependable follow up care
- Lack of timely access to specialty care
- Lack of a chronic disease management system

These items will be further discussed in the body of this report along with my recommendations.

Considering the extent and severity of immediate past and current non-compliant issues, I believe it is important to create a "priority list" of items that must be addressed by ADF health care team. In the first 90 days, ADF should aim to establish a true QA/PI program by creating a quality improvement committee to include medical, mental health and detention representation. This committee should:

1. Set goals and accountabilities as well as create a tracking system to monitor system performance and to inform management of areas of poor performance.
2. Perform a comprehensive audit of all medical records to identify other medical diagnosis that may have gone unacknowledged or untreated similar to the several examples that were identified during my chart reviews.

3. Identify detainees with chronic medical conditions who may have not undergone their initial or follow up chronic disease clinic evaluations similar to the serval examples that were identified during my chart reviews.

The following issues will take much longer.

1. Identify a solution to the medication storage issue.
2. Begin the process of transitioning to an electronic medical record.

Report Organization

In addition to my review of the three specific **medical complaints** I will provide an overall assessment of the **performance of healthcare services** at the ADF based on PBNDS 2011, modified 2016, Medical Care, 4.3, section II (Expected Outcomes) and section V. (Expected Practices). I will support my overall assessment of the performance of health care services at ADF 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 ADF as well as a random chart audits based on various criteria including chronic disease, non-emergent health care request (sick call), Emergency Room (ER) referrals, specialty care services, etc.

My Credentials

(b) (6)

Medical Complaints

Below, is my review and assessment of the following medical complaints at ADF that were retained by CRCL:

18-09-ICE-0352: American Immigration Council (AIC) and American Immigration Lawyers Association (AILA) complaint alleging inadequate medical and mental health care at DCDF. The complaint raised a number of systemic medical and mental health deficiencies that were founded by my review and will be discussed throughout this report. While the complaint provided pseudonyms, making it difficult to specifically review the medical concerns alleged, I was able to identify one of the complaints due to the nature of the allegation. The complaint involved a pregnant woman diagnosed with active pulmonary TB alleging delay in diagnosis and care.

Adult pregnant detainee (Detainee #1) admitted to ADF on January 24, 2018. While receiving appropriate prenatal care including outside obstetrics follow ups, Detainee #1 was sent to local Emergency Room (ER) for complaint of shortness of breath. She was evaluated at the ER and was returned back to ADF on the same day. Few days later, sputum Acid-Fast Bacilli (AFB) smears that were collected as part of the work up for the reported shortness of breath returned positive for Mycobacterium Tuberculosis (MTB). Detainee #1 was immediately placed in respiratory isolation and a contact investigation of the other female detainees in the same housing unit was carried out in partnership with the local health department. Detainee was placed on appropriate medications until her release from the facility.

Status of allegation that pregnant woman with TB received delayed care: Unfounded.

17-12-ICE-0463: allegation that a pregnant woman was forced to work against her will.

Detainee #2 - a female detainee who was admitted to Aurora Detention Facility (ADF) on September 12, 2017, and underwent a chronic care clinic visit with the facility physician that same day. She was 6 months pregnant at the time of her admission to ADF. Detainee #2 reported a history of methamphetamines and cocaine dependence. She reported to prenatal care prior to her arrival at ADF. She underwent a medical and mental health screening on admission to ADF. She was screened negative for TB. She underwent a psychiatric evaluation on September 14, 2017 and was started on prenatal vitamins on September 15, 2017. She was held in close

observation area of ADF on September 14 and 15, 2017 when she was reported to be in good health and had fetal heart tones that were within normal range. She was referred to outside Obstetrics services and was evaluated by an obstetrician on October 5, 2017, who found no issues with her pregnancy but recommended the addition of iron tablets due to Detainee #2's mild anemia. She had a negative pap smear test and a negative screening for Zika virus. On September 20, 2017, Detainee #2 submitted a request for additional food. She was started on evening snack packs that same day. She complained of lower abdominal pain on October 8, 2017 without vaginal discharge or bleeding. She did report vomiting blood but this was not substantiated or observed by anyone before or after her report. She was observed for several hours in the main clinic before returning to her housing unit once she was pain free. Detainee #2 was released from ADF on October 10, 2017.

I did not find any sick call requests or medical or administrative grievances with regard to her complaint of having to work against her will. Additionally, I confirmed with other female detainees that cleaning of the housing units is a shared responsibility among detainees.
Status: Unfounded.

18-06-ICE-0155: Allegation that a male detainee did not receive appropriate care after being assaulted by other detainees.

Detainee #3 - adult male detainee who was admitted to Aurora Detention Facility (ADF) on January 26, 2018. He received a medical and mental health screening that same day. He reported a history of high blood pressure, low back pain and drug abuse. He received a special needs pass for a lower level, lower bunk bed, due to his chronic low back pain. He was evaluated by a physician assistant on January 31, 2018. He had his first chronic care clinic visit on the same day. He had a follow up physician evaluation on February 2, 2018, who ordered several x-rays due to Detainee #3's report of previous trauma to his head and several other areas (prior to admission to ADF). X-rays of skull, right foot and lumbar spine on February 8, 2018 were all negative for acute injuries. He reported blurry vision of January 29, 2018 for which he underwent a visual acuity check and found not to have any acute visual issues. He was referred to psychiatric services on January 25, 2018 for feeling anxious. He was evaluated by psychiatric services on February 6, 2018 and had two dental appointments on February 20 and 26, 2018. His blood work on February 10, 2018 indicated moderately severe hypothyroidism. He was also

found to have a high Creatin level and moderate proteinuria all of which can be explained caused by hypothyroidism. Detainee #3 was started on thyroid replacement therapy on February 16, 2018. On March 8, 2018, he reported being assaulted by other detainees. He was evaluated by nursing staff who did not observed any outward injuries. He was started on Ibuprofen for pain and was referred to the medical provider. Detainee #3 was evaluated by the facility physician on March 13, 2018. On that day, he also reported numbness to his right leg. Physician started him on pain medication for 15 days and ordered a lumbar spine x-ray that was performed two days later and was negative for acute injuries. It did show osteoporosis and moderate degenerative disease (both are age related). On March 29, 2018, Detainee #3 reported a fall from standing position. He was evaluated by nursing staff and was kept under close observation for 24 hours with neuro-check exams every eight hours. He was sent back to his housing unit the following day with a special needs authorization allowing him to keep a walking cane or crutches in his possession. Detainee #3 was released from ADF on March 30, 2018.

Status: Unfounded.

18-03-ICE-0036: Death in custody involving male detainee undergoing opiate withdrawal.

I have studied the findings of a very detailed review of this case by the Office of Professional Responsibility, External Reviews and Analysis Unit and agree with the findings and recommendations of this report. Below is a brief synopsis of my personal review of this case. Detainee #4 - an adult male detainee who was admitted to ADF from November 17, 2017 until his death on December 2, 2017. He reported chronic methadone dependence at a very high dose of 190 mg per day. He also reported to be experiencing opiate withdrawal symptoms. Detainee #4 was housed in the close observation area of the ADF medical unit which is only a few feet away from the nursing station. Over the pursuing two weeks, there is ample documentation of deterioration of this detainee's condition including worsening of opiate withdrawal symptoms, anorexia, nausea and vomiting, diarrhea, weakness, generalized pain, malaise, etc. Even though Detainee #4 was placed on "opiate detox protocol" shortly after admission to ADF, there is very little documentation about him actually receiving his medications or nursing assessments including measurements of his vital signs according to the protocol that he was placed on. For an unknown reason, nursing staff continued to assess Detainee #4's withdrawal symptoms using an alcohol withdrawal assessment tool instead of the appropriate opiate withdrawal assessment tool.

Detainee #4's detention was further complicated after he threatened to kill himself due to not receiving adequate care. Despite continued worsening of his condition to the point of not being able to stand up or to walk, Detainee #4 was neither evaluated by the facility provider staff (PA or physician) even once, nor was he referred to the local emergency room until his final collapse on December 2, 2017. While the medical examiner ruled the cause of death "undetermined", the complete lack of medical leadership, supervision and care that this detainee was exposed to is simply astonishing and stands out as one of the most egregious failures to provide optimal care in my experience. The magnitude of failures to care for this detainee is only surpassed by the number of such failures. It truly appears that this system failed at every aspect of care possible beginning from using the correct withdrawal assessment tool to performing basic nursing functions including the ability to recognize medical emergency situations to an astonishing lack of physician supervision, leadership and accountability. I am additionally concerned that the mortality review that was conducted by ADF after Detainee #4's death failed to acknowledge the gravity of this event and the magnitude of the system's failure to provide a safe detention environment or to effectively care for the health and wellbeing of this detainee. In fact, the only recommendation that resulted from this mortality review was that ADF nursing should summon the 911 emergency services sooner and according to their "clinical judgement" when faced with life and death situations. This recommendation ignores the depth and the span of ADF's failure to comply with the minimum standards of care according to PBNDS and/or the National Commission on Correctional Health Care (NCCHC) as outlined below.

Status: Founded.

Below are the PBNDS 2011 and NCCHC standards that were not met in the care of Detainee #4 and my recommendations for remediation:

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

NCCHC J-A-01: Inmates have access to care for their serious medical, dental and mental health needs

NCCHC J-E-09: Patient medical, dental and mental health care is coordinated and monitored from admission to discharge.

Findings:

ADF failed to timely diagnose the life threatening (in this case, life ending) deterioration of this detainee's condition resulting from his opiate and potentially alcohol withdrawal and to provide adequate treatment for these conditions.

Recommendations:

1. Detainees identified as having chronic medical conditions should receive their initial provider encounter within two working days of arrival at the detention facility.
2. ADF should establish better monitoring and coordination of care for detainees with serious medical condition. This includes improved communication between nursing and the responsible medical provider as well as improved documentation by all healthcare staff.
3. ADF should ensure that all provider orders are carried out by the nursing staff.
4. Detainees identified as suffering from opiate dependence and withdrawal should undergo an initial and regularly scheduled evaluations using evidence based assessment tool designed for the care of individuals suffering from opiate withdrawal. The correct tool in this case would have been the Clinical Opiate Withdrawal Scale (COWS).

PBNDS 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.

Findings:

ADF failed to timely transfer the care of Detainee #4 to a facility capable to care for acutely ill patients similar to this detainee.

Recommendations:

1. ADF should develop and implement a policy that clearly identifies when the health care needs of a detainee far exceeds the capabilities of the ADF and its staff. ADF must train and educate the nursing staff based on such policy to recognize when a detainee's health care needs are

beyond the capabilities of ADF.ADF must additionally train and educate the nursing staff to contact the facility's responsible physician as frequently as indicated to address detainees' urgent/emergent medical conditions.

2. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous program improvement.

PBNDS II. 8: A detainee who requires close, chronic or convalescent medical supervision shall be treated in accordance with a written treatment plan conforming to accepted medical practices for the condition in question, approved by a licensed physician, dentist or mental health practitioner.

Findings:

While the main diagnosis for this detainee was opiate detox, ADF failed to use the appropriate evidence based opiate withdrawal monitoring tool (COWS). Detainee #4 had several CIWA-ar assessment questionnaires completed on him even though this tool is strictly meant for use in individuals suffering from alcohol detox. Additionally, there is no evidence that Detainee #4's care was monitored by the facility physician.

Recommendations:

1. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees.
2. Detainees identified as suffering from opiate dependence and withdrawal should undergo an immediate initial and regularly scheduled evaluations using evidence based assessment tool designed for the care of individuals suffering from opiate withdrawal. The correct tool in this case would have been the Clinical Opiate Withdrawal Scale (COWS).

PBNDS 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:

There are several examples in this detainee's chart to indicate that ADF failed to adequately monitor the care of this detainee. These include multiple missed scheduled medications, missed scheduled vital signs, lack of a single provider evaluation despite severe and worsening condition.

Recommendations:

1. ADF must create an accountable and failsafe system to address all scheduled patient services including medication administration, vital signs, provider appointments, etc.
2. ADF must provide a reliable system of providing opportunities for face to face provider evaluation and consultation with detainees whose medical condition are beyond the scope of nursing practice. Once this systems is put in place, ADF must be audited on a regular basis to ensure adherence to the expectations and sustainability.

PBNDS II.15: Each detainee shall receive a comprehensive health assessment, including a physical examination and mental health screening, by a qualified, licensed health care professional no later than 14 days after entering into ICE custody or arrival at facility. For the purposes of the comprehensive medical examination, a qualified licensed health provider includes the following: physicians, physician assistants, nurses, nurse practitioners, or others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients.
NCCHC J-E-04: Inmates receive initial health assessments.

Findings:
Despite severe and worsening medical condition stemming from chronic opiate abuse and withdrawal, Detainee #4 did not receive an initial health assessment during his two-week detention at ADF.

Recommendations:

1. Detainees identified as having chronic medical conditions should receive their initial provider encounter within two working days of arrival at the detention facility.

PBNDS II. 18: Detainees experiencing severe, life-threatening intoxication or withdrawal

symptoms shall be transferred immediately for either on-site or off- site emergency department evaluation.

PBNDS V.K: Substance Dependence and Detoxification

NCCHC J-F-04: Inmates who are intoxicated or undergo withdrawal are appropriately managed and treated.

Findings:

ADF failed to identify and transfer this detainee in a timely manner to a higher level of care. ADF does not provide infirmary level care.

Recommendations:

1. ADF should develop and implement a policy that clearly identifies when the health care needs of a detainee far exceeds the capabilities of the ADF and its staff. ADF must train and educate the nursing staff based on such policy to recognize when a detainee's health care needs are beyond the capabilities of ADF.
2. ADF must additionally train and educate the nursing staff to contact the facility's responsible physician as frequently as indicated to address detainees' urgent/emergent medical conditions.
3. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous program improvement.

PBNDS II. 20: Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees.

Findings:

Detainee #4 did not receive the medications that were ordered for him according to the physician order and the established protocols at ADF. As documented in the External Review and Analysis Unit (ERAU) review, Detainee #4 received only five of potential 42 doses of anxiety medication, less than half of his medications for sleep and restlessness, less than half of his pain medication and

only four of potential 42 doses of medication for nausea and vomiting which he is documented to have suffered while in detention at ADF.

Recommendations:

1. ADF must re-educate and hold accountable the nursing staff to account for all doses of medications that detainees are scheduled to receive.
2. ADF must create an accountable and failsafe system to address all scheduled patient services including medication administration. Once this system is in place, ADF must be audited on a regular basis to ensure adherence to the expectations and sustainability.

PBNDS V.A. 2: Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services

Findings:

Because ADF does not provide infirmary level care that would have been required to provide the medically necessary and appropriate medical care for Detainee #4, it should have transferred him to a higher acuity facility. It did not. Additionally, ADF failed to acknowledge and/or adequately address this detainee's severe and worsening medical condition while he was detained at that facility.

Recommendations:

1. ADF should develop and implement a policy that clearly identifies when the health care needs of a detainee far exceeds the capabilities of the ADF and its staff. ADF must train and educate the nursing staff based on such policy to recognize when a detainee's health care needs are beyond the capabilities of ADF.
2. ADF must additionally train and educate the nursing staff to contact the facility's responsible physician as frequently as indicated to address detainees' urgent/emergent medical conditions.
3. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous program improvement.

PBNDS V.A. 3: Comprehensive, routine and preventive health care, as medically indicated

Findings:
ADF failed to provide timely and comprehensive care for the severe and worsening medical condition of this detainee. Despite repeated and documented episodes of poor health including loss of consciousness and fall, ADF responsible physician did not examine Detainee #4 even once throughout his two-week detention at the facility.

Recommendations:

1. ADF should develop and implement a policy that clearly identifies when the health care needs of a detainee far exceeds the capabilities of the ADF and its staff. ADF must train and educate the nursing staff based on such policy to recognize when a detainee's health care needs are beyond the capabilities of ADF.
2. ADF must additionally train and educate the nursing staff to contact the facility's responsible physician as frequently as indicated to address detainees' urgent/emergent medical conditions.
3. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous program improvement.

PBNDS V.A. 7: Hospitalization as needed within the local community

Findings:
While ADF does not provide infirmary level care, it failed to recognize the severity of this detainee's health condition that most certainly required transfer to a higher level of care and hospitalization.

Recommendations:

1. ADF should develop and implement a policy that clearly identifies when the health care needs of a detainee far exceeds the capabilities of the ADF and its staff. ADF must train and educate

the nursing staff based on such policy to recognize when a detainee's health care needs are beyond the capabilities of ADF.

2. ADF must additionally train and educate the nursing staff to contact the facility's responsible physician as frequently as indicated to address detainees' urgent/emergent medical conditions.
3. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous program improvement.

PBNDS V.B: All facilities shall provide medical staff and sufficient support personnel to meet these standards.

Findings:
According to the ERAU report, at the time of Detainee #4's detention at ADF the positions of Director of Nursing and Advanced Practice Providers (APP) were vacant. Both of these vacancies were in part responsible for ADF's failures to meet the minimum standards of care according to PBNDS and NCCHC.

Recommendations:

1. ADF should conduct a staff analysis to identify the staffing needs for a facility of this size and maintain such staffing level, particularly in key health care positions to ensure the ability to meet the minimum standards of care. .

PBNDS V.N: Where a detainee has a serious medical or mental health condition or otherwise requires special or close medical care, medical staff shall complete a medical/psychiatric alert form or equivalent and file the form in the detainee's medical record.

Findings:
ADF failed to complete a medical alert form for Detainee #4.

Recommendations:

1. ADF must comply with all required elements of PBNDS standard of care and complete a medical/ mental health alert form for detainees with serious medical/ mental health conditions and include these forms in detainees' health records.

PBNDS V.J: Medical and Mental Health Screening of New Arrivals

Findings:
Despite having significant medical issues, ADF failed to offer Detainee #4 an initial provider evaluation within two working days.

Recommendations:
1. Detainees identified as having chronic medical conditions should receive their initial provider encounter within two working days of arrival at the detention facility.

PBNDS V.W: Special Needs and Close Medical Supervision

Findings:
ADF failed to provide close medical supervision to Detainee #4 despite his documented severe and worsening medical conditions. Detainee #4 did not receive a single face to face provider evaluation during his entire two-week detention at ADF.

Recommendations:
1. ADF should develop and implement a policy that clearly identifies when the health care needs of a detainee far exceeds the capabilities of the ADF and its staff. ADF must train and educate the nursing staff based on such policy to recognize when a detainee's health care needs are beyond the capabilities of ADF.
2. ADF must additionally train and educate the nursing staff to contact the facility's responsible physician as frequently as indicated to address detainees' urgent/emergent medical conditions.
3. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous

program improvement.

Performance of Health Care Services

As mentioned in the executive summary, I found several areas of care that met PBNDS and NCCHC standards of care for detention facilities. Below, I will focus my findings to those PBNDS and/or NCCHC standards that were **not met** along with my recommendations for remediation.

PBNDS II. 1. Detainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment.
NCCHC J-A-01. Inmates have access to care for their serious medical, dental and mental health needs.
NCCHC J-E-09. Patient medical, dental, and mental health care is coordinated and monitored from admission to discharge.

Findings:
Detainees who are identified as having acute and chronic medical conditions based on laboratory tests that were performed at ADF are expected to have these conditions acknowledged and then treated according to the existing minimal standards of care. We found several instances in which screening tests including HIV, HgbA1C, TSH, Urinalysis, etc. had gone unacknowledged or acknowledged but untreated.
Representative cases include # 4,6,8,9,11,16,17,22,29,30,34 below.

Additionally, detainees with medical conditions that require referral to outside specialty services are expected to receive such referrals within a reasonable amount of time. We found several examples of specialty referrals that had unduly long wait times.
Representative cases include # 3,5,8,10,12,21,33 below.

Recommendations:

- ADF must create an accountable and failsafe system to address abnormal lab results and provide an opportunity for face to face provider consultation with the patient. Once such a system in put in place, it must be audited on a regular basis to ensure adherence to the expectations and sustainability.

- Detainees identified as having HIV/AIDS should receive an evaluation by an infectious disease specialist in a timely manner and ideally within 14 days (best practice).
- Detainees identified as needing specialty services should receive an evaluation by a specialist in a timely manner and ideally within 30 days (best practice).

PBNDS II. 3. The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP). All written materials provided to detainees shall generally be translated into Spanish. Where practicable, provisions for written translation shall be made for other significant segments of the population with limited English proficiency. Newly-admitted detainees shall be informed orally or in a manner in which the detainee understands about how to access, appeal or communicate concerns about health services.

Findings:
Facility utilizes a language line that is available 24/7. There is documentation that this tool is in use to provide language services to detainees who do not speak English. This service is also available for tele-psychiatry services. We observed English and Spanish versions of consent form, non-emergency health care requests (Kite) form, refusal form, etc. Additionally, the tablet system used for electronic submission of non-emergency health care requests allows the detainees to submit their request in several languages including English and Spanish. Detainees receive a video orientation to the ADF health care services. This video is in both English and Spanish.
We observed however, that responses to medical grievances that are submitted in Spanish are retuned to detainees in English. There appears to have been a shift in approach to this effort since at the outset grievances submitted in Spanish were responded to in Spanish as well. This practice, however, has stopped.

Recommendations:
- ADF must respond to medical grievances in a language that the grievant understands.

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

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

Findings:

While detainees have the ability to submit either paper or electronic non-emergency health care requests (sick call requests), there is no way of assessing the timeliness of this process due to lack of a tracking mechanism at this time. The paper log and the electronic log currently used to identify total, open and closed sick call requests are inconsistent. The nursing personnel report receiving anywhere from 30 to 60 daily sick call requests per day. The existing logs, however, put this number at only 18 requests per day. We were told that there was a recent push to catch up with all the backlogged sick call requests. As part of this process nursing staff were delivering "nurse sick call" visits inside the housing units and within the multi-purpose rooms located at each housing unit. We were told that this practice has stopped now that they have "caught up" with backlogged sick call requests. It remains to be verified if sick call requests are being addressed in a timely manner. During our joint town hall meetings with male and female detainees within their housing units, detainees voiced dissatisfaction with the sick call process. It is difficult to assess if the dissatisfaction is due to sick call back log or the fact that detainees are not able to access the provider staff despite repeat sick call requests and grievances.

Detainees must have "unrestricted opportunity to freely request health care services". During our visit, we observed several housing units that did not have any paper sick call request forms within the housing unit while they maintained a "Sick Call Box". We were told later that an administrative decision had been made to transition the sick call process completely from paper to electronic format using tablets. While this may prove to be a suitable alternative to using paper sick call requests, until and unless a QI study identifies and addresses all potential barriers to the use of the tablet system, the complete elimination of paper sick call forms is not ideal. One example of a potential barrier to the use of tablet system is the detainee knowledge gap in using electronic tools particularly in the case of older detainees and those who do not speak English or Spanish. Another issue with the transition of sick call requests to the tablet system is the fact that the current system limits detainees access to the tablets (tablets are not accessible to detainees on a 24/7 basis).

Recommendations:

- ADF should reinstate the use of paper sick call request forms while increasing the training amongst detainees on the use of electronic submissions. These trainings should be provided weekly, in the dorms, as needed, to ensure that the detainee population is aware on the method of submitting an electronic sick call request form. The abrupt switch from paper sick call request forms to an electronic platform without allowing for a safe transition period will undoubtedly leave many detainees without a real option for requesting health care services.
- ADF must create a system to allow for tracking of sick call requests to ensure that all sick call requests that result in provider referral are addressed by the facility provider in a timely manner.
- ADF must perform a QI study to identify and mitigate all potential barriers to the universal use of electronic tablets for the sick call request process prior to elimination of paper sick call request forms.

PBNDS II. 5. Detainees shall receive continuity of care from time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community-based providers as medically-appropriate.
NCCHC J-F-01: Patients with chronic disease, other significant health conditions, and disabilities receive ongoing multidisciplinary care aligned with evidence-based standards.

Findings:
Detainees with chronic medical conditions are supposed to receive and initial provider (MD, PA) evaluation within the first 30 days of admission. This is not occurring in a consistent manner. Detainees are then supposed to receive interval provider evaluations based on the severity of their illness and the degree of disease control. This interval is supposed to be 90 days or less. This is not occurring consistently either. Almost all provider encounters post intake are episodic in nature and due to an acute issue that may be completely unrelated to the chronic medical condition the detainee is suffering from. During these encounters the

chronic medical condition is not addressed.
Representative cases include # 10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29, 32, 33, 34 below.

Recommendations:

- Detainees identified as having chronic medical conditions should receive their initial provider encounter within the first two working days of arrival at the detention facility.
- ADF must create a chronic disease management system that allows for timely initial and follow up care for ADF detainees.
- ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous program improvement.

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

Findings:
Detainees have good access to emergency medical care. Their access to specialty care including Obstetrics (for pregnant detainees) and Infectious disease (for HIV positive detainees) seem to be limited and not timely. Several examples of detainees waiting for various specialty health care services will be provided in the next section.
Representative cases include # 3,6,8,10,12,21,33 below.

Recommendations:

- Detainees identified as being pregnant should receive an evaluation by an obstetrician specialist in a timely manner and ideally within 14 days of detainment.
- Detainees identified as having HIV/AIDS should receive an evaluation by an infectious disease specialist in a timely manner and ideally within 14 days of detainment.

- Detainees identified as needing specialty services should receive an evaluation by a specialist in a timely manner and ideally within 30 days of detainment.
- ADF must ensure continuity of care including timely continuity of critical medications such as HIV medications.

PBNDS II. 12. Detainees with chronic conditions shall receive care and treatment, as needed, that includes monitoring of medications, diagnostic testing and chronic care clinics.
NCCHC J-F-01. Patients with chronic disease, other significant health conditions, and disabilities receive ongoing multidisciplinary care aligned with evidence-based standards.

Findings:
We found several examples of unacknowledged or untreated medical conditions of different severity including HIV, diabetes, hypothyroidism and chronic hematuria.
Representative cases include # 4, 6, 8, 9, 11, 16, 17, 22, 29 below.

Additionally, the chronic care clinic system appears to be broken and detainees are not receiving routinely scheduled chronic care clinic visits.
Representative cases include # 10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29, 32, 33, 34 below.

Recommendations:
- ADF must create an accountable and failsafe system to address abnormal lab results and provide an opportunity for face to face provider consultation with the patient. Once such a system in put in place, it must be audited on a regular basis to ensure adherence to the expectations and sustainability.
- Detainees identified as having chronic medical conditions should receive their initial provider encounter within the first two working days of arrival at the detention facility.
- ADF must create a chronic disease management system that allows for timely initial and follow up care for ADF detainees.
- ADF must create a system to ensure that acute medical conditions are brought up to the attention of the facility provider staff and that such conditions are addressed by the provider

staff.

PBNDS II. 18. Detainees experiencing severe, life-threatening intoxication or withdrawal symptoms shall be transferred immediately for either on-site or off- site emergency department evaluation.

Findings:
ADF suffered a recent death in custody related to a male detainee undergoing opiate (and possibly alcohol) detox and withdrawal. ADF failed to identify and transfer this detainee in a timely manner to a higher level of care. This is further discusses in the "Response to Formal Complaints" section under complaint **#18-03-ICE-0036** above.

PBNDS II. 19. Pharmaceuticals and non-prescription medicines shall be secured, stored and inventoried.
NCCHC J-D-01. Pharmaceutical operations meet the needs of the facility and conform to the legal requirements.

Findings:
ADF has a medication room with open stock prescription and non-prescription medications that are not (and cannot be) inventoried. There is no possible way of preventing diversion of these medications as nursing staff has full unimpeded and unmonitored access to these stock medications. Controlled substances are secured and inventoried.
Representative case includes #35 below.

Recommendations:

- ADF must create a medication storage system that will allow for safe and restricted storage of all stock medications. There are many ways of achieving this including the use of blister package stock medications and use of Pyxis machines.

PBNDS II. 20. Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in

a manner that seeks to preserve the privacy and personal health information of detainees.
NCCHC J-C-05. Personnel who administer or deliver prescription medication are appropriately trained.
NCCHC J-D-02. Medications are provided in a timely, safe, and sufficient manner.

Findings:
We observed two medication pass episodes. It was evident to us that two patient identification processes was not followed by the medication nurses. Additionally, the hand/mouth check of the detainees receiving medication was inconsistent at best. Detainees huddle around the medication cart making it impossible to maintain the privacy of health information of detainees receiving medications.
Representative case includes #36 below.

Recommendations:

- ADF must reeducate the nursing staff regarding the correct process for ensuring two-patient identification.
- ADF must put in place a robust hand/mouth check process (including the custody staff) to mitigate the potential for medication hording or overdose.
- ADF must train nursing staff to account for all doses of medications that detainees are scheduled to receive. Blank spaces in the MAR document can only be interpreted as missed medications and contribute to an incomplete medical record.

PBNDS II. 25. Medical and mental health interviews, screenings, appraisals, examinations, procedures and administration of medication shall be conducted in settings that respect detainees' privacy in accordance with safe and/orderly operations of the facility.
NCCHC J-A-07. Health care encounters and exchanges of information remain private.

Findings:
While we were told that the practice of carrying out the nurse sick call encounters within the detainee housing units had ceased just prior to our arrive at the facility, it remains to be seen if the facility is able to remain up to date with the sick call request load.

Recommendations:

- All medical health care encounters are to occur in a clinically appropriate setting that is not only conducive to conducting a private interview and examination but also provides a hygienic and clinically equipped environment to facilitate such encounters.

PBNDS 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 V. EE. 1. Quarterly Administrative Meetings

PBNDS 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:

ADF does not have an existing Quality Improvement program. We were told by the currently HSA that an initial QAPI meeting was held earlier this year for the first time. ADF intends to conduct such meeting monthly or more frequently as needed. Additionally, ADF has hired one full time FTE Quality nurse who is charged with helping the HSA with leading the QAPI efforts.

Recommendations:

- ADF must create a quality improvement committee and establish a standing interval meeting no less often than every three months and should include leaders from health care and detention divisions.
- The quality improvement committee should identify 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 plan to address these issues and monitor the ongoing performance of the system.
- The quality improvement committee must ensure that at least one process and/or outcome quality improvement study is completed each year.

PBNDS V. A. 2. Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services

NCCHC J-A-01. Inmates have access to care for their serious medical, dental and mental health needs.

Findings:

We observed several instances of delay in detainees care related to specialty services such as ID, Ob, etc. We additionally discovered several instances in which detainees' medical conditions were either not acknowledge or acknowledged but not addressed appropriately. Representative cases include # 3,6,8,10,12,21,33 below.

Recommendations:

- Detainees identified as having chronic medical conditions should receive their initial provider encounter within the first two working days of arrival at the detention facility.
- Detainees identified as being pregnant should receive an evaluation by an obstetrician specialist in a timely manner and ideally within 14 days of detainment.
- Detainees identified as having HIV/AIDS should receive an evaluation by an infectious disease specialist in a timely manner and ideally within 14 days of detainment.
- Detainees identified as needing specialty services should receive an evaluation by a specialist in a timely manner and ideally within 30 days of detainment.

PBNDS V. A. 3. Comprehensive, routine and preventive health care, as medically indicated

NCCHC J-A-01. Inmates have access to care for their serious medical, dental and mental health needs.

Findings:

We observed several instances in which the chronic disease clinic encounters occurred late (more than 30 days after arrival at the facility) and follow up encounters in intervals greater than 90 days or not at all after the initial chronic care appointment.

Representative cases include #

10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,32,33,34 below.

Recommendations:

- Detainees identified as having chronic medical conditions should receive their initial provider encounter within the first two working days of arrival at the detention facility.
- Detainees identified as needing specialty services should receive an evaluation by a specialist in a timely manner and ideally within 30 days.
- ADF must create a chronic disease management system that allows for timely initial and follow up care for ADF detainees.

PBNDS V. A. 5. Specialty health care

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

Findings:

We observed significant delays in access to specialty health care.

Representative cases include # 3, 6, 8, 10, 12, 21, 33 below.

Recommendations:

- Detainees identified as being pregnant should receive an evaluation by an obstetrician specialist in a timely manner and ideally within 14 days of detainment.
- Detainees identified as having HIV/AIDS should receive an evaluation by an infectious disease specialist in a timely manner and ideally within 14 days of detainment.
- Detainees identified as needing specialty services should receive an evaluation by a specialist in a timely manner and ideally within 30 days.

PBNDS V. B. Designation of Authority

The current HSA is a registered nurse and has been on the job since March of this year. We believe that her commitment and engagement will serve this program well. The designated clinical medical authority (CMA) is a DO. He has just recently joined the ADF health care

team. We observed nothing to suggest that HSA and CMA are not working collaboratively to direct the health care delivery at ADF. We asked for and received a written staffing plan that includes the addition of new staff including new physician assistant, new Quality Assurance nurse and a few new nursing staff.

While the current leadership structure meets this standard, there has been a longstanding and significant void of leadership at both the HSA and the CMA positions at ADF that were directly and indirectly responsible for the poor outcomes in some cases and an overall failure to comply with many PBNDS and NCCHC standards of care as outlined throughout this report.

Recommendations:

- Sustain and strengthen the existing leadership structure at ADF by providing them with the support needed in terms of technology (electronic health records) and programs (QAPI, pharmacy management).

PBNDS V. G. Pharmaceutical Management

NCCHC J-D-01. Pharmaceutical operations meet the needs of the facility and conform to the legal requirements.

Findings:

ADF has a medication room with open stock prescription and non-prescription medications that are not (and cannot be) inventoried. There is no possible way of preventing diversion of these medications as nursing staff has full unimpeded and unmonitored access to these stock medications. Controlled substances are secured and inventoried.

Recommendations:

- ADF must create a medication storage system that will allow for safe and restricted storage of all stock medications. There are many ways of achieving this including the use of blister package stock medications and use of Pyxis machines.

PBNDS V. J. Medical and Mental Health Screening of New Arrivals

Findings:

We observed several examples of detainees with significant medical issues not receiving their provider evaluation within two working days.

Representative cases include # 1, 3, 5, 7, 8, 9, 10, 14, 15, 20, 21, 27, 29, 32, 34 below.

Recommendations:

- Detainees identified as having chronic medical conditions should receive their initial provider encounter within the first two working days of arrival at the detention facility.

PBNDS V. K. Substance Dependence and Detoxification

Findings/ Recommendations:

This item has been discussed in detail under the complaint # **18-03-ICE-0036** above.

PBNDS 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:

During our visit, we observed several housing units that did not have any paper sick call request forms within the housing unit while they maintained a "Sick Call Box". We were told later that an administrative decision had been made to transition the sick call process completely from paper to electronic format using tablets.

Recommendations:

- While the above initiative may prove to be a suitable alternative to using paper sick call requests, until and unless a QI study identifies and addresses all potential barriers to the use of the tablet system, ADF should not eliminate the use of paper sick call forms. One example of a potential barrier to the use of tablet system is the detainee knowledge gap in using electronic tools particularly in the case of older detainees and those who do not speak English or Spanish. Another issue with the transition of sick call requests to the tablet system is the

fact that the current system limits detainees access to the tablets (tablets are not accessible to detainees on a 24/7 basis).

PBNDS V. U. Delivery of Medication

Findings:
We observed several examples of interruptions in medication delivery or at least lack of documentation of continuous delivery of medications. Medication Administration Records (MARs) routinely show days that are not initialed by nursing staff to indicate that a medication was delivered to the detainees. Additionally we observe lack of universal 2-patient ID practices and hand/mouth checks after administration of medications.
Representative case includes # 36 below.

Recommendations:

- ADF must reeducate the nursing staff regarding the correct process for ensuring two-patient identification.
- ADF must put in place a robust hand/mouth check process (including the custody staff) to mitigate the potential for medication hording or overdose.
- ADF must train nursing staff to account for all doses of medications that detainees are scheduled to receive. Blank spaces in the MAR document can only be interpreted as missed medications and contribute to an incomplete medical record.

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

Findings:
ADF still uses paper health records. While the detainee charts were for the most part complete and organized in a manner that allowed for ease of review, there were several elements that were routinely missing from the chart or were in the chart in an incomplete manner. These include medication administration records, specialty referrals and specialty

visits, etc.

Representative cases include # 5, 7, 8, 11, 13, 16, 18, 19, 23, 25, 26, 27, 28, 29,36 below.

Recommendations:

- ADF must educate nursing staff regarding the importance of completing the required documentation for initial vital signs on all new admissions.
- ADF must educate nursing staff regarding the importance of completing the required documentation for medical provider referral particularly in a detainee with an obvious chronic medical condition. Medical records cannot be considered complete without this.
- ADF must maintain an accurate, up to date and complete medical record for each detainee to ensure continuity of care and prevent errors or duplication of effort.
- All health care encounters including outside specialty encounters must be included in the medical record.
- As mentioned in the executive summary, it is strongly recommended that ADF transitions into an electronic medical record system without which complying with the above recommendations is extremely difficult if not impossible.

PBNDS V. CC. Terminal Illness or Death of a Detainee

NCCHC J-A-09. The responsible health authority conducts a thorough review of all deaths in custody in an effort to improve care and prevent future deaths.

Findings/ Recommendations:

This item has been discussed in detail under the complaint # **18-03-ICE-0036** above.

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 and NCCHC standards that are unmet as indicated above.

1. Admitted to ADF on May 4, 2018 and was identified as having HTN, anemia, heart murmur and hypothyroidism. Did not have his initial provider health assessment until May 9, 2018.

2. Admitted to ADF on August 31, 2017 and was identified as having asthma and gastroesophageal reflux disease. Detainee reported not having access to sick call request forms in his housing unit.

3. Admitted to ADF on July 25, 2018 with the history of being HIV positive. Received his initial provider encounter on August 1, 2018. He was referred to the Infectious Disease clinic on July 31, 2018. Detainee was still waiting for his specialty visit when we left ADF on August 16th.

4. Admitted to ADF on August 25, 2017. Was discovered to have elevated blood glucose, elevated HgbA1C and elevated TSH. Had not seen a provider for any of the above findings.

5. Admitted to ADF on May 2, 2018 with history of Hypertension. There is no medical provider referral documented in the intake screening form. Received first provider evaluation on May 9, 2018 and was sent to the ED for uncontrolled blood pressure. Was admitted to the hospital on May 9, 2018 through May 13, 2018 and was discharged back to ADF on four blood pressure medications. Was sent to ED again for hypertensive crisis (blood pressure of 241/148) on June 26, 2018. Was started on a clonidine "sliding scale" via phone conversation with the medical director. Did not have a face to face evaluation with the physician.

6. Admitted to ADF on June 3, 2018 with diagnosis of pregnancy. Was seen by facility physician assistant on June 5, 2018 and was referred to Ob/Gyn specialist. Detainee was still waiting for her initial Ob/Gyn visit at the time of our visit of this audit on August 15, 2018. During the visit with the PA, detainee reported bloody stools and epigastric pain. A blood test for H. Pylori returned positive on June 6, 2018 but there is no evidence in the medical record that this detainee received any treatment for this condition.

7. Was admitted to ADF on June 22, 2018 with diagnosis of diabetes. There is no medical provider referral documented in the intake screening form. Did not receive his first provider evaluation until June 26, 2018.

8. Was admitted to ADF on May 11, 2018 with diagnosis of metastatic cancer. There is no medical provider referral documented in the intake screening form. Did not receive his first provider evaluation until May 24, 2018. Has not received any additional provider encounters at ADF since this initial visit. Had an elevated HgbA1C on May 21, 2018 that until now has never been addressed. Detainee was not evaluated by an oncologist until August 7, 2018. The oncology note including future plans and recommendations were not in the medical record at the time of this audit.

9. Was admitted to ADF on June 21, 2018 with diagnosis of hypertension, high cholesterol and colon cancer status post resection 3 years ago. Did not receive her health assessment provider encounter until June 26, 2018. Additionally, was discovered to have an elevated serum bilirubin on June 28, 2018 that has never been addressed or follow up.

10. Was admitted to ADF on May 7, 2018 with diagnosis of Asthma and seizure. On May 8th reported the same history to the nursing staff. On May 14th reported the same history to the PA for which he was referred to neurology. On May 17th reported the same history to the physician. Detainee has not been evaluated by the outside

neurology specialist or an ADF provider since May 17th.

11. Was admitted to ADF on June 22, 2018 with diagnosis of hypertension. There is no medical provider referral documented in the intake screening form. Did not receive his first chronic care clinic provider evaluation until July 30, 2018. Was found to have high serum cholesterol and triglyceride on July 2, 2018. Neither of these findings have been acknowledge or treated.

12. Was admitted to ADF on December 27, 2017 with diagnosis of hypertension and epilepsy. Detainee had a seizure on January 5 and 7, February (missing date on nursing note), 19, and 28, March 14 and 17, April 4 and 9, May 5, June 19 and July 16. The first documented provider visit was not until February 2, 2018 with the physician assistant. The first chronic care clinic date was March 14, 2018. Detainee has not seen a provider since June 21, 2018. We were told that this detainee was evaluated by neurology in May 2018 and is currently waiting for an MRI of brain. Neither of these documents was available in the detainee's chart at the time of this audit however.

13. Was admitted to ADF on June 22, 2018 with diagnosis of hypertension and diabetes. There is no medical provider referral documented in the intake screening form. Detainee did not receive his first chronic care clinic provider evaluation until July 30, 2018.

14. Was admitted to ADF on November 11, 2017 with diagnosis of hypertension, hypercholesterolemia, and chronic kidney disease. Detainee did not receive his first provider evaluation until January 18, 2018 and did not undergo his initial chronic disease clinic evaluation until March 19, 2018. His first chronic disease clinic follow up was on August 7, 2018.

15. Was admitted to ADF on July 24, 2018 with diagnosis of hypertension. Detainee received his initial health assessment provider evaluation on July 30, 2018. Detainee

has not yet received his initial chronic disease clinic evaluation by the time of this audit.

16. Was admitted to ADF on June 20, 2018 with diagnosis of hypertension and diabetes. There is no medical provider referral documented in the intake screening form. Detainee did not receive his first chronic care clinic provider evaluation until July 30, 2018. Additionally, while patient arrived at ADF on metformin and aspirin and was documented to have an elevated HgbA1C and blood glucose level, he is currently off his diabetes medications with plan for "follow up in 90 days".

17. Was admitted to ADF on July 25, 2018. The intake note states reports no medical history but detainee is known to have abdominal tuberculosis for which he is under treatment. On July 12, 2018 he was documented to have a very high HgbA1C (10.2). This, however, is not mentioned in the physician note on July 26 and has not been acknowledged or treated by the time of this audit. Detainee has not undergone his initial chronic disease clinic evaluation.

18. Was admitted to ADF on June 27, 2018 with diagnosis of hypertension and diabetes. Detainee did not undergo his initial chronic disease clinic evaluation until July 30, 2018. He was ordered to receive baseline labs for his conditions. None of the lab results were present in this detainee's chart (either not done or not included in the medical records).

19. Was admitted to ADF on July 20, 2018 with diagnosis of diabetes. Detainee still has not undergone his initial chronic disease clinic evaluation. Additionally, baseline labs ordered on July 27 were not present in the detainee's medical chart at the time of this audit (either not done or not included in the medical records).

20. Was admitted to ADF on July 20, 2018. Detainee did not receive his initial provider evaluation until August 1 and still has not had his initial chronic disease clinic appointment.

21. Was admitted to ADF on July 25, 2018 with diagnosis of HIV and Hepatitis C. Detainee did not receive his HIV medication until August 1, 2018. He has not received any provider visits at ADF or by an outside infectious disease specialist since his arrival at ADF.

22. Was admitted to ADF on April 14, 2018 with diagnosis of diabetes. Detainee received his initial chronic disease clinic encounter on May1, 2018 but has not had any other provider follow up since that date. Additionally, detainee was documented to have an elevated TSH on April 20, 2018 that has not been acknowledged nor treated.

23. Was admitted to ADF on June 22, 2018 with diagnosis of hypertension and diabetes. There is no medical provider referral documented in the intake screening form. Did not receive his first chronic care clinic provider evaluation until July 30, 2018.

24. Was admitted to ADF on June 25, 2018 with diagnosis of asthma. Detainee did not undergo his initial chronic disease clinic evaluation until July 30, 2018.

25. Was admitted to ADF on September 19, 2017 with diagnosis of chronic back pain due to gun short wound from several years ago. There is no medical provider referral documented in the intake screening form. Detainee has submitted more than 10 sick call requests regarding back pain and bullet protruding through his skin causing him pain and chronic purulent discharge (the medical expert examined this detainee and verified the above complaint). On March 11, 2018 the medical director instructed the detainee to "seek help after he was released from the detention facility". No treatment was rendered. Upon inquiry, we were told that this detainee has an appointment with outside general surgery on August 22nd. This information was not available on the detainee's medical record.

26. Was admitted to ADF on July 20, 2018. At intake, this 22 year old detainee reported gynecological problems including not having a menstrual cycle for six months. She

was not referred for medical follow up. On July 22, she was referred to medical for elevated blood pressure and headache. At the time of this audit, this detainee still had not had a provider evaluation for any of her conditions.

27. Was admitted to ADF on July 18, 2018 with history of coronary artery disease, status post four myocardial infarctions. There is no referral to medical on the intake screening. Detainee's first provider encounter was on July 23, 2018. During detainee's first encounter with the facility physician on August 7, 2018, there is no mention of the history of heart disease. Detainee was found to have elevated HgbA1C and TSH on July 25, 2018. Neither of these conditions were acknowledged or treated by the physician.

28. Admitted to ADF on August 8, 2018 with hypertension (blood pressure at intake was 158/102). There was no referral to medical on the intake screening. On August 10, 2018, detainee's blood pressure was again significantly elevated (155/111). Nursing staff carried out the "HTN protocol" which includes notifying the physician. There is no documentation that the facility physician was notified. By the time of this audit, this detainee still had not had a provider follow up for his hypertension.

29. Was admitted to ADF on March 2, 2018 with asthma. Intake screening did not document an initial vital sign. Detainee's initial provider encounter was not until March 26th. I was not able to confirm if the initial chronic disease clinic encounter had ever occurred.

30. Was admitted to ADF on January 26, 2018. Detainee submitted numerous sick call requests for "dizziness and fatigue" and "burning on urination" (February 4, March 2, May 28, and June 2). Detainee was documented to have hematuria (blood in the urine) on four separate occasions (January 28, May 29, June 3, and July 6). Detainee has had only two provider encounters both with the facility PA. On July 13 she was seen for acute pain after a fall. On August 6 she was seen for lower abdominal pain and "gas". She was treated twice by oral antibiotics, on January 28 and on June 3. Both

treatments were telephone orders by the facility physician. Despite numerous sick call requests and documented pathology (persistent hematuria), this detainee was never evaluated by the facility physician nor was she referred to an outside specialist (urology or gynecology) to determine the etiology of her medical issues.

31. Was admitted to ADF on June 2, 2018 with asthma. Detainee submitted a sick call request on July 6 for "shortness of breath". She received a nebulizer treatment followed by a telephone order by the facility physician for oral steroids. Detainee experienced the same treatment on August 2, 2018. At the time of this audit, this detainee had not had a single provider follow up despite two episodes of asthma exacerbation resulting in the use of oral steroids.

32. Was admitted to ADF on February 26, 2018 with asthma. Detainee's first provider encounter was not until March 14, 2018. This detainee has not had a chronic disease clinic follow up in the past 5 months.

33. Was admitted to ADF on April 17, 2018 with HIV. Even though the detainee had his first provider encounter on April 19, 2018, he did not received his HIV medications until May 29, 2018 when he had his infectious disease specialist visit (this documentation was not present in the detainee's medical records). The initial chronic disease encounter with facility physician was on May 1, 2018. There is no evidence of continued follow up since that date.

34. Was admitted to ADF on May 9, 2017 with hypertension and hypercholesterolemia. Detainee's first provider encounter was not until May 22, 2017. His initial chronic disease clinic encounter did not occur until June 22, 2017. The only chronic disease follow up in the medical record is on April 4, 2018 almost a year later. Additionally, this detainee is documented to have an elevated TSH on May 17, 2017 that until the time of this audit had gone unacknowledged and untreated.

35. (this is not a chart review) ADF has a medication room with open stock prescription and

non-prescription medications that are not (and cannot be) inventoried. There is no possible way of preventing diversion of these medications as nursing staff has full unimpeded and unmonitored access to these stock medications. Controlled substances are secured and inventoried.

36. (this is not a chart review) We observed two instances of medication pass. In both instances it became evident to us that two-patient identification procedure was not followed at ADF. Additionally, there was no reliable hand/mouth check which significantly increases the likelihood of medication hording practices and the potential for instances of medication overdose. We also observed several examples of interruptions in medication delivery or at least lack of documentation of continuous delivery of medications. Medication Administration Records (MARs) routinely show days that are not initialed by nursing staff to indicate that a medication was delivered to the detainees.

Summary of Recommendations:

1. ADF should develop and implement a policy that clearly identifies when the health care needs of a detainee far exceeds the capabilities of the ADF and its staff. ADF must train and educate the nursing staff based on such policy to recognize when a detainee's health care needs are beyond the capabilities of ADF.
2. ADF must additionally train and educate the nursing staff to contact the facility's responsible physician as frequently as indicated to address detainees' urgent/emergent medical conditions.
3. ADF must hold the provider staff accountable to providing timely and definitive care to the detainees by establishing recurring interval chart reviews as part of an overall continuous program improvement.
4. Detainees identified as suffering from opiate dependence and withdrawal should undergo an initial and regularly scheduled evaluations using evidence based assessment tool designed for the care of individuals suffering from opiate withdrawal. The correct tool in this case would have been the Clinical Opiate Withdrawal Scale (COWS).
5. Detainees identified as having chronic medical conditions should receive their initial provider encounter within two working days of arrival at the detention facility.
6. ADF must create a chronic disease management system that allows for timely initial and follow up care for ADF detainees.
7. ADF should conduct a staff analysis to identify the staffing needs for a facility of this size and maintain such staffing level, particularly in key health care positions to ensure the ability to meet the minimum standards of care.
8. ADF must comply with all required elements of PBNDS standard of care and complete a medical/ mental health alert form for detainees with serious medical/ mental health conditions and include these forms in detainees' health records.
9. ADF must respond to medical grievances in a language that the grievant understands.
10. All medical health care encounters are to occur in a clinically appropriate setting that is not only conducive to conducting a private interview and

examination but also provides a hygienic and clinically equipped environment to facilitate such encounters.

11. ADF must transitions into an electronic medical record system.
12. Perform a QI study to proactively identify and address all potential barriers to the use of the tablet system prior to the complete elimination of paper sick call forms.
13. Detainees identified as being pregnant should receive an evaluation by an obstetrician specialist in a timely manner and ideally within 14 days of detainment (best practice).
14. Detainees identified as having HIV/AIDS should receive an evaluation by an infectious disease specialist in a timely manner and ideally within 14 days (best practice).
15. Create an accountable and failsafe system to address abnormal lab results and provide an opportunity for face to face provider consultation with the patient. Once such a system in put in place, it must be audited on a regular basis to ensure adherence to the expectations and sustainability.
16. Educate nursing staff regarding the importance of completing the required documentation for medical provider referral particularly in a detainee with an obvious chronic medical condition.
17. Stop the practice of "sliding scale Clonidine" to treat hypertension. I have never witnessed the use of a clonidine "sliding scale" during my 25 years of practicing medicine and consider it unsafe and inappropriate treatment.
18. Provide an opportunity for detainees with significant medical issues to have face to face evaluations with the physician.
19. All health care encounters including outside specialty encounters must be included in the medical record.
20. Detainees identified as needing specialty services should receive an evaluation by a specialist in a timely manner and ideally within 30 days.
21. Create a chronic disease management system that allows for timely initial and follow up care for ADF detainees.
22. Maintain an accurate, up to date and complete medical record for each detainee to ensure continuity of care and prevent errors or duplication of effort.

23. Ensure continuity of care including timely continuity of critical medications such as HIV medications.
24. Hold the provider staff accountable to providing timely and definitive care to the detainees.
25. Create a system to allow for tracking of sick call requests to ensure that all sick call requests that result in provider referral are addressed by the facility provider in a timely manner.
26. Create a system to ensure that acute medical conditions are brought up to the attention of the facility provider staff and that such conditions are addressed by the provider staff.
27. Create a medication storage system that will allow for safe and restricted storage of all stock medications. There are many ways of achieving this including the use of blister package stock medications and use of Pyxis machines.
28. Put in place a robust hand/mouth check process (including the custody staff) to mitigate the potential for medication hording or overdose.
29. Train nursing staff to account for all doses of medications that detainees are scheduled to receive. Blank spaces in the MAR document can only be interpreted as missed medications and contribute to an incomplete medical record.
30. Sustain and strengthen the existing leadership structure at ADF by providing them with the support needed in terms of technology (electronic health records) and programs (QAPI, pharmacy management).
31. ADF should establish better monitoring and coordination of care for detainees with serious medical condition. This includes improved communication between nursing and the responsible medical provider as well as improved documentation by all healthcare staff.
32. ADF should ensure that all provider orders are carried out by the nursing staff.
33. ADF must create a quality improvement committee and establish a standing interval meeting no less often than every three months.
34. The quality improvement committee should ideally include leaders from health care and detention divisions.
35. The quality improvement committee should identify 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 plan to address these issues and monitor the ongoing performance of the system.

36. The quality improvement committee must ensure that at least one process and/or outcome quality improvement study is completed each year.
37. ADF must re-educate and hold accountable the nursing staff to account for all doses of medications that detainees are scheduled to receive.
38. ADF must create an accountable and failsafe system to address all scheduled patient services including medication administration. Once this system is in place, ADF must be audited on a regular basis to ensure adherence to the expectations and sustainability.
39. ADF must put in place a robust hand/mouth check process (including the custody staff) to mitigate the potential for medication hording or overdose.
40. ADF must train nursing staff to account for all doses of medications that detainees are scheduled to receive. Blank spaces in the MAR document can only be interpreted as missed medications and contribute to an incomplete medical record.
41. ADF must educate nursing staff regarding the importance of completing the required documentation for initial vital signs on all new admissions.
42. ADF must reeducate the nursing staff regarding the correct process for ensuring two-patient identification.
43. ADF should reinstate the use of paper sick call request forms while increasing the training amongst detainees on the use of electronic submissions. These trainings should be provided weekly, in the dorms, as needed, to ensure that the detainee population is aware on the method of submitting an electronic sick call request form. The abrupt switch from paper sick call request forms to an electronic platform without allowing for a safe transition period will undoubtedly leave many detainees without a real option for requesting health care services.
44. ADF must create a system to allow for tracking of sick call requests to ensure that all sick call requests that result in provider referral are addressed by the facility provider in a timely manner.

Appendix:

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REPORT FOR THE
U.S. DEPARTMENT OF HOMELAND SECURITY
OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES
Onsite August 14-16, 2018

Investigation regarding Denver Contract Detention Facility

Complaints reviewed in this report included:
Complaint No. 18-03-ICE-0036
Complaint No. 18-09-ICE-0352

Prepared by (b) (6) M.D.
Report date: August 17, 2018

Protected by the Deliberative Process Privilege

Executive Summary

The Denver Contract Detention Facility (DCDF) is privately owned and operated by the GEO Group, Inc. (GEO) of Boca Raton, Florida. The facility holds detainees for U.S. Immigration and Customs Enforcement (ICE) and the United States Marshal Service. On August 14, 2018, the total ICE population of 823, which included 106 female detainees.

This site assessment regarding the mental health services and suicide prevention program at the DCDF occurred from August 14-16, 2018.

DCDF was accredited by the National Commission on Correctional Health Care (NCCHC) in August 2015. According to the Health Services Administrator (HSA), the next NCCHC survey is scheduled during the next 12 months.

Mental health services are provided by a fulltime psychologist, one part-time licensed clinical social worker, and three part-time telepsychiatrists. Efforts are in place to fund an additional fulltime mental health clinician. A fulltime registered nurse is the telepsychiatry coordinator.

Positive aspects of the mental health system included the following:

1. No suicides for at least years.
2. Competent mental health clinician assigned to ICE detainees.
3. Generally good mental health policies and procedures.

Problematic aspects of the mental health system included the following:

1. Lack of administrative mental health leadership.
2. Inadequate mental health staffing allocations.
3. Lack of knowledge by staff regarding relevant mental health policies and procedures.
4. An inadequate quality improvement (QI) system.
5. Inadequate basic statistics relevant to the mental health system related to all of the above.
6. Issues regarding compliance with relevant aspects of the suicide prevention and intervention policy and procedure.

The below Summary of Recommendations summarizes my "Priority" recommendations for DCDF alongside references to relevant sections of the Performance Based National Detention Standards (PBNDS) 2011.[1] Appendix I summarizes my findings and recommendations specific to the mental health sections of Standard 4.3, Medical Care and Standard 4.4, Medical Care (Women) of the PBNDS 2011, 2016 modifications. Appendix II summarizes my findings and recommendations specific to Standard 4.6, Significant Self-harm and Suicide Prevention and

[1] DCDF operates under PBNDS 2011, 2016 modifications.

Intervention of the same PBNDS standards. Appendix III provides a summary specific to health care record reviews.

Executive Summary

Summary of Recommendations (only Priority recommendations are summarized in this section)

Standards and Procedures *(based on PBNDS 2011, 2016 modifications)*

PBNDS 2011 Standard 4.3, Medical Care

Recommendations Under 4.3, II. Expected Outcomes

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

> **Recommendations:** Although DCDF staff developed a mental health referral logging system, all the referrals are considered "urgent." There is no prioritization of the acuity of the referrals. Further, due to lack of staffing, the logging system is not kept current. This leads to untimely responses to the mental health requests. DCDF mental health staff should ensure referrals are triaged based on acuity (i.e., urgent, emergent, and routine) in contrast to all being treated as urgent referrals.
>
> Additionally, DCDF should implement a QI system to review the electronic requests to assess the percentage of referrals that are urgent, emergent, and routine, and whether such referrals are seen in a timely manner. A QI process should also look at the ability of detainees to successfully use the electronic tablet self-referral process. Implementing a QI process to review the referral process is necessary to determine whether detainees are actually receiving a continuum of health services.

4.3, II.2: "The facility shall have a mental health staffing component on call to respond to the needs of the detainee population 24 hours a day, seven days a week."

> **Recommendation:** DCDF's mental health coverage during off hours is provided by a non-psychiatric physician on-call, instead of a mental health professional. Per PBNDS 2011 and DCDF's Policy #622 (Psychiatric Emergencies and Disorders), DCDF should ensure there is mental health coverage 24 hours and seven days a week.

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

Recommendation: There were instances where detainees, who are prescribed a new medication, were not scheduled to see the psychiatrist for follow-up in a timely manner. In some cases, the follow-up did not even occur. In addition, detainees refusing all appointments were not seen to determine their reasons for such refusals. CRCL recommends DCDF develop and implement a tracking system and a QI process to ensure timely access and timely follow-up of mental health services.

4.3, II.20: "Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees."

Recommendation: See Recommendation under **4.3, II.4**

4.3, II.21: "Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements."

Recommendations: Currently, there is no person with appropriate mental health credentials, on site, whose responsibility is to serve as director mental health services at DCDF, and it is difficult to assess the adequacy of the staffing allocations for mental health services due to the paucity of basic data relevant to the mental health services at DCDF. As a result, CRCL recommends that DCDF establish a Director of Mental Health position. Additionally, CRCL recommends that DCDF conduct a staffing needs analysis to determine the appropriate mental health staffing allocations needed.

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.'"

Recommendations: As evidenced by a review of selected health care records, SMU detainees on the mental health caseload have access to care issues similar to general population detainees. CRCL recommends that DCDF address the access to care issues that SMU detainees on a mental health caseload have, which appear related to staffing allocation issues, management information system issues, and the lack of an administrative mental health director position.

4.3, II.28: "Adequate space and staffing for the use of services of the ICE Tele-Health Systems, inclusive of tele-radiology (ITSP) and tele medicine, shall be provided."

Recommendations: The telepsychiatrists have not come on site at DCDF, and the telepsychiatry coordinator spends much of her time trying to locate and scan records to the telepsychiatrists. CRCL recommends that DCDF revise Policy #627-A (Telehealth) to require a telepsychiatrist to be on site at least once every

six months. The policy should also be revised to specify which health care records should be scanned to the telepsychiatrist prior to the appointment.

Furthermore, CRCL recommends that DCDF evaluate whether they have adequate telepsychiatry staffing since detainees are reportedly only scheduled for a 20-25 minute initial psychiatric examination; such assessments usually require 45-60 minutes.

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."

Recommendations: CRCL recommends that DCDF develop an adequate QI system. This QI system should evaluate, among other things, the referral process (including the number of emergent, urgent, and routine referrals); the timeliness of the referral process; and the timeliness of follow-ups to the referral process as stated under Recommendation 4.3, II.I; 4.3, II.4; and 4.3, II.20. A staffing needs analysis should also be implemented to determine appropriate mental health staffing at DCDF in accordance with Recommendations 4.3, II.21 and 4.3, II.28.

Recommendations under 4.3, V. Expected Practices

4.3, V.N. Medical/Psychiatric Alerts and Holds
"Where a detainee has a serious medical or mental health condition or otherwise requires special or close medical care, medical staff shall complete a Medical/Psychiatric Alert form (IHSC-834) or equivalent, and file the form in the detainee's medical record. Where medical staff furthermore determine the condition to be serious enough to require medical clearance of the detainee prior to transfer or removal, medical staff shall also place a medical hold on the detainee using the Medical/Psychiatric Alert form (IHSC-834) or equivalent, which serves to prevent ICE from transferring or removing the detainee without the prior clearance of medical staff at the facility. The facility administrator shall receive notice of all medical/psychiatric alerts or holds, and shall be responsible for notifying ICE/ERO of any medical alerts or holds placed on a detainee that is to be transferred."

Recommendations: DCDF does not place psychiatric alerts and holds as required by the Standard 4.3, V.N. CRCL recommends that DCDF begin placing psychiatric alerts and in compliance with the standard.

4.3, V.O. Mental Health Program
4.3, V.O.3. Mental Health Evaluation
"Based on intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider

and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.

Such evaluation and screenings shall include:

a. reason for referral;
b. history of any mental health treatment or evaluation;
c. history of illicit drug/alcohol use or abuse or treatment for such;
d. history of suicide attempts;
e. current suicidal/homicidal ideation or intent;
f. current use of any medication;
g. estimate of current intellectual function;
h. mental health screening, to include prior history physical, sexual or emotional abuse;
i. impact of any pertinent physical condition, such as head trauma;
j. recommend actions for any appropriate treatment, including but not limited to the following:
   1) remain in general population with psychotropic medication and counseling,
   2) "short-stay" unit or infirmary,
   3) Special Management Unit, or
   4) community hospitalization; and
k. recommending and/or implementing a treatment plan, including recommendations concerning transfer, housing, voluntary work and other program participation."

Recommendations: The treatment plans in the mental health evaluations were either vague or not implemented. CRCL recommends DCDF develop treatment plans that address the detainee's current clinical condition adopts the referenced strategies from Standard 4.6, V.E. CRCL recommends that DCDF develop and implement a treatment plan form to address the fact that treatment plans were frequently vague and to help DCDF comply with the requirement to develop treatment plans.

4.3, V.O.4. Referrals and Treatment
"Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.
The provider shall develop an overall treatment/management plan.

If the detainee's mental illness or developmental or intellectual disability needs exceed the treatment capability of the facility, a referral for an outside mental health facility may be initiated.

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; [sic]."

Recommendations: Mental health assessments are not routinely completed within 72 hours of referral as a result of staffing allocation issues. Additionally, detainees prescribed psychotropic medications are not routinely evaluated by a psychiatrist. CRCL recommends that DCDF conduct all mental health assessments within 72 hours of referral and ensure that all detainees prescribed psychotropic medications are routinely evaluated by a psychiatrist on at least a monthly basis to be consistent with this standard.

4.3, V.X. Notifications of Detainees with Serious Illnesses and Other Specified Conditions

1. **Serious Mental Illness**

"For the purposes of this section, the following non-exhaustive categories of conditions should be considered to constitute a serious mental illness:

(a) conditions that a qualified medical provider has determined to meet the criteria for a "serious mental disorder or condition" pursuant to applicable ICE policies, including:
   - a mental disorder that is causing serious limitations in communication, memory, or general mental and/or intellectual functioning (e.g. communicating, conducting activities of daily life, social skills); or a severe medical condition(s) (e.g. traumatic brain injury or dementia) that is significantly impairing mental function; or
   - one or more of the following active psychiatric symptoms and/or behavior: severe disorganization, active hallucinations or delusions, mania, catatonia, severe depressive symptoms, suicidal ideation and/or behavior, marked anxiety of impulsivity.

- significant symptoms of one of the following:
   - Psychosis or Psychotic Disorder;
   - Bipolar Disorder;
   - Schizophrenia or Schizoaffective Disorder;
   - Major Depressive Disorder with Psychotic Features;
   - Dementia and/or a Neurocognitive Disorder; or
   - Intellectual Development Disorder (moderate, severe, or profound).

(b) any ongoing or recurrent conditions that have required a recent or prolonged hospitalization, typically for greater than 14 days, or a recent and prolonged stay in the medical clinic of a detention or correctional facility, typically for greater than 30 days;

(c) any condition that would preclude the alien from being housed, typically for greater than 30 days, in a non-restrictive setting (such as a general population housing unit, as opposed to a special management unit or a medical clinic);

(d) any other mental illness determined to be serious by IHSC."

Recommendations: When requested by CRCL, the mental health staff were unable to provide information regarding the number of detainees with a SMI. CRCL recommends DCDF identify detainees with an SMI and develop and implement a policy and procedure specific to detainees with a SMI.

4.3, V.Y. Restraints

"Restraints for medical or mental health purposes may be authorized only by the facility's CMA or designee, after determining that less restrictive measures are not appropriate. In the absence of the CMA, qualified medical personnel may apply restraints upon declaring a medical emergency. Within one- hour of initiation of emergency restraints or seclusion, qualified medical staff shall notify and obtain an order from the CMA or designee.

a. The facility shall have written procedures that specify:
   1) the conditions under which restraints may be applied;
   2) the types of restraints to be used;
   3) the proper use, application and medical monitoring of restraints;
   4) requirements for documentation, including efforts to use less restrictive alternatives; and
   5) after-incident review.

The use of restraints requires documented approval and guidance from the CMA. Record-keeping and reporting requirements regarding the medical approval to use restraints shall be consistent with other provisions within these standards, including documentation in the detainee's A-file, detention and medical file."

> **Recommendations:** Although the use of restraints for medical or mental health purposes was reported to be rare, staff was unfamiliar with DCDF policies #628 and #628-B (Therapeutic Seclusion and Restraints), which are consistent with the standards. CRCL recommends DCDF train mental health staff on the above policies and relevant standard.

PBNDS 2011 Standard 4.6, Significant Self-harm and Suicide Prevention and Intervention

4.6, V. Expected Practices

"Each detention facility shall have a written suicide prevention and intervention program, including a multidisciplinary suicide prevention committee, that shall be reviewed and approved by the clinical medical authority (CMA), approved and signed by the health services administrator (HSA) and facility administrator, and reviewed annually.

The multidisciplinary suicide prevention committee shall, at a minimum, comprise representatives from custody, mental health, and medical staff. The committee shall meet on at least a quarterly basis to provide input regarding all aspects of the facility's suicide prevention and intervention program, including suicide prevention policies and staff training. The committee shall convene following any suicide attempt to review and, if necessary, assist in the implementation of corrective actions.

At a minimum, the suicide prevention and intervention program shall include procedures to address suicidal detainees. Key components of this program must include the following:

1. staff training;
2. identification;

3. referral;
4. evaluation;
5. treatment;
6. housing;
7. monitoring;
8. communication;
9. intervention;
10. notification and reporting;
11. review; and
12. debriefing."

Recommendations: DCDF's Suicide Intervention and Prevention Policy (#907 and 907A) and an additional policy, 16.1.11-AUR, Suicide Recognition and Prevention, were found to be not compliant with the requirements of PBNDS 2011 Standard 4.6 in several instances. CRCL recommends that DCDF revise their suicide prevention policies to be compliant with Standard 4.6, including:

1) Revise Policy #907 and 907A to include the specific requirements related to treatment plans that are in Standard 4.6, V.E.
2) Revise Attachment 1 of the Policy #907 and 907A (Suicide Watch Log and Notes) to indicate that the default property includes a suicide blanket, suicide mattress, suicide pillow, or book; and revise Policy #907 and 907A to allow level one suicide watch detainees to receive property as required by Standard 4.6, V.F.1.
3) Revise Policy #907 and 907A to require follow-up assessments within 72 hours as opposed to seven days to be compliant with Standard 4.6, V.F.4.
4) Revise Policy #907 and 907A to require one-to-one monitoring when a detainee is placed on constant watch in accordance with Standard 4.6, V.F. The Policy currently allows for a staff member to monitor up to three detainees who are on constant watch which is not compliant.
5) Revise Policy #907 and 907A to ensure that the provision of suicide smocks and the provision of regular clothing, including undergarments, is made on a case-by-case basis as required by Standard 4.6, V.F.2.
6) Revise Policy #907 and 907 to prohibit level 2 observation status detainees (staggered 15 minute checks) from being placed in an isolation cell as this is prohibited by Standard 4.6, V.F.
7) Revise Policy #16.1.11-AUR, Suicide Recognition and Prevention to prohibit the use of "no harm contracts" which are prohibited under Standard 4.6, V.A.

In addition, following a review of the June 2018 corporate audit, CRCL recommends that DCDF rectify the problems found with the suicide prevention program that were identified during that audit.

CRCL also recommends that DCDF ensures that the facility's suicide prevention program monitors the guidelines in Policy #907 and 907A for training, identification, referral, assessment, and intervention, and that the facility require a suicide risk assessment prior to changing and/or discharging a detainee suicide watch status, as opposed to only requiring an SRA when a detainee is placed on suicide watch status.

4.6, V.A. Staff Training

"All facility staff members who interact with and/or are responsible for detainees shall receive comprehensive suicide prevention training, during orientation and at least annually. Initial suicide prevention training for all staff responsible for supervising detainees should consist of a minimum of eight hours of instruction.

Subsequent annual suicide prevention training should consist of a minimum of two hours of refresher instruction.

All of the following interests should be incorporated into the required suicide prevention training:

1. Environmental concerns: why the environments of detention facilities are conducive to suicidal behavior.
2. First Aid training: standard first aid training, cardiopulmonary resuscitation (CPR) training and training in the use of emergency equipment (that may be located in each housing area of the detention facility).
3. Liability: liability issues associated with detainee suicide.
4. Recognizing verbal and behavioral cues that indicate potential suicide.
5. Demographic, cultural and precipitating factors of suicidal behavior.
6. Responding to suicidal and depressed detainees.
7. Effective communication between correctional and health care personnel.
8. Necessary referral procedures.
9. Constant observation and suicide-watch procedures.
10. Follow-up monitoring of detainees who have already attempted suicide.
11. Reporting and written documentation procedures.

Requesting that a detainee promise not to engage in suicidal behavior, also known as "contracting for safety," is not recognized or supported by experts, and is an ineffective method of suicide prevention. "Contracting for safety" provides no guarantee that the patient shall not attempt suicide, and may give staff a false sense of security. This practice is not to be relied on by staff."

Recommendations: Currently, DCDF offers to all staff 2.5 hours of initial suicide prevention training and 1.5 hours of annual training. CRCL recommends that DCDF increase the length of their initial and annual suicide prevention training to be consistent with the requirements of Standard 4.6, which requires eight hours of

initial suicide prevention training and two hours refresher training annually. CRCL also recommends that DCDF update Policy #16.1.11-AUR to be consistent with the requirements under Standard 4.6, V.A and DCDF Policy #907 and 907A, which both prohibit "No Harm Agreements."

4.6, V.E. Treatment

"Based on the evaluation, as stipulated above, a mental health provider or other appropriately trained medical personnel shall develop a treatment plan. This plan must be documented and placed in the detainee's medical record. The treatment plan shall address the environmental, historical and psychological factors that contribute to the detainee's suicidal ideation. The treatment plan shall include:

1. strategies and interventions to be followed by the staff and detainee if suicidal ideation reoccurs;
2. strategies for the detainee's improved functioning; and
3. regular follow-up appointments based on the level of acuity."

Recommendations: Given the vagueness in DCDF's Policy #907 and 907A regarding treatment plans, CRCL recommends that DCDF revise Policy #907 and 907A to more clearly require a treatment plan in the context of the detainee's current clinical condition that addresses the referenced strategies from Standard 4.6, V.E. CRCL also recommends that DCDF begin implementing treatment plans for all detainees on suicide watch.

4.6, V.F. Housing and Monitoring

"A suicidal detainee requires close supervision in a setting that minimizes opportunities for self- harm. If a staff member identifies someone who is at risk of significant self-harm or suicide, the detainee must be placed on suicide precautions and immediately referred to a qualified mental health professional.

The qualified mental health professional may place the detainee in a special isolation room designed for evaluation and treatment with continuous monitoring that must be documented every 15 minutes or more frequently if necessary. All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every 8 hours conducted by clinical staff, and daily mental health treatment by a qualified clinician. The isolation room must be suicide resistant, which requires that it be free of objects and structural elements that could facilitate a suicide attempt. Security staff shall ensure that the room is inspected prior to the detainee's placement so that there are no objects that pose a threat to the detainee's safety.

If the qualified mental health professional determines that the detainee requires a special isolation room but there is either no space in the medical housing unit or a medical housing unit does not exist, the detainee may, as a last resort, be temporarily placed in an administrative segregation cell in a Special Management Unit, provided space has been

approved for this purpose by the medical staff and such space allows for constant and unobstructed observation. The facility administrator shall immediately notify ICE of such placement and indicate what level of monitoring the facility is providing. The facility administrator shall also work with ICE and the medical authority to identify alternative placements, including transfer of the detainee to a facility that can provide appropriate housing.

Suicidal detainees who are temporarily placed in a Special Management Unit shall have access to all programs and services, including recreation, visitation, telephones, counsel, and other services available to the general population, to the maximum extent possible. The facility shall ensure that the decision to place a suicidal detainee in an administrative segregation cell in Special Management Unit is not punitive in nature, and, as required by "A. Placement in Administrative Segregation" in Standard 2.12 "Special Management Units", detainees in administrative segregation shall not be commingled with detainees in disciplinary segregation.

Detainees on suicide precautions who have not been placed in an isolated confinement setting by the qualified mental health professional will receive documented close observation at staggered intervals not to exceed 15 minutes (e.g. 5, 10, 7 minutes), checks at least every 8 hours by clinical staff, and daily mental health treatment by a qualified clinician."

> **Recommendations:** The DCDF Policy #907 and 907A, Suicide Prevention and Intervention, allows for the assigned staff member to monitor up to three detainees who are on Level 1 constant watch. However, this is not consistent with Standard 4.6, V.F, which requires one-to-one when a detainee is placed on continuous observation. Additionally, under Policy #907 and 907A, Level 2 observation status allows for observation to occur on a staggered 15-minute basis if the detainee is placed in a suicide resistant cell. However, this is not consistent with this provision, which requires constant observation whenever a detainee is placed in a special isolation room. Therefore, CRCL recommends DCDF revise its policies and practice to ensure that monitoring of Level 1 and Level 2 suicide statuses is conducted according to the standard. CRCL also recommends that DCDF ensure that if suicidal detainees are temporarily placed in the SMU, they have access to all programs and services available to the general population, which does not appear to be occurring.

4.6, V.F.2. Clothing, Hygiene, and Privacy

"The qualified mental health professional shall assess the detainee to determine whether a suicide smock is necessary. The facility may allow suicidal detainees under constant one-to-one monitoring to wear the standard issue clothing, minus any shoe laces, belts, or other accessories that could be used by a detainee to commit suicide or self-harm. Detainees should be provided suicide smocks to wear only when clinically indicated. Such special clothing must provide the detainee with sufficient warmth and modesty. A decision whether to provide underwear to detainees in suicide smocks shall be made by the clinical medical authority. Under no circumstance shall detainees be held without clothing.

Suicidal detainees shall be allowed to shower, perform bodily functions, and change clothing with as much privacy as possible under the continuous observation of staff, and without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances.

Although staff of the opposite gender can be assigned to suicide watch, including constant observation, the facility must have procedures in place that enable a detainee on suicide watch to avoid exposing himself or herself to nonmedical staff of the opposite gender. This may be accomplished, for example, by substituting medical staff or same gender security staff to observe the periods of time when a detainee is showering, performing bodily functions, or changing clothes. It may also be accomplished by providing a shower with a partial curtain or other privacy shields. The privacy standards apply whether the viewing occurs in a cell or elsewhere.

However, any privacy accommodations must be implemented in a way that does not pose a safety risk for the individual on suicide watch. Safety is paramount when conducting a suicide watch, and if an immediate safety concern or detainee conduct makes it impractical to provide same gender coverage during a period in which the inmate is undressed, the detainee should continue to be observed, and any such incident should be documented."

> **Recommendations:** DCDF's Policy #907 and 907A, Suicide Prevention and Intervention, does not appear to permit suicidal detainees under constant one-to-one monitoring to wear the standard issue clothing and/or undergarments, minus any shoe laces, belts, or other accessories that could be used by a detainee to commit suicide or self-harm, which is inconsistent the standard. CRCL recommends DCDF revise Policy #907 and 907A to be consistent with Standard 4.6, V.F.2, which requires that the facility make case-by-case determinations regarding whether a detainee on suicide precautions may wear the standard issue clothing and undergarments.
>
> While onsite, it was observed that at least one of the two cells designated as suicide resistant contained a bed designed for using four point restraints. The structure of the bed, which includes four areas at the bottom to attach restraints to, is not suicide resistant. This bed should only be used for detainees requiring the use of restraints or those on suicide watch/precautions that are under constant watch. CRCL recommends that DCDF ensure that all cells designated for suicide watch are suicide resistant in accordance with Standard 4.6, V.F.

4.6, V.I. Notification and Reporting
"In the event of a suicide attempt, all appropriate ICE and ICE Health Service Corps (IHSC) officials shall be notified through the chain of command. The detainee's family, if known, and appropriate outside authorities shall also be immediately notified.

In the event that a detainee dies as a result of a suicide, the Notification and Reporting of Detainee Deaths Directive shall be followed.

In both cases, medical staff shall complete an Incident Report Form within 24 hours, and all staff who came into contact with the detainee before the suicide attempt or death shall submit a statement describing their knowledge of the detainee and the incident."

Recommendations: CRCL recommends that DCDF ensure that suicide alert notifications are being sent to the appropriate chain of command given deficiencies found in this area through reviewing the June 2018 corporate audit.

Summary of Recommendations:

CRCL's mental health expert made the following priority recommendation regarding medical and mental health care at DCDF. All of these recommendations relate to the 2011 PBNDS Medical Care standard which ensures detainees have access to appropriate and necessary medical, dental, and mental health care, including emergency services:

1. Although DCDF staff developed a mental health referral logging system, all the referrals were considered "urgent." There is no prioritization of the acuity of the referrals. Further, the logging system is not kept current. This leads to untimely responses to the mental health requests. DCDF mental health staff should ensure referrals are triaged based on acuity (i.e., urgent, emergent, and routine) in contrast to all being treated as urgent referrals. Additionally, DCDF should implement a QI system to review the electronic requests to assess the percentage of referrals that are urgent, emergent, and routine, and whether such referrals are seen in a timely manner. The QI process should also review the detainee's ability to successfully use the electronic tablet request process. Implementing a QI process to review the referral process is necessary to determine whether detainees actually receiving a continuum of health services. (**4.3, II.1**)

2. DCDF's mental health coverage during off hours is provided by a non-psychiatric physician on-call, instead of a mental health professional. CRCL recommends DCDF ensures there is mental health coverage 24 hours and seven days a week, per PBNDS 2011 and DCDF's policy #622 (Psychiatric Emergencies and Disorders). (**4.3, II.2**)

3. There were instances where detainees, who are prescribed a new medication, were not scheduled to see the psychiatrist for follow-up in a timely manner. In some cases, the follow-up did not ever occur. In addition, detainees refusing all appointments were not seen to determine their reasons for such refusals. CRCL recommends DCDF develop and implement a tracking system and a QI process to ensure timely access and timely follow-up of mental health services. (**4.3, II.4**)

4. Currently, there is no person with appropriate mental health credentials, on site, whose responsibility is to serve as director mental health services at DCDF, and it is difficult to assess the adequacy of the staffing allocations for mental health services due to the paucity of basic data relevant to the mental health services at DCDF. CRCL recommends that DCDF establish a Director of Mental Health position. Additionally, CRCL recommends that DCDF conduct a staffing needs analysis to determine the appropriate mental health staffing allocations needed. (**4.3, II.21**)

5. As evidenced by a review of selected health care records, SMU detainees on the mental health caseload have access to care issues similar to general population detainees. CRCL

recommends that DCDF address the access to care issues that SMU detainees on a mental health caseload have, which appear related to staffing allocation issues, management information system issues, and the lack of an administrative mental health director position. (**4.3, II.27**)

6. The telepsychiatrists have not come on site at DCDF, and the telepsychiatry coordinator spends much of her time trying to locate and scan records to the telepsychiatrists. CRCL recommends that DCDF revise their Policy #627-A (Telehealth) to require a telepsychiatrist to be on site at least once every six months. The Policy should also be revised to specify which health care records should be scanned to the telepsychiatrist prior to the appointment. Furthermore, CRCL recommends that DCDF evaluate whether it has adequate telepsychiatry staffing since detainees are reportedly only scheduled for a 20-25 minute initial psychiatric examination; such assessments usually require 45-60 minutes. (**4.3, II.28**)

7. CRCL recommends that DCDF develop an adequate QI system. This QI system should evaluate, among other things, the referral process (including the number of emergent, urgent, and routine referrals); the timeliness of the referral process; and the timeliness of follow-ups to the referral process as stated under Recommendation 4.3, II.I; 4.3, II.4; and 4.3, II.20. CRCL also recommends that DCDF conduct a staffing needs analysis to determine appropriate mental health staffing at DCDF in accordance with Recommendations 4.3, II.21 and 4.3, II.28. (**4.3, II.30**)

8. DCDF does not place psychiatric alerts and holds as required by PBNDS 2011, 4.3, V.N. CRCL recommends that DCDF begin placing psychiatric alerts and holds in compliance with the standard. (**4.3, V.N**)

9. The treatment plans in the mental health evaluations were either vague or not implemented. CRCL recommends DCDF develop treatment plans that address the detainee's current clinical condition adopts the referenced strategies from Standard 4.6, Significant Self-harm and Suicide Prevention and Intervention. CRCL recommends that DCDF develop and implement a treatment plan form to address the fact that treatment plans were frequently vague and to help DCDF comply with the requirement to develop treatment plans. (**4.3, V.O.3**)

10. Mental health assessments are not routinely completed within 72 hours of referral as a result of staffing allocation issues. Additionally, detainees prescribed psychotropic medications are not routinely evaluated by a psychiatrist. CRCL recommends DCDF conduct all mental health assessments within 72 hours of referral and ensure that all detainees prescribed psychotropic medications are routinely evaluated by a psychiatrist on at least a monthly basis. (**4.3, V.O.4**)

11. When requested by CRCL, the mental health staff were unable to provide information regarding the number of detainees with a SMI. CRCL recommends

DCDF develop and implement a policy and procedure that can identify and track detainees with a SMI. (**4.3, V.X)**

12. Although the use of restraints for medical or mental health purposes was reported to be rare, DCDF staff was unfamiliar with DCDF policies #628 and #628-B (Therapeutic Seclusion and Restraints), which are consistent with the standards. CRCL recommends DCDF train mental health staff on the above policies and relevant standard. (**4.3, V.Y**)

The following priority recommendations relate to the PBNDS 2011 Standard 4.6, Significant Self-harm and Suicide Prevention and Intervention which protects the health and wellbeing of ICE detainees through a comprehensive Significant Self-Harm and Suicide Prevention and Intervention Program that minimizes risk:

13. DCDF's Suicide Intervention and Prevention Policy (#907 and 907A) and an additional policy, 16.1.11-AUR, Suicide Recognition and Prevention, were found to be not compliant with the requirements Standard 4.6, V in several instances. CRCL recommends that DCDF revise their suicide prevention policies to be compliant with Standard 4.6, including:
    1) Revise Policy #907 and 907A to include the specific requirements related to treatment plans that are in Standard 4.6, V.E.
    2) Revise Attachment 1 of the Policy #907 and 907A (Suicide Watch Log and Notes) to indicate that the default property includes a suicide blanket, suicide mattress, suicide pillow, or book; and revise Policy #907 and 907A to allow level one suicide watch detainees to receive property as required by Standard 4.6, V.F.1.
    3) Revise Policy #907 and 907A to require follow-up assessments within 72 hours as opposed to seven days to be compliant with Standard 4.6, V.F.4.
    4) Revise Policy #907 and 907A to require one-to-one monitoring when a detainee is placed on constant watch in accordance with Standard 4.6, V.F. The Policy currently allows for a staff member to monitor up to three detainees who are on constant watch which is not compliant.
    5) Revise Policy #907 and 907A to ensure that the provision of suicide smocks and the provision of regular clothing, including undergarments, is made on a case-by-case basis as required by Standard 4.6, V.F.2.
    6) Revise Policy #907 and 907 to prohibit level 2 observation status detainees (detainees who are observed on staggered 15 minute checks) from being placed in an isolation cell as this is prohibited by Standard 4.6, V.F.
    7) Revise Policy #16.1.11-AUR, Suicide Recognition and Prevention to prohibit the use of "no harm contracts" which are prohibited under Standard 4.6, V.A.

In addition, following a review of the June 2018 corporate audit, CRCL recommends that DCDF rectify the problems with the suicide prevention program that were identified during that audit.

CRCL also recommends that DCDF ensure that the facility's suicide prevention program monitors the guidelines in Policy #907 and 907A for training, identification, referral, assessment, and intervention, and that the facility require a suicide risk assessment (SRA) prior to changing and/or discharging a detainee from suicide watch status, as opposed to only requiring an SRA when a detainee is placed on suicide watch status. (**4.6, V**)

14. Currently, DCDF offers to all staff 2.5 hours of initial suicide prevention training and 1.5 hours of annual training. CRCL recommends that DCDF increase the length of their initial and annual suicide prevention training to be consistent with the requirements of Standard 4.6, which requires eight hours of initial suicide prevention training and two hours refresher training annually. CRCL also recommends that DCDF update Policy #16.1.11-AUR to be consistent with the requirements under Standard 4.6, V.A and DCDF Policy #907 and 907A, which both prohibit "No Harm Agreements." (**4.6, V.A**)

15. Given the vagueness in DCDF's Policy #907 and 907A regarding treatment plans, CRCL recommends that DCDF revise the Policy #907 and 907A to more clearly require a treatment plan in the context of the detainee's current clinical condition that addresses the referenced strategies from Standard 4.6, V.E. CRCL also recommends that DCDF begin implementing treatment plans for all detainees on suicide watch as required by the standard. (**4.6, V.E**)

16. The DCDF Policy #907 and 907A, Suicide Prevention and Intervention, allows the assigned staff member to monitor up to three detainees who are on Level 1 constant watch. However, this is not consistent with Standard 4.6, V.F., which requires one-to-one when a detainee is placed on continuous observation. Additionally, under Policy #907 and 907A, Level 2 observation status allows for observation to occur on a staggered 15-minute basis if the detainee is placed in a suicide resistant cell. However, this is not consistent with this provision, which requires constant observation whenever a detainee is placed in a special isolation room. Therefore, CRCL recommends DCDF revise its policies and practice to ensure that monitoring of Level 1 and Level 2 suicide statuses is being conducted according to the standard. CRCL also recommends that DCDF ensure that if suicidal detainees are temporarily placed in the SMU, they have access to all programs and services available to the general population, which does not appear to be occurring. (**4.6, V.F**)

17. DCDF's Policy #907 and 907A, Suicide Prevention and Intervention, does not appear to permit suicidal detainees under constant one-to-one monitoring to wear the standard issue

clothing and/or undergarments, minus any shoe laces, belts, or other accessories that could be used by a detainee to commit suicide or self-harm, which is inconsistent with the standard. CRCL recommends DCDF revise Policy #907 and 907A to be consistent with Standard 4.6, V.F.2, which requires that the facility make case-by-case determinations regarding whether a detainee on suicide precautions may wear the standard issue clothing and undergarments.

While onsite, it was observed that at least one of the two cells designated as suicide resistant contained a bed designed for using four point restraints. The structure of the bed, which includes four areas at the bottom to attach restraints to, is not suicide resistant. This bed should only be used for detainees requiring the use of restraints or those on suicide watch/precautions that are under constant watch. CRCL recommends that DCDF ensure that all cells designated for suicide watch are suicide resistant in accordance with Standard 4.6, V.F. (**4.6, V.F.2**)

18. CRCL recommends that DCDF ensure that suicide alert notifications are being sent to the appropriate chain of command given deficiencies found in this area after reviewing the June 2018 corporate audit.

Appendix I
Mental Health Care

Findings and Recommendations Under PBNDS 2011 Standard 4.3, Medical Care

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

***Medical facilities within the detention facility shall achieve and maintain current accreditation with the National Commission on Correctional Health Care (NCCHC), and shall maintain compliance with those standards.*"

Findings: Access to health care services by detainees occurs through both a self-referral system via the use of a kiosk (i.e., tablets) or paper referrals, and by staff referral (predominantly via the intake health care screening process). Staff reported that most of the detainees were not technologically competent to use the kiosk system, which meant that most self-referrals were generated by paper referrals. It was estimated that approximately 60 health care referrals per day were generated, which are initially triaged by nursing staff (b)(6) R.N., who schedules the telepsychiatry appointments, estimated that she receives, on average, 15 to 20 mental health referrals per week.

We were informed that beginning August 13, 2018 self-referrals would only be done via the electronic tablets. This is concerning based on information obtained from staff relevant to the difficulties many detainees have in using the tablet referral process.

A quality improvement system has not been implemented relevant to the self-referral process.

On August 14, 2018, (b)(6) and I interviewed female detainees in two community meeting-like settings within housing unit B-1 as well as male detainees in a similar setting within housing unit A2 (a high security setting). Detainees consistently described lack of timely responses as well as no response to self-referrals made via either paper or by the use of the tablets.

A mental health referral logbook was implemented about six weeks ago by (b)(6) R.N. All referrals during this period of time have been considered to be urgent, which means (b)(6) attempts to schedule an appointment with the psychiatrist or psychologist within 72 hours. Priority is given to detainees who are referred via the Prison Rape Elimination Act (PREA) process, are suicidal, and/or in need of a pre-segregation mental health clearance assessment.
Due to her multiple job responsibilities, (b)(6) has been unable to keep up-to-date the referral logbook.

Several of the complaints regarding lack of timely response and/or access to self-referrals were consistent with the health care record review (see Appendix III, Review of Records).

Recommendations: (Priority) Although DCDF staff developed a mental health referral logging system, all the referrals are considered "urgent." There is no prioritization of the acuity of the referrals. Further, due to lack of staffing, the logging system is not kept current. This leads to untimely responses to the mental health requests. DCDF mental health staff should ensure referrals are triaged based on acuity (i.e., urgent, emergent, and routine) in contrast to all being treated as urgent referrals.

Additionally, DCDF should implement a QI system to review the electronic requests to assess the percentage of referrals that are urgent, emergent, and routine, and whether such referrals are seen in a timely manner. A QI process should also look at the ability of detainees to successfully use the electronic tablet self-referral process. Implementing a QI process to review the referral process is necessary to determine whether detainees are actually receiving a continuum of health services.

4.3, II.2: "The facility shall have a mental health staffing component on call to respond to the needs of the detainee population 24 hours a day, seven days a week."

Findings: Mental health coverage during off hours is provided by the non-psychiatric physician on-call in contrast to mental health staff. Up until recently, it was thought that on-call mental health coverage during off hours was not needed although staff reported that such an assessment is being reconsidered at the present time. This reconsideration appears to be related, in part, to the average daily population which has increased from about 700 detainees to approximately 1000 detainees during the past several months.

The current practice is not consistent with DCDF's Policy #622 (Psychiatric Emergencies and Disorders), which requires a mental health professional being available for consultation to medical staff 24 hours and seven days a week.

Recommendations: (Priority) DCDF's mental health coverage during off hours is provided by a non-psychiatric physician on-call, instead of a mental health professional. Per PBNDS 2011 and DCDF's Policy #622 (Psychiatric Emergencies and Disorders), DCDF should ensure there is mental health coverage 24 hours and seven days a week.

4.3, II.3: "The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP). The facility will provide detainees with disabilities with effective communication, which may include the provision of auxiliary aids, such as readers, materials in Braille, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs),

interpreters, and note-takers, as needed. The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities.

All written materials provided to detainees shall generally be translated into Spanish. Where practicable, provisions for written translation shall be made for other significant segments of the population with limited English proficiency.

Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate.

Newly-admitted detainees shall be informed orally or in a manner in which the detainee understands about how to access, appeal or communicate concerns about health services."

Findings: The current mental health staff is bilingual (i.e., English and Spanish speaking). Professional interpretation and translation services via the telephone are available, which is confirmed by review of the Telephone Line Services, Inc. log.

All written materials provided to detainees are also available in Spanish.

Recommendations: Continue to monitor the staff's use of the professional interpretation and translation services, particularly for languages other than Spanish via the telephone line services log.

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

Findings: The self-referral process is available on a daily basis.

The review of health care records (see Appendix III) indicated some that some detainees, who are being prescribed a new medication, are not scheduled to see the psychiatrist in a timely manner for follow-up purposes.

In addition, the review of records indicated that planned mental health follow-up periodically did not occur. In addition, detainees refusing all appointments were not seen cell front to further assess their reasons for such refusals.

Recommendations: Detainees, who are prescribed a new medication, should receive timely follow-up by the prescribing psychiatrist. In general, a 90-day follow-up is not timely under such circumstances.

(Priority) There were instances where detainees, who are prescribed a new medication, were not scheduled to see the psychiatrist for follow-up in a timely manner. In some

cases, the follow-up did not even occur. In addition, detainees refusing all appointments were not seen to determine their reasons for such refusals. CRCL recommends DCDF develop and implement a tracking system and a QI process to ensure timely access and timely follow-up of mental health services.

4.3, II.5: "Detainees shall receive continuity of care from time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community-based providers as medically-appropriate."

Findings: Health care staff generally receive very short notice of detainees being discharged or transferred from the facility. A 14-day supply of medications and transfer summaries are provided for detainees being transferred to another facility. A summary of the medical records does not occur unless specifically requested. An appropriate transfer form has been implemented.

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."

Findings: A process is in place for sending detainees with a medical or mental health emergency, which cannot be handled at the DCDF, to the emergency room at the nearby University HospitalDenver Medical Center.

DCDF Policy #624-A (Psychiatric Inpatient Facility Referrals) adequately addresses the process for transferring detainees in need of psychiatric inpatient treatment.

4.3, II.7: "A transportation system shall provide timely access to health care services that are not available at the facility. Procedures for use of this transportation system shall include: a) prioritization of medical needs; b) urgency (such as the use of an ambulance instead of standard transportation); c) transfer of medical information and medications; and d) safety and security concerns of all persons."

Findings: A contract with an ambulance service for emergency purposes has been established. GEO transport are used for non-emergency purposes.

4.3, II.8: "A detainee who requires close, chronic or convalescent medical supervision shall be treated in accordance with a written treatment plan conforming to accepted medical practices for the condition in question, approved by a licensed physician, dentist or mental health practitioner."

Findings: Refer to report by Esmaeil Porsa, M.D.

4.3, II.9: "Twenty-four hour emergency medical and mental health services shall be available to all detainees."

Findings: See Standard 4.3, II.2 findings.

4.3, II.10: "Centers for Disease Control and Prevention (CDC) guidelines for the prevention and control of infectious and communicable diseases shall be followed."

Findings: Refer to report by (b)(6)

4.3, II.11: "Occupational Safety and Health Administration (OSHA) and applicable state guidelines for managing bio-hazardous waste and decontaminating medical and dental equipment shall be followed."

Findings: Refer to report by (b)(6)

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: Refer to report by (b)(6)

4.3, II.13: "The facility administrator shall notify ICE/ERO, in writing, of any detainee whose medical or mental health needs require special consideration in such matters as housing, transfer or transportation."

Findings: The above reportedly occurs when appropriate.

4.3, II.14: "Each detainee shall receive a comprehensive medical, dental and mental health intake screening as soon as possible, but no later than 12 hours after arrival at each detention facility. Detainees who appear upon arrival to raise urgent medical or mental health concerns shall receive priority in the intake screening process."

Findings: The mental health intake screening is performed by nursing staff as part of the intake health care process. The mental health screening questions that are part of the health care intake screening process are appropriate for mental health screening purposes.

Refer to the report by (b)(6)

4.3, II.15: "Each detainee shall receive a comprehensive health assessment, including a physical examination and mental health screening, by a qualified, licensed health care professional no later than 14 days after entering into ICE custody or arrival at facility. For the purposes of the comprehensive medical examination, a qualified licensed health provider includes the following: physicians, physician assistants, nurses, nurse practitioners, or others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients."

Findings: Refer to report by (b)(6)

4.3, II.16: "Qualified, licensed health care professionals shall classify each detainee on the basis of medical and mental health needs. Detainees shall be referred for evaluation, diagnosis, treatment and stabilization as medically indicated."

Findings: Licensed mental health staff provide diagnostic services upon referral. DCDF does not have a classification system based on mental health need.

Recommendations: Consider developing a mental health classification system based on level of mental health care needed, if any, for tracking purposes as well as quality improvement purposes. Specifically, the form entitled "Health Summary for Classification" (HS-132) could easily be modified for such purposes.

4.3, II.17: "At no time shall a pregnant detainee be restrained, absent truly extraordinary circumstances that render restraints absolutely necessary."

Findings: Refer to report by (b)(6)

4.3, II.18: "Detainees experiencing severe, life-threatening intoxication or withdrawal symptoms shall be transferred immediately for either on-site or off- site emergency department evaluation."

Findings: Refer to report by (b)(6)

4.3, II.19: "Pharmaceuticals and non-prescription medicines shall be secured, stored and inventoried."

Findings: Refer to report by (b)(6)

4.3, II.20: "Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees."

Findings: Many detainees reported significant delays (e.g., 2 to 4 weeks) in receiving medications once admitted to the facility.

Recommendations: (Priority) See Recommendation under **4.3, II.4**

4.3, II.21: "Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements."

Findings: The current mental health staffing was as follows:

- 1 psychologist (b)(6) Ph.D.) His hours were increased from 32 hours/week to 40 hours/week appoximately 2-3 months ago.
- 1 LCSW (b)(6) LCSW) for 32 hrs/week.
- 3 telepsychiatrists providing a total of 24 hrs/week.
- FTE R.N. whose role is predominantly to coordinate the telepsychiatry process.
- A 40 hr/week position for another contract mental health clinician has recently been approved. Recruiting efforts have not yet been initiated.

The credentialing process for the telepsychiatrists is done, apparently, at the corporate headquarters level in contrast being performed by DCDF.

(b)(6) reported that he has rare contact with any of the telepsychiatrists. In general, s caseload is predominantly ICE detainees and Ms. (b) (6) reportedly provides about 10 hrs/week of mental health services to ICE detainees.

(b)(6) B.S.N., R.N. has been the health care administrator since about April 2018.

It is difficult to assess the adequacy of the staffing allocations for mental health services due to the paucity of basic data relevant to the mental health services at DCDF. For example, staff were unable to easily provide the percentage of the total ICE population that was on the mental health caseload. Staff was unable to indicate how many detainees with a serious mental illness (SMI) were on the mental health caseload. Staff was unable to provide information relevant to the number of detainees receiving psychotropic medications based on class (e.g. how many were receiving antipsychotic medications, mood stabilizers, antidepressants, etc.).

Based on reported clinician caseload numbers, it is estimated that about 220 detainees were receiving mental health services, which means that about 22% of the total detainee population was on the mental health caseload. However, the accuracy of this statistic is unclear.

There is no person with appropriate mental health credentials, on site, whose responsibility is to serve as director mental health services at DCDF.

Recommendations: (Priority) Currently, there is no person with appropriate mental health credentials, on site, whose responsibility is to serve as director mental health services at DCDF, and it is difficult to assess the adequacy of the staffing allocations for mental health services due to the paucity of basic data relevant to the mental health services at DCDF. As a result, CRCL recommends that DCDF establish a Director of Mental Health position. Additionally, CRCL recommends that DCDF conduct a staffing needs analysis to determine the appropriate mental health staffing allocations needed.

4.3, II.22: "Detention and health care personnel shall be trained initially and annually in the proper use of emergency medical equipment and shall respond to health-related emergency situations."

Findings: Refer to report by (b)(6)

4.3, II.23: "Information about each detainee's health status shall be treated as confidential, and health records shall be maintained in accordance with accepted standards separately from other detainee detention files and be accessible only in accordance with written procedures and applicable laws. Health record files on each detainee shall be well organized, available to all practitioners and properly maintained and safeguarded."

Findings: The mental health section of the health care record ranged from being well organized to having "loose" records in the chart that were not yet filed in the proper section. Psychiatrists' notes were in the progress section and, at times, in the mental health section of the health care record.

Recommendations: The location of the psychiatrists' progress notes should be standardized.

4.3, II.24: "Informed consent standards shall be observed and adequately documented. Staff shall make reasonable efforts to ensure that detainees understand their medical condition and care."

Findings: Written informed consents forms were present in the health care records reviewed.

4.3, II.25: "Medical and mental health interviews, screenings, appraisals, examinations, procedures and administration of medication shall be conducted in settings that respect detainees' privacy in accordance with safe and/orderly operations of the facility."

Findings: Mental health assessments and treatment are performed in a confidential manner unless clinically contraindicated. However, detainees complained that they spent hours in a holding area by the medical unit prior to be seen by a mental health clinician.

Recommendations: Detainees should not be waiting for hours for mental health appointments because it often serves as a barrier to obtaining treatment, especially for detainees with a SMI who often do not feel they need such treatment.

4.3, II.26: "A detainee's request to see a health care provider of the same gender should be considered; when not feasible, a same-gender chaperone shall be provided. When care is provided by a health care provider of the opposite gender, a detainee shall be provided a same-gender chaperone upon the detainee's request."

Findings: Refer to report by (b)(6)

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.'"

Findings: Mental health rounds reportedly occur on a weekly basis. As evidenced by reviewing selected health care records, SMU detainees on the mental health caseload have access to care issues similar to general population inmates, which appears related to staffing allocation issues, management information system issues, and the lack of an administrative mental health director position.

Recommendations: (Priority) As evidenced by a review of selected health care records, SMU detainees on the mental health caseload have access to care issues similar to general population detainees. CRCL recommends that DCDF address the access to care issues that SMU detainees on a mental health caseload have, which appear related to staffing allocation issues, management information system issues, and the lack of an administrative mental health director position.

4.3, II.28: "**Adequate space and staffing for the use of services of the ICE Tele-Health Systems, inclusive of tele-radiology (ITSP) and tele medicine, shall be provided."

Findings: (b)(6) R.N. serves as the telepsychiatry coordinator for scheduling purposes. She reported that routine telepsychiatry appointments are usually allotted 15-20 minutes and initial psychiatric examinations 20-25 minutes. The scanning of records that are sent to the tele-psychiatrist requires much of her time. In addition, it is often difficult to locate the actual record due to an ineffective sign-out system within the medical records department.

The telepsychiatrists have not been on site.

Recommendations: (Priority) The telepsychiatrists have not come on site at DCDF, and the telepsychiatry coordinator spends much of her time trying to locate and scan records to the telepsychiatrists. CRCL recommends that DCDF revise Policy #627-A (Telehealth) to require a telepsychiatrist to be on site at least once every six months. The policy should also be revised to specify which health care records should be scanned to the telepsychiatrist prior to the appointment.

Furthermore, CRCL recommends that DCDF evaluate whether they have adequate telepsychiatry staffing since detainees are reportedly only scheduled for a 20-25 minute initial psychiatric examination; such assessments usually require 45-60 minutes.

4.3, II.29: "All detainees shall receive medical and mental health screenings, interventions and treatments for gender-based abuse and/or violence, including sexual assault and domestic violence."

Findings: PREA screening is performed by a classification officer as part of the admission process. The lack of confidentiality during the screening process should be remedied.

Refer to the report by (b)(6)

Recommendations: Remedy the lack of confidentiality during the screening process.
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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."

Findings: DCDF has a very rudimentary quality improvement process. A nurse has recently been hired to essentially serve as a director of quality improvement although this nurse does not have prior experience with the quality improvement process

Recommendations: (Priority) CRCL recommends that DCDF develop an adequate QI system. This QI system should evaluate, among other things, the referral process (including the number of emergent, urgent, and routine referrals); the timeliness of the referral process; and the timeliness of follow-ups to the referral process as stated under Recommendation 4.3, II.I; 4.3, II.4; and 4.3, II.20. A staffing needs analysis should also be implemented to determine appropriate mental health staffing at DCDF in accordance with Recommendations 4.3, II.21 and 4.3, II.28.

Findings and Recommendations under Standard 4.3, V. Expected Practices

4.3, V.A: "Every facility shall directly or contractually provide its detainee population with the following:

1. Initial medical, mental health and dental screening;
2. Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services;
3. Comprehensive, routine and preventive health care, as medically indicated;
4. Emergency care;
5. Specialty health care;
6. Timely responses to medical complaints; and
7. Hospitalization as needed within the local community.
8. Staff or professional language services necessary for detainees with limited English

proficiency (LEP) during any medical or mental health appointment, sick call, treatment, or consultation.

***Medical facilities within the detention facility shall achieve and maintain current accreditation with the National Commission on Correctional Health Care (NCCHC),and shall maintain compliance with those standards.*"

Findings: See findings under Standard 4.3, II for 1-2 and 8. Refer to report by Esmaeil Porsa, M.D. for 3-7. DCDF was accredited by NCCHC in August 2015.

4.3, V.B. Designation of Authority
"A designated health services administrator (HSA) or the equivalent in non-IHSC staffed detention facilities shall have overall responsibility for health care services pursuant to a written agreement, contract or job description. The HSA is a physician or health care professional and shall be identified to detainees.

The designated clinical medical authority (CMA) at the facility shall have overall responsibility for medical clinical care pursuant to a written agreement, contract or job description. The CMA shall be a medical doctor (MD) or doctor of osteopathy (DO). The CMA may designate a clinically trained professional to have medical decision making authority in the event that the CMA is unavailable.

When the HSA is other than a physician, final clinical judgment shall rest with the facility's designated CMA. In no event shall clinical decisions be made by non-clinicians.

The HSA shall be authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program. The CMA together with the HSA establishes the processes and procedures necessary to meet the medical standards outlined herein."

Findings: (b)(6), B.S.N., R.N. has been the health care administrator since about April 2018.

Refer to report by (b)(6)

"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.

Health care personnel perform duties within their scope of practice for which they are credentialed by training, licensure, certification, job descriptions, and/or written standing or direct orders by personnel authorized by law to give such orders."

Findings: See findings under Standard 4.3 Medical Care, II.

"The facility administrator, in collaboration with the CMA and HSA, negotiates and maintains arrangements with nearby medical facilities or health care providers to provide required health care not available within the facility, as well as identifying custodial officers to transport and remain with detainees for the duration of any off-site treatment or hospital admission."

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.C. Communicable Disease and Infection Control

Findings: Refer to report by (b)(6)

4.3, V.D. Notifying Detainees about Health Care Services
"In accordance with standard "6.1 Detainee Handbook," the facility shall provide each detainee, upon admittance, a copy of the detainee handbook and local supplement, in which procedures for access to health care services are explained.

Health care practitioners should explain any rules about mandatory reporting and other limits to confidentiality in their interactions with detainees. Informed consent shall be obtained prior to providing treatment (absent medical emergencies). Consent forms and refusals shall be documented and placed in the detainee's medical file.

In accordance with the section on Orientation in standard "2.1 Admission and Release," access to health care services, the sick call and medical grievance processes shall be included in the orientation curriculum for newly admitted detainees."

Findings: Refer to report by (b)(6)

4.3, V.E. Translation and Language Access for Detainees with Limited English Proficiency
"Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. Where appropriate staff interpretation is not available, facilities will make use of professional interpretation services. Detainees shall not be used for interpretation services during any medical or mental health service. Interpretation and translation services by other detainees shall only be provided in an emergency medical situation.

Facilities shall post signs in medical intake areas in English, Spanish, and languages spoken by other significant segments of the facility's detainee population listing what language assistance is available during any medical or mental health treatment, diagnostic test, or evaluation."

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.F. Facilities

4.3, V.F.1. Examination and Treatment Area

"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.

A holding/waiting area shall be located in the medical facility under the direct supervision of custodial officers. A detainee toilet and drinking fountain shall be accessible from the holding/waiting area."

Findings: Refer to report by (b)(6)

4.3, V.F.2. Medical Records

"Medical records shall be kept separate from detainee detention records and stored in a securely locked area within the medical unit."

Findings: Staff reported that medical records are often difficult to locate because they have not been timely returned to the medical records department.

Refer to report by (b)(6)

4.3, V.F.3. Medical Housing

"If there is a specific area, separate from other housing areas, where detainees are admitted for health observation and care under the supervision and direction of health care personnel, consideration shall be given to the detainee's age, gender, medical requirements and custody classification and the following minimum standards shall be met:

a. Care
   1) Physician at the facility or on call 24 hours per day;
   2) Qualified health care personnel on duty 24 hours per day when patients are present;
   3) Staff members within sight or sound of all patients;
   4) Maintenance of a separate medical housing record distinct from the complete medical record; and
   5) Compliance with all established guidelines and applicable laws.
      Detainees in medical housing shall have access to other services such as telephone, legal access and materials, consistent with their medical conditions.
      Prior to placing a detainee with a mental illness in medical housing, a determination shall be made by a medical or mental health professional that placement in medical housing is medically necessary.
b. Wash Basins, Bathing Facilities and Toilets
   1) Detainees shall have access to operable washbasins with hot and cold running water at a minimum ratio of 1 for every 12 detainees, unless state or local building codes specify a different ratio.
   2) Sufficient bathing facilities shall be provided to allow detainees to bathe daily, and sufficient bathing facilities shall be physically accessible for detainees with

disabilities, as required by the applicable accessibility standard. Water shall be thermostatically controlled to temperatures ranging from 100 F to 120 F degrees.

3) Detainees shall have access to operable toilets and hand-washing facilities 24 hours per day and shall be permitted to use toilet facilities without staff assistance. Unless state or local building or health codes specify otherwise:
   a) toilets shall be provided at a minimum ratio of 1 to every 12 detainees in male facilities and 1 for every 8 in female facilities, and
   b) all housing units with three or more detainees shall have a minimum of two toilets.

Findings: The medical clinic area does have two suicide resistant rooms that are used for suicide watch purposes and restraint for mental health purposes. However, a detainee in one of these rooms during the first day of the site visit managed to cause the facility's fire alarm to go off by tampering with the sprinkler. This medical clinic is staffed 24 hours per day by nursing staff. Staff indicated that this was an unusual incident.

Refer to report by (b)(6)

Recommendations: Consider whether one of the observation cells should have the fixed bed moved in a manner that would prevent an inmate from standing on it and having access to the sprinkler head.

4.3, V.G. Pharmaceutical Management

"Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include:

1. a formulary of all prescription and nonprescription medicines stocked or routinely procured from outside sources;
2. identification of a method for promptly approving and obtaining medicines not on the formulary;
3. prescription practices, including requirements that medications are prescribed only when clinically indicated, and that prescriptions are reviewed before being renewed;
4. procurement, receipt, distribution, storage, dispensing, administration and disposal of medications;
5. secure storage and disposal and perpetual inventory of all controlled substances (DEA Schedule II-V), syringes, and needles;
6. medicine administration error reports to be kept for all administration errors;
7. all staff responsible for administering or having access to pharmaceuticals to be trained on medication management before beginning duty;
8. all pharmaceuticals to be stored in a secure area with the following features:
   a. a secure perimeter;
   b. access limited to authorized medical staff (never detainees);
   c. solid walls from floor to ceiling and a solid ceiling;
   d. a solid core entrance door with a high security lock (with no other access); and

e. a secure medication storage area;
9. administration and management in accordance with state and federal law;
10. supervision by properly licensed personnel;
11. administration of medications by properly licensed, credentialed, trained personnel under the supervision of the health services administrator (HSA), clinical medical authority (CMA), both; and
12. documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders."

Findings: Refer to report by (b)(6)

4.3, V.H. Nonprescription Medications
"The facility administrator and HSA shall jointly approve any nonprescription medications that are available to detainees outside of health services (e.g., sold in commissary, distributed by housing officers, etc.), and shall jointly review the list, on an annual basis at a minimum."

Findings: Refer to report by (b)(6)

4.3, V.I. Medical Personnel
"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."

Findings: Refer to report by (b)(6)

4.3, V.J. Medical and Mental Health Screening of New Arrivals
"As soon as possible, but no later than 12 hours after arrival, all detainees shall receive, by a health care provider or a specially trained detention officer, an initial medical, dental and mental health screening and be asked for information regarding any known acute or emergent medical conditions. Any detainee responding in the affirmative shall be sent for evaluation to a qualified, licensed health care provider as quickly as possible, but in no later than two working days.

Detainees who appear upon arrival to raise urgent medical or mental health concerns shall receive priority in the intake screening process. For intrasystem transfers, a qualified health care professional will review each incoming detainee's health record or health summary within 12 hours of arrival, to ensure continuity of care.

For LEP individuals, interpretation for the screening will be conducted by facility staff with appropriate language capabilities or through professional interpretation services, as described in Section E of this standard ("Translation and Language Access for Detainees with Limited English Proficiency").

If screening is performed by a detention officer, the facility shall maintain documentation of

the officer's special training, and the officer shall have available for reference the training syllabus, to include education on patient confidentiality of disclosed information.

The screening shall inquire into the following:

1. any past history of serious infectious or communicable illness, and any treatment or symptoms;
2. history of physical and mental illness;
3. pain assessment;
4. current and past medication;
5. allergies;
6. past surgical procedures;
7. symptoms of active TB or previous TB treatment;
8. dental care history;
9. use of alcohol, tobacco and other drugs, including an assessment for risk of potential withdrawal;
10. possibility of pregnancy;
11. other relevant health problems identified by the CMA responsible for screening inquiry;
12. observation of behavior, including state of consciousness, mental status, appearance, conduct, tremor, sweating;
13. history of suicide attempts or current suicidal/homicidal ideation or intent;
14. observation of body deformities and other physical abnormalities;
15. inquire into a transgender detainee's gender self- identification and history of transition-related care, when a detainee self-identifies as transgender;
16. past hospitalizations;
17. chronic illness (including, but not limited to, hypertension and diabetes);
18. dietary needs; and
19. any history of physical or sexual victimization or perpetrated sexual abuse, and when the incident occurred.

Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.

For further information and guidance, see standard "2.1 Admission and Release."
Initial screenings shall be conducted in settings that respect detainees' privacy and include observation and interview questions related to the detainee's potential suicide risk and mental health. For further information, see standard "4.6 Significant Self-harm and Suicide Prevention and Intervention."

If, at any time during the screening process, there is an indication of need of, or a request for, mental health services, the HSA must be notified within 24 hours. The CMA, HSA or other qualified licensed health care provider shall ensure a full mental health evaluation, if indicated. Mental health evaluations must be conducted within the timeframes prescribed in "O. Mental

Health Program" of this standard.

All facilities shall have policies and procedures in place to ensure documentation of the initial health screening and assessment.

The health intake screening shall be conducted using the IHSC Intake Screening Form (IHSC 795A) or equivalent and shall be completed prior to the detainee's placement in a housing unit. The Intake Screening Form attached as Appendix 4.3.A mirrors form IHSC 795A and may be used by facilities to ensure compliance with screening requirements in these standards.

Upon completion of the In-Processing Health Screening form, the detention officer shall immediately notify medical staff when one or more positive responses are documented. Medical staff will then assess priority for treatment (e.g. urgent, today or routine).

Limited-English proficient detainees and detainees who are hearing impaired shall be provided interpretation or translation services or other assistance as needed for medical care activities.

Language assistance may be provided by another medical staff member competent in the language or by a professional service, such as a telephone interpretation service."

> **Findings:** See findings under Standard 4.3 Medical Care, II. The intake health care screening process does include relevant mental health screening questions.

4.3, V.K. Substance Dependence and Detoxification

"All detainees shall be evaluated through an initial screening for use of and/or dependence on mood- and mind-altering substances, alcohol, opiates, hypnotics, sedatives, etc. Detainees who report the use of such substances shall be evaluated for their degree of reliance on and potential for withdrawal from the substance.

The CMA shall establish guidelines for evaluation and treatment of new arrivals who require detoxification.

Detainees experiencing severe or life-threatening intoxication or withdrawal shall be transferred immediately to an emergency department for evaluation.

Once evaluated, the detainee will be referred to an appropriate facility qualified to provide treatment and monitoring for withdrawal, or treated on-site if the facility is staffed with qualified personnel and equipment to provide appropriate care."

> **Findings:** Refer to report by (b)(6)

4.3, V.L. Privacy and Chaperones

4.3, V.L.1. Medical Privacy
"Medical and mental health interviews, screenings, appraisals, examinations, procedures, and administration of medication shall be conducted in settings that respect detainees' privacy."

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.L.2. Same-Gender Providers and Chaperones
"A detainee's request to see a health care provider of the same gender should be considered; when not feasible, a same-gender chaperone shall be provided.

When care is provided by a health care provider of the opposite gender, a detainee shall be provided a same-gender chaperone upon the detainee's request.

A same-gender chaperone shall be provided, even in the absence of a request by the detainee, when a medical encounter involves a physical examination of sensitive body parts, to include breast, genital, or rectal examinations, by a provider of the opposite gender.

Only medical personnel may serve as chaperones during medical encounters and examinations."

Findings: Refer to report by (b)(6)

4.3, V.M. Comprehensive Health Assessment

Findings: Refer to report by (b)(6)

4.3, V.N. Medical/Psychiatric Alerts and Holds
"Where a detainee has a serious medical or mental health condition or otherwise requires special or close medical care, medical staff shall complete a Medical/Psychiatric Alert form (IHSC-834) or equivalent, and file the form in the detainee's medical record. Where medical staff furthermore determine the condition to be serious enough to require medical clearance of the detainee prior to transfer or removal, medical staff shall also place a medical hold on the detainee using the Medical/Psychiatric Alert form (IHSC-834) or equivalent, which serves to prevent ICE from transferring or removing the detainee without the prior clearance of medical staff at the facility. The facility administrator shall receive notice of all medical/psychiatric alerts or holds, and shall be responsible for notifying ICE/ERO of any medical alerts or holds placed on a detainee that is to be transferred.

Potential health conditions meriting the completion of a Medical/Psychiatric Alert form may include, but are not limited to:

1. medical conditions requiring ongoing therapy, such as:

a. active TB
b. infectious diseases
c. chronic conditions

2. mental health conditions requiring ongoing therapy, such as:
   a. suicidal behavior or tendencies
3. ongoing physical therapy
4. pregnancy"

Findings: DCDF does not place psychiatric alerts and holds as required above.

Recommendations: (Priority) DCDF does not place psychiatric alerts and holds as required by the Standard 4.3, V.N. CRCL recommends that DCDF begin placing psychiatric alerts and in compliance with the standard.

4.3, V.O. Mental Health Program

4.3, V.O.1. Mental Health Services Required

"Each facility shall have an in-house or contractual mental health program, approved by the appropriate medical authority that provides:

a. intake screening Form IHSC 795A (or equivalent) for mental health concerns;
b. referral as needed for evaluation, diagnosis, treatment and monitoring of mental illness by a competent mental health professional.
c. crisis intervention and management of acute mental health episodes;
d. transfer to licensed mental health facilities of detainees whose mental health needs exceed the capabilities of the facility; and
e. a suicide prevention program."

Findings: See findings under Standard 4.3 Medical Care, II.. See also Appendix II (Suicide Prevention).

4.3, V.O.2. Mental Health Provider

"The term 'mental health provider' includes psychiatrists, physicians, psychologists, clinical social workers and other appropriately licensed independent mental health practitioners."

Findings: As above.

4.3, V.O.3. Mental Health Evaluation

"Based on intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.

Such evaluation and screenings shall include:

h. reason for referral;
i. history of any mental health treatment or evaluation;
j. history of illicit drug/alcohol use or abuse or treatment for such;
k. history of suicide attempts;
l. current suicidal/homicidal ideation or intent;
m. current use of any medication;
n. estimate of current intellectual function;
l. mental health screening, to include prior history physical, sexual or emotional abuse;
m. impact of any pertinent physical condition, such as head trauma;
n. recommend actions for any appropriate treatment, including but not limited to the following:
   1) remain in general population with psychotropic medication and counseling,
   2) "short-stay" unit or infirmary,
   3) Special Management Unit, or
   4) community hospitalization; and
o. recommending and/or implementing a treatment plan, including recommendations concerning transfer, housing, voluntary work and other program participation."

Findings: The mental health evaluations reviewed as part of the health care records review (see Appendix III) generally included the above referenced elements. However, treatment plans were frequently not explicit and a treatment plan form has not been developed or implemented.

The typed assessments by (b)(6) were generally comprehensive in nature.

Recommendations: (Priority) The treatment plans in the mental health evaluations were either vague or not implemented. CRCL recommends DCDF develop treatment plans that address the detainee's current clinical condition adopts the referenced strategies from Standard 4.6, V.E. CRCL recommends that DCDF develop and implement a treatment plan form to address the fact that treatment plans were frequently vague and to help DCDF comply with the requirement to develop treatment plans.

4.3, V.O.4. Referrals and Treatment
"Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.

The provider shall develop an overall treatment/management plan.

If the detainee's mental illness or developmental or intellectual disability needs exceed the treatment capability of the facility, a referral for an outside mental health facility may be initiated.

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; [sic]."

Findings: Mental health assessments are not routinely completed within 72 hours of referral as a result of staffing allocation issues.

Detainees prescribed psychotropic medications are not routinely evaluated by a psychiatrist on at least a monthly basis.

Recommendations: (Priority) Mental health assessments are not routinely completed within 72 hours of referral as a result of staffing allocation issues. Additionally, detainees prescribed psychotropic medications are not routinely evaluated by a psychiatrist. CRCL recommends that DCDF conduct all mental health assessments within 72 hours of referral and ensure that all detainees prescribed psychotropic medications are routinely evaluated by a psychiatrist on at least a monthly basis to be consistent with this standard.

4.3, V.O.5. Medical Isolation
"The CMA may authorize medical isolation for a detainee who is at high risk for violent behavior because of a mental health condition. The CMA shall be responsible for the daily reassessment of the need for continued medical isolation to ensure the health and safety of the detainee.

Medical isolation shall not be used as a punitive measure."

Findings: Policy #628 (Therapeutic Seclusion and Restraints) was reviewed. The local mental health staff did not appear to be familiar with this policy.

Seclusion was reported to rarely be used at DCDF.

Recommendations: Mental health staff should be trained on Policy #628 (Therapeutic Seclusion and Restraints)

4.3, V.O.6. Involuntary Administration of Psychotropic Medication
"Involuntary administration of psychotropic medication to detainees shall comply with established guidelines and applicable laws, and shall be performed only pursuant to the specific, written and detailed authorization of a physician. Absent declared medical emergency, before psychotropic medication is involuntarily administered, it is required that the HSA contact ERO management, who shall then contact respective ICE Office of Chief Counsel to facilitate a request for a court order to involuntarily medicate the detainee.

Prior to involuntarily administering psychotropic medication, absent a declared medical

emergency, the authorizing physician shall:

a. review the medical record of the detainee and conduct a medical examination;
b. specify the reasons for and duration of therapy, and whether the detainee has been asked if he/she would consent to such medication;
c. specify the medication to be administered, the dosage and the possible side effects of the medication;
d. document that less restrictive intervention options have been exercised without success;
e. detail how medication is to be administered;
f. monitor the detainee for adverse reactions and side effects; and
g. prepare treatment plans for less restrictive alternatives as soon as possible.

Also see section "Z: Informed Consent and Involuntary Treatment" later in this detention standard."

Findings: Policy #610 (Forced Psychotropic Medications), which addresses the use of psychotropic medications on an emergency basis, was reviewed. This policy was consistent with the above standard. DCDF does not have a policy relevant to the use of nonemergency involuntary medications.

It is likely that DCDF would be unable to use involuntary medications on a nonemergency basis within the state of Colorado. However, a policy should be developed to address this issue.

Recommendations: DCDF should develop a policy on the use of involuntary medications on a nonemergency basis.

4.3, V.P. Referrals for Sexual Abuse Victims or Abusers

"If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate.

When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral.

For the purposes of this section, a "qualified medical practitioner" or "qualified mental health practitioner" means a health or mental health professional, respectively, who in addition to being qualified to evaluate and care for patients within the scope of his/her professional practice, has successfully completed specialized training for treating sexual abuse victims."

Findings: Information was obtained from the PREA coordinator. A referral process is in place as required above although data was not available relevant to whether the 72 hour timeframe is being met.

Refer to the report by (b)(6)

Recommendations: DCDF should QI detainees are receiving a mental health evaluation no later than 72 hours after the referral.

4.3, V.Q. Annual Health Examinations

Findings: Refer to report by (b)(6)

4.3, V.R. Dental Treatment

Findings: Refer to report by (b)(6)

4.3, V.S. Sick Call

"Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting. This procedure shall include:

1. clearly written policies and procedures;
2. sick call process shall be communicated in writing and verbally to detainees during their orientation;
3. regularly scheduled "sick call" times shall be established and communicated to detainees;
4. an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

If the procedure requires a written request slip, such slips shall be provided in English and the most common languages spoken by the detainee population of that facility. Limited-English proficient detainees and detainees who are hearing impaired shall be provided interpretation/translation services or other assistance as needed to complete a request slip.

All detainees, including those in SMUs, regardless of classification, shall have access to sick call. See standard "2.12 Special Management Units" for details.

All facilities shall maintain a permanent record of all sick call requests."

Findings: See findings under Standard 4.3 Medical Care, II. Refer to report by (b)(6) (b)(6)

4.3, V.T. Emergency Medical Services and First Aid

Findings: Refer to report by (b)(6)

4.3, V.U. Delivery of Medication

"Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained.

1. If prescribed medication must be delivered at a time when medical staff is not on duty, the medication may be distributed by detention officers, where it is permitted by state law to do so, who have received proper training by the HSA or designee.
2. The facility shall maintain documentation of the training given any officer required to distribute medication, and the officer shall have available for reference the training syllabus or other guide or protocol provided by the health authority.
3. Detainees may not deliver or administer medications to other detainees.
4. All prescribed medications and medically necessary treatments shall be provided to detainees on schedule and without interruption, absent exigent circumstances.
5. Detainees who arrive at a detention facility with prescribed medications or who report being on such medications, shall be evaluated by a qualified health care professional as soon as possible, but not later than 24 hours after arrival, and provisions shall be made to secure medically necessary medications.
6. Detainees shall not be charged for any medical services to include pharmaceuticals dispensed by medical personnel

Findings: Refer to report by (b)(6)

4.3, V.V. Health Education and Wellness Information

Findings: Refer to report by (b)(6)

4.3, V.W. Special Needs and Close Medical Supervision

Findings: Refer to report by (b)(6)

4.3, V.X. Notifications of Detainees with Serious Illnesses and Other Specified Conditions

"The facility administrator and clinical medical authority shall ensure that the Field Office Director is notified as soon as practicable of any detainee housed at the facility who is determined to have a serious physical or mental illness or to be pregnant, or have medical complications related to advanced age, but no later than 72 hours after such determination. The

written notification shall become part of the detainee's health record file."

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.X.1. Serious Physical Illness

Findings: Refer to report by (b)(6)

4.3, V.X.2. Serious Mental Illness

"For the purposes of this section, the following non- exhaustive categories of conditions should be considered to constitute a serious mental illness:

a) conditions that a qualified medical provider has determined to meet the criteria for a "serious mental disorder or condition" pursuant to applicable ICE policies, including:
   - a mental disorder that is causing serious limitations in communication, memory, or general mental and/or intellectual functioning (e.g. communicating, conducting activities of daily life, social skills); or a severe medical condition(s) (e.g. traumatic brain injury or dementia) that is significantly impairing mental function;
   - or one or more of the following active psychiatric symptoms and/or behavior: severe disorganization, active hallucinations or delusions, mania, catatonia, severe depressive symptoms, suicidal ideation and/or behavior, marked anxiety of impulsivity.
   - significant symptoms of one of the following:
     - Psychosis or Psychotic Disorder;
     - Bipolar Disorder;
     - Schizophrenia or Schizoaffective Disorder;
     - Major Depressive Disorder with Psychotic Features;
     - Dementia and/or a Neurocognitive Disorder; or
     - Intellectual Development Disorder (moderate, severe, or profound).

b) any ongoing or recurrent conditions that have required a recent or prolonged hospitalization, typically for greater than 14 days, or a recent and prolonged stay in the medical clinic of a detention or correctional facility, typically for greater than 30 days;

c) any condition that would preclude the alien from being housed, typically for greater than 30 days, in a non-restrictive setting (such as a general population housing unit, as opposed to a special management unit or a medical clinic);

d) any other mental illness determined to be serious by IHSC.

Findings: Mental health staff were unable to provide information regarding the number of detainees with a SMI, which appeared, in part, related to lack of a policy specific to detainees with a SMI.

Recommendations: (Priority) When requested by CRCL, the mental health staff were unable to provide information regarding the number of detainees with a SMI. CRCL recommends DCDF identify detainees with an SMI and develop and implement a policy and procedure specific to detainees with a SMI.

4.3, V.X.3. Pregnancy

Findings: Refer to report by (b)(6)

4.3, V.Y. Restraints

"Restraints for medical or mental health purposes may be authorized only by the facility's CMA or designee, after determining that less restrictive measures are not appropriate. In the absence of the CMA, qualified medical personnel may apply restraints upon declaring a medical emergency. Within one- hour of initiation of emergency restraints or seclusion, qualified medical staff shall notify and obtain an order from the CMA or designee.

b. The facility shall have written procedures that specify:
   1) the conditions under which restraints may be applied;
   2) the types of restraints to be used;
   3) the proper use, application and medical monitoring of restraints;
   4) requirements for documentation, including efforts to use less restrictive alternatives; and
   5) after-incident review.

The use of restraints requires documented approval and guidance from the CMA. Record-keeping and reporting requirements regarding the medical approval to use restraints shall be consistent with other provisions within these standards, including documentation in the detainee's A-file, detention and medical file."

Findings: Fortunately, the use of restraints for such purposes was reported to be rare. Policies #628 and #628-B (Therapeutic Seclusion and Restraints) were reviewed and are consistent with the above standard.

Staff did not appear to be very informed regarding the above policies.

Recommendations: (Priority) Although the use of restraints for medical or mental health purposes was reported to be rare, staff was unfamiliar with DCDF policies #628 and #628-B (Therapeutic Seclusion and Restraints), which are consistent with the standards. CRCL recommends DCDF train mental health staff on the above policies and relevant standard.

4.3, V.Z. Continuity of Care

"The facility HSA must ensure that a plan is developed that provides for continuity of medical care in the event of a change in detention placement or status.

The detainee's medical needs shall be taken into account prior to any transfer of the detainee to another facility. Alternatives to transfer shall be considered, taking into account the disruption that a transfer will cause to a detainee receiving medical care. Upon transfer to another facility, the medical provider shall prepare and provide a Medical Transfer Summary as required by "C. Responsibilities of the Health Care Provider at the Sending Facility," found in Standard 7.4 "Detainee Transfers." In addition, the medical provider shall ensure that at least 7 day (or, in the case of TB medications, 15 day and in the case of HIV/AIDS medications, 30 day) supply of medication shall accompany the detainee as ordered by the prescribing authority.

Upon removal or release from ICE custody, the detainee shall receive up to a 30 day supply of medication as ordered by the prescribing authority and a detailed medical care summary as described in "BB. Medical Records" of this standard. If a detainee is on prescribed narcotics, the clinical health authority shall make a determination regarding continuation, based on assessment of the detainee. The HSA must ensure that a continuity of treatment care plan is developed and a written copy provided to the detainee prior to removal."

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.AA. Informed Consent and Involuntary Treatment

"Involuntary treatment is a decision made only by medical staff under strict legal restrictions. When a detainee refuses medical treatment, and the licensed health care provider determines that a medical emergency exists, the physician may authorize involuntary medical treatment. Prior to any contemplated action involving non-emergent involuntary medical treatment, respective ICE Office of Chief Counsel shall be consulted.

1. Upon admission at the facility, documented informed consent shall be obtained for the provision of health care services.
2. All examinations, treatments, and procedures are governed by informed consent practices applicable in the jurisdiction.
3. A separate documented informed consent is required for invasive procedures, including surgeries, invasive diagnostic tests, and dental extractions.
4. Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication's side effects, shall be obtained.
5. If a consent form is not available in a language the detainee understands, professional interpretation services will be provided as described in Section E ("Translation and Language Access for Detainees with Limited English Proficiency") and documented on the form.
6. If a detainee refuses treatment and the CMA or designee determines that treatment is necessary, ICE/ERO shall be consulted in determining whether involuntary treatment shall be pursued.
7. If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to explain to the detainee the necessity for and propriety of the recommended treatment.
8. Medical staff shall ensure that the detainee's questions regarding the treatment are answered by appropriate medical personnel.
9. Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee's medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatment.
10. The clinical medical authority and facility administrator shall look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding.
11. Facilities should make efforts to involve trusted individuals such as clergy or family members should a detainee refuse treatment.
12. A detainee who refuses examination or treatment may be segregated from the general population when such segregation is determined medically necessary by the CMA. Segregation shall only be for medical reasons that are documented in the medical record, and may not be used for punitive purposes. Such segregation shall only occur after a determination by a component mental health professional has taken place that shows the

segregation shall not adversely affect the detainee's mental health.

13. In the event of a hunger strike, see standard "4.2 Hunger Strikes." Standard "4.7 Terminal Illness, Advance Directives and Death" provides details regarding living wills and advance directives, organ donations and do not resuscitate (DNR) orders.

Findings: Documentation of written informed consent relevant to the provision mental health services was present in the health care records reviewed.

Refer to the report by (b)(6)

4.3, V.BB. Medical Records

4.3, V.BB.1. Health Record File

"The HSA shall maintain a complete health record on each detainee that is:

a. Organized uniformly in accordance with appropriate accrediting body standards;
b. Available to all practitioners and used by them for health care documentation; and
c. Properly maintained and safeguarded in a securely locked area within the medical unit."

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.BB.2. Confidentiality and Release of Medical Records

"All medical providers, as well as detention officers and staff shall protect the privacy of detainees' medical information in accordance with established guidelines and applicable laws. These protections apply, not only to records maintained on paper, but also to electronic records where they are used. Staff training must emphasize the need for confidentiality and procedures must be in place to limit access to health records to only authorized individuals and only when necessary.

Information about a detainee's health status and a detainee's health record is confidential, and the active medical record shall be maintained separately from other detention records and be accessible in accordance with applicable laws and regulations.

The HSA shall provide the facility administrator and designated staff information that is necessary as follows:

a. to preserve the health and safety of the detainee, other detainees, staff or any other person;
b. for administrative and detention decisions such as housing, voluntary work assignments, security and transport; or
c. for management purposes such as audits and inspections.

When information is covered by the Privacy Act, specific legal restrictions govern the release of medical information or records.

Detainees who indicate they wish to obtain copies of their medical records shall be provided with the appropriate request form. ICE/ERO, or the facility administrator, shall provide limited-English proficient detainees and detainees who are hearing impaired with interpretation or translation

services or other assistance as needed to make the written request, and shall assist in transmitting the request to the facility HSA.

Upon his/her request, while in detention, a detainee or his/her designated representative shall receive information from their medical records. Copies of health records shall be released by the HSA directly to a detainee or their designee, at no cost to the detainee, within a reasonable timeframe after receipt by the HSA of a written authorization from the detainee.

A written request may serve as authorization for the release of health information, as long as it includes the following information, and meets any other requirements of the HSA:

a. address of the facility to release the information;
b. name of the individual or institution to receive the information;
c. detainee's full name, A-number (or other facility identification number), date of birth and nationality;
d. specific information to be released with inclusive dates of treatment; and
e. detainee's signature and date.

Following the release of health information, the written authorization shall be retained in the health record.

Detainees are to be informed that if they are released or removed from custody prior to laboratory results being evaluated, the results shall be made available by contacting the detention facility and providing a release of information consent."

Findings: Refer to report by (b)(6)

4.3, V.BB.3. Inactive Health Record Files
"Inactive health record files shall be retained as permanent records in compliance with locally established procedures and the legal requirements of the jurisdiction."

Findings: Refer to report by (b)(6)

4.3, V.BB.4. Transfer and Release of Detainees
"ICE/ERO and the HSA shall be notified when detainees are to be transferred or released. Detainees shall be transferred, released or removed, with proper medication to ensure continuity of care throughout the transfer and subsequent intake process, release or removal (see "W. Continuity of Care," above). Those detainees who are currently placed in a medical hold status must be evaluated and cleared by a licensed independent practitioner.

(LIP) prior to transfer or removal. In addition, the CMA or designee must inform the facility administrator in writing if the detainee's medical or psychiatric condition requires a medical escort during removal or transfer.

a. Notification of Medical/Psychiatric Alerts or Holds
Upon receiving notification that a detainee is to be transferred, appropriate medical staff at the

sending facility shall notify the facility administrator of any medical/psychiatric alerts or holds that have been assigned to the detainee, as reflected in the detainee's medical records. The facility administrator shall be responsible for providing notice to ICE/ERO of any medical alerts or holds placed on a detainee that is to be transferred.

b. Notification of Transfers, Releases and Removals The HSA shall be given advance notice by ICE/ERO prior to the release, transfer or removal of a detainee, so that medical staff may determine and provide for any medical needs associated with the transfer, release or removal.
c. Transfer of Medical Information
   1) When a detainee is transferred to another detention facility, the sending facility shall ensure that a Medical Transfer Summary accompanies the detainee, as required in "C. Responsibilities of the Health Care Provider at the Sending Facility" found in Standard 7.4 "Detainee Transfers.". Upon request of the receiving facility, the sending facility shall transmit a copy of the full medical record within 5 business days, and sooner than that if determined by the receiving facility to be a medically urgent matter.
   2) Upon removal or release from ICE custody, the detainee shall be provided medication, referrals to community-based providers as medically appropriate, and a detailed medical care summary. This summary should include instructions that the detainee can understand and health history that would be meaningful to future medical providers. The summary shall include, at a minimum, the following items:
      a) patient identification;
      b) tuberculosis (TB) screening results (including results date) and current TB status if TB disease is suspected or confirmed;
      c) current mental, dental, and physical health status, including all significant health issues, and highlighting any potential unstable issues or conditions which require urgent follow-up;
      d) current medications, with instructions for dose, frequency, etc., with specific instructions for medications that must be administered en route;
      e) any past hospitalizations or major surgical procedures;
      f) recent test results, as appropriate;
      g) known allergies;
      h) any pending medical or mental health evaluations, tests, procedures, or treatments for a serious medical condition scheduled for the detainee at the sending facility. In the case of patients with communicable disease and/or other serious medical needs, detainees being released from ICE custody are given a list of community resources, at a minimum;
      i) copies of any relevant documents as appropriate;
      j) printed instructions on how to obtain the complete medical record; and
      k) the name and contact information of the transferring medical official.

The IHSC Form 849 or equivalent, or the Medical Transfer Summary attached as Appendix 4.3.C, which mirrors IHSC Form 849, may be used by facilities to ensure compliance with these standards."

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.CC. Terminal Illness or Death of a Detainee
"Procedures to be followed in the event of a detainee's terminal illness or death are in standard "4.7 Terminal Illness, Advance Directives and Death." The standard also addresses detainee organ donations."

Findings: Refer to report by (b)(6)

4.3, V.DD. Medical Experimentation

Findings: Refer to report by (b)(6)

4.3, V.EE. Administration of the Medical Department
4.3, V.EE.1. Quarterly Administrative Meetings

Findings: Refer to report by (b)(6)

4.3, V.EE.2. Health Care Internal Review and Quality Assurance
The HSA shall implement a system of internal review and quality assurance. The system shall include:

a. participation in a multidisciplinary quality improvement committee;
b. collection, trending and analysis of data along with planning, interventions and reassessments;
c. evaluation of defined data;
d. analysis of the need for ongoing education and training;
e. on-site monitoring of health service outcomes on a regular basis through the following measures:
   1) chart reviews by the responsible physician or his/her designee, including investigation of complaints and quality of health records;
   2) review of practices for prescribing and administering medication;
   3) systematic investigation of complaints and grievances;
   4) monitoring of corrective action plans;
   5) reviewing all deaths, suicide attempts and illness outbreaks;
   6) developing and implementing corrective- action plans to address and resolve identified problems and concerns;
   7) reevaluating problems or concerns, to determine whether the corrective measures have achieved and sustained the desired results;
   8) incorporating findings of internal review activities into the organization's educational and training activities;
   9) maintaining appropriate records of internal review activities; and
   10) ensuring records of internal review activities comply with legal requirements on confidentiality of records.

Findings: See findings under Standard 4.3 Medical Care, II.

4.3, V.EE.3. Peer Review
"The HSA shall implement an intra-organizational, external peer review program for all

independently licensed medical professionals. Reviews shall be conducted at least annually."

Findings: Peer review, which is guided by a corporate policy and procedure, occurs yearly via chart reviews.

4.3, V.FF. Examinations by Independent Medical Service Providers and Experts
"On occasion, medical and/or mental health examinations by a practitioner or expert not associated with ICE or the facility may provide a detainee with information useful in administrative proceedings. If a detainee seeks an independent medical or mental health examination, the detainee or his/her legal representative shall submit to the Field Office Director a written request that details the reasons for such an examination. Ordinarily, the Field Office Director shall approve the request for independent examination, as long as such examination shall not present an unreasonable security risk. Requests for independent examinations shall be responded to as quickly as practicable. If a request is denied, the Field Office Director shall advise the requester in writing of the rationale.

Neither ICE/ERO nor the facility shall assume any costs of the examination, which will be at the detainee's expense. The facility shall provide a location for the examination but no medical equipment or supplies and the examination must be arranged and conducted in a manner consistent with maintaining the security and good order of the facility."

Findings: A local practice is consistent with this standard.

4.3, V.GG. Tele-Health Systems
***The facility, when equipped with appropriate technology and adequate space, shall provide for the use of services of the ICE Tele-Health Systems, inclusive of tele-radiology (ITSP), tele-psychiatry and tele-medicine.*

1. The cost of the equipment, equipment maintenance, staff training and credentialing (as outlined in the contract), arrangements for x-ray interpretation and administration by a credentialed radiologist; and data transmission to and from the detention facility, shall be provided by the facility and charged directly to ICE.
2. The facility administrator shall coordinate with the ITSP to ensure adequate space is provided for the equipment, connectivity is available, and electrical services are installed.
3. Immediate 24-hour access, seven days a week, to equipment for service and maintenance by ITSP technicians shall be granted.
4. A qualified tele-health coordinator shall be appointed and available for training by the ITSP. Qualified, licensed and credentialed medical staff shall be available to provide tele-health services as guided by state and federal requirements and restrictions.

Findings: See findings under Standard 4.3 Medical Care, II.

Findings and Recommendations Under PBNDS 2011 4.3, Medical Forms:

- Appendix 4.3.A: Intake Screening
- Appendix 4.3.B: Physical Examination/Health Appraisal
- Appendix 4.3.C: Medical Transfer Summary

Findings: Refer to report by (b)(6)

Findings and Recommendations Under PBNDS 2011 Standard 4.4, Medical Care (Women)

Findings: Refer to report by (b)(6)

4.4, B.2. Initial Health Assessment

"If the initial medical intake screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. Consistent with Standard "4.3 Medical Care," when a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment, and when a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral.

If the initial medical intake screening indicates the possibility of pregnancy, referral shall be initiated and the detainee shall receive a health assessment as soon as appropriate or within two working days.

If the initial medical intake screening indicates any history of domestic abuse or violence, the detainee shall be referred for and receive a mental health evaluation by a qualified mental health provider within 72 hours, or sooner if appropriate, consistent with Standard "4.3 Medical Care." medical encounter involves a physical examination."

Findings: See findings under Standard 4.3 Medical Care, II.. Refer to report by (b)(6) (b)(6)

4.4, V.F. Mental Health Services

"In addition to mental health services offered to all detainees, mental health assessments shall be offered to any detainee who has given birth, miscarried or terminated a pregnancy in the past 45 days."

Findings: Refer to report by (b)(6)

Findings and Recommendations Under PBNDS 2011 Standard 4.5, Personal Hygiene

Findings: Refer to report by (b)(6)

Findings and Recommendations Under PBNDS 2011 Standard 4.6, Significant Self-harm and Suicide Prevention and Intervention

Findings: See Appendix II.

Findings and Recommendations Under PBNDS 2011 Standard 4.7, Terminal Illness, Advance Directives and Death

Findings: Refer to report by (b)(6)

Appendix II

Suicide Prevention

Findings and Recommendations Under PBNDS 2011 Standard 4.6, Significant Self-harm and Suicide Prevention and Intervention

4.6, V. Expected Practices
"Each detention facility shall have a written suicide prevention and intervention program, including a multidisciplinary suicide prevention committee, that shall be reviewed and approved by the clinical medical authority (CMA), approved and signed by the health services administrator (HSA) and facility administrator, and reviewed annually.

The multidisciplinary suicide prevention committee shall, at a minimum, comprise representatives from custody, mental health, and medical staff. The committee shall meet on at least a quarterly basis to provide input regarding all aspects of the facility's suicide prevention and intervention program, including suicide prevention policies and staff training. The committee shall convene following any suicide attempt to review and, if necessary, assist in the implementation of corrective actions.

At a minimum, the suicide prevention and intervention program shall include procedures to address suicidal detainees. Key components of this program must include the following:

1. staff training;
2. identification;
3. referral;
4. evaluation;
5. treatment;
6. housing;
7. monitoring;
8. communication;
9. intervention;
10. notification and reporting;
11. review; and
12. debriefing."

Findings: Policy #907 and 907A (Suicide Prevention and Intervention) were reviewed, which generally address all the elements of the above standard. However, the following issues need to be addressed in Policy #907 and 907A:

1. It does not appear that the institution's suicide prevention program monitors the guidelines for training, identification, referral, assessment, and intervention outlined in the policy.
2. A suicide risk assessment (SRA) is required as part of the process for placing an detainee on suicide watch status. However, a SRA is not required prior to changing and/or discontinuing a detainee suicide watch status.

3. The Policy is too vague regarding either a formalized treatment plan or safety plan being developed for detainees placed on suicide watch status.
4. Attachment 1 (suicide watch log and notes) appears to indicate that the default property does not include a suicide blanket, suicide mattress, suicide pillow or book.
5. Follow-up assessment following discharge from suicide watch is to occur "within seven days from the time of discharge or sooner as clinically indicated or required by the client," which is not consistent with the 72-hour follow-up required by PBNDS 2011 Standard 4.6, V.F.4, Post-Discharge from Suicide Watch provision, referenced later in this report.
6. Level 1 continuous observation status allows for the assigned staff member to monitor up to three detainees who are on constant watch. This is not consistent with PBNDS 2011 Standard 4.6, V.F., Housing and Monitoring, described later in this appendix, which requires one-to-one when a detainee is placed on continuous observation.
7. When a detainee is placed on Level 1 continuous observation, the policy requires that all regular clothing be removed from the detainee, including any undergarments. This is not consistent with PBNDS 2011 Standard 4.6, V.F.2, described later in this appendix, which requires that a determination is made on a case by case basis.
8. When a detainee is placed on Level 1 continuous observation, the Policy prohibits the detainee from receiving any property. This is not consistent with Standard 4.6, V.F.1, described later in this appendix, which requires that deprivations and restrictions placed on suicidal detainees must be kept at a minimum.
9. Level 2 observation status allows for observation to occur on a staggered 15-minute basis if the detainee is placed in a suicide resistant cell. However, this is not consistent with Standard 4.6, V.F., described later in this appendix, which requires constant observation whenever a detainee is placed in a special isolation room.

An additional policy was reviewed, 16.1.11-AUR, Suicide Recognition and Prevention. This policy indicates that staff should have detainees sign a "No Harm Agreement." This is neither consistent with PBNDS 2011 Standard 4.6, A, Staff Training nor DCDF policies 907 and 907A.

An audit closeout report (apparently related to a June 2018 corporate audit) identified significant issues relevant to implementation of the suicide prevention policy that included the following:

1. Compliance issues with correctional officer observations.
2. Compliance issues with clinical documentation.
3. Suicide alert notifications not being sent to the appropriate chain of command.
4. Lack of a local operating policy addressing notifications specific to potential, attempted or completed suicides.
5. Lack of participation of medical staff in the suicide prevention team meetings.

6. Mock suicide emergency drills not being signed off with all participants.
7. Lack of compliance with required suicide training.

Review of records of a small sample of detainees who had been on suicide watch indicated that follow-up plans were not implemented.

Recommendations: (Priority) DCDF's Suicide Intervention and Prevention Policy (#907 and 907A) and an additional policy, 16.1.11-AUR, Suicide Recognition and Prevention, were found to be not compliant with the requirements of PBNDS 2011 Standard 4.6 in several instances. CRCL recommends that DCDF revise their suicide prevention policies to be compliant with Standard 4.6, including:

1) Revise Policy #907 and 907A to include the specific requirements related to treatment plans that are in Standard 4.6, V.E.
2) Revise Attachment 1 of the Policy #907 and 907A (Suicide Watch Log and Notes) to indicate that the default property includes a suicide blanket, suicide mattress, suicide pillow, or book; and revise Policy #907 and 907A to allow level one suicide watch detainees to receive property as required by Standard 4.6, V.F.1.
3) Revise Policy #907 and 907A to require follow-up assessments within 72 hours as opposed to seven days to be compliant with Standard 4.6, V.F.4.
4) Revise Policy #907 and 907A to require one-to-one monitoring when a detainee is placed on constant watch in accordance with Standard 4.6, V.F. The Policy currently allows for a staff member to monitor up to three detainees who are on constant watch which is not compliant.
5) Revise Policy #907 and 907A to ensure that the provision of suicide smocks and the provision of regular clothing, including undergarments, is made on a case-by-case basis as required by Standard 4.6, V.F.2.
6) Revise Policy #907 and 907 to prohibit level 2 observation status detainees (staggered 15 minute checks) from being placed in an isolation cell as this is prohibited by Standard 4.6, V.F.
7) Revise Policy #16.1.11-AUR, Suicide Recognition and Prevention to prohibit the use of "no harm contracts" which are prohibited under Standard 4.6, V.A.

In addition, following a review of the June 2018 corporate audit, CRCL recommends that DCDF rectify the problems found with the suicide prevention program that were identified during that audit.

CRCL also recommends that DCDF ensures that the facility's suicide prevention program monitors the guidelines in Policy #907 and 907A for training, identification, referral, assessment, and intervention, and that the facility require a suicide risk assessment prior to changing and/or discharging a detainee suicide

watch status, as opposed to only requiring an SRA when a detainee is placed on suicide watch status.

4.6, V.A, Staff Training
"All facility staff members who interact with and/or are responsible for detainees shall receive comprehensive suicide prevention training, during orientation and at least annually. Initial suicide prevention training for all staff responsible for supervising detainees should consist of a minimum of eight hours of instruction.

Subsequent annual suicide prevention training should consist of a minimum of two hours of refresher instruction.

All of the following interests should be incorporated into the required suicide prevention training:

1. Environmental concerns: why the environments of detention facilities are conducive to suicidal behavior.
2. First Aid training: standard first aid training, cardiopulmonary resuscitation (CPR) training and training in the use of emergency equipment (that may be located in each housing area of the detention facility).
3. Liability: liability issues associated with detainee suicide.
4. Recognizing verbal and behavioral cues that indicate potential suicide.
5. Demographic, cultural and precipitating factors of suicidal behavior.
6. Responding to suicidal and depressed detainees.
7. Effective communication between correctional and health care personnel.
8. Necessary referral procedures.
9. Constant observation and suicide-watch procedures.
10. Follow-up monitoring of detainees who have already attempted suicide.
11. Reporting and written documentation procedures.

Requesting that a detainee promise not to engage in suicidal behavior, also known as "contracting for safety," is not recognized or supported by experts, and is an ineffective method of suicide prevention. "Contracting for safety" provides no guarantee that the patient shall not attempt suicide, and may give staff a false sense of security. This practice is not to be relied on by staff."

Findings: The initial suicide prevention training offered to all staff consists of 2.5 hours. All staff reportedly have received this training.

Annual training consisted of 1.5 hours. All staff reportedly have received this training.

A mock emergency response drill occurs on both shifts every quarter. However, the recent corporate audit indicated that mock suicide emergency drills were not being signed off by all participants.

Policy #16.1.11-AUR, Suicide Recognition and Prevention indicates that staff should have detainees sign a "No Harm Agreement."

Recommendations: (**Priority**) Currently, DCDF offers to all staff 2.5 hours of initial suicide prevention training and 1.5 hours of annual training. CRCL recommends that DCDF increase the length of their initial and annual suicide prevention training to be consistent with the requirements of Standard 4.6, which requires eight hours of initial suicide prevention training and two hours refresher training annually. CRCL also recommends that DCDF update Policy #16.1.11-AUR to be consistent with the requirements under Standard 4.6, V.A and DCDF Policy #907 and 907A, which both prohibit "No Harm Agreements."

4.6, V.B.1, Initial Screening
"All detainees shall receive an initial mental health screening within 12 hours of admission by a qualified health care professional or health-trained correctional officer who has been specially trained, as required by "J. Medical and Mental Health Screening of New Arrivals" in Standard 4.3 "Medical Care". The results of the screening shall be documented on the approved intake screening form, which contains observation and interview questions related to the potential for significant self-harm/suicide.

At the time of screening, staff should also assess relevant available documentation as to whether the detainee has been a suicide risk in the past, including during any prior periods of detention or incarceration."

Findings: See findings under Standard 4.3. Medical Care. The screening is occurring.

4.6, V.B.2, Ongoing Identification
"Detainees also may be identified as being at risk for significant self-harm/suicide at any time while in ICE custody. Staff must therefore remain vigilant in recognizing and appropriately reporting when a risk is identified. This identification may result from a self-referral or through daily observation and/or interaction with medical staff, contract security staff or an ICE officer.

Qualified, on-call clinical medical staff shall be available 24 hours per day for immediate consultation."

Findings: Standard 4.6, V.B.2 is consistent with the relevant policy and procedure specific to suicide prevention.

4.6, V.B.3, Significant Self-Harm/Suicidal Detainee
"If medical staff determines that a detainee is at imminent risk of bodily injury or death, medical

staff may make a recommendation to hospitalize the detainee for purposes of his/her evaluation and/or treatment. If the detainee is mentally incompetent, or is mentally competent and refuses, it may be necessary to petition the appropriate federal court to intervene against the detainee's refusal for purposes of his/her hospitalization and treatment. In such cases, the local ICE Office of Chief Counsel shall be consulted regarding appropriate further action."

Findings: Standard 4.6, V.B.3 is consistent with the relevant policy and procedure specific to psychiatric hospitalization.

4.6, V.C. Referral
"Detainees who are identified as being "at risk" for significant self-harm or suicide shall immediately be referred to the mental health provider for an evaluation, which shall take place within 24 hours of the identification. Until this evaluation takes place, security staff shall place the detainee in a secure environment on a constant one-to-one visual observation."

Findings: Standard 4.6, V.C. is consistent with the relevant policy and procedure specific to suicide prevention.

Recommendations: A QI process should assess compliance with the relevant provision of this policy.

4.6, V.D. Evaluation
"This evaluation shall be conducted by a qualified mental health professional which will determine the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility. This evaluation shall be documented in the medical record and must include the following information:

1. relevant history;
2. environmental factors;
3. lethality of suicide plan;
4. psychological factors;
5. diagnoses;
6. a determination of seriousness of suicide risk;
7. level of supervision needed;
8. referral/transfer for inpatient care (if needed);
9. instructions to medical staff for care; and
10. a treatment plan, including reassessment time frames.

Detainees placed on suicide watch shall be re evaluated by appropriately trained and qualified medical staff on a daily basis. The re-evaluation must be documented in the detainee's medical record.

Only the mental health professional, CMA, or designee may terminate a suicide watch after a current suicide risk assessment is completed. A detainee may not be returned to the general population until this assessment has been completed."

Findings: Standard 4.6, V.D. is consistent with the relevant policy and procedure specific to suicide prevention.

A review of a small sample of detainees' health care records, who appeared to be suicidal, demonstrated that appropriate suicide risk assessments had been completed.

4.6, V.E. Treatment
"Based on the evaluation, as stipulated above, a mental health provider or other appropriately trained medical personnel shall develop a treatment plan.

This plan must be documented and placed in the detainee's medical record. The treatment plan shall address the environmental, historical and psychological factors that contribute to the detainee's suicidal ideation. The treatment plan shall include:

1. strategies and interventions to be followed by the staff and detainee if suicidal ideation reoccurs;
2. strategies for the detainee's improved functioning; and
3. regular follow-up appointments based on the level of acuity."

Findings: As previously referenced, DCDF's suicide prevention policy is too vague regarding developing either a formalized treatment plan or safety plan for detainees placed on suicide watch status.

Recommendations: (Priority) Given the vagueness in DCDF's Policy #907 and 907A regarding treatment plans, CRCL recommends that DCDF revise Policy #907 and 907A to more clearly require a treatment plan in the context of the detainee's current clinical condition that addresses the referenced strategies from Standard 4.6, V.E. CRCL also recommends that DCDF begin implementing treatment plans for all detainees on suicide watch.

4.6, V.F. Housing and Monitoring
"A suicidal detainee requires close supervision in a setting that minimizes opportunities for self- harm. If a staff member identifies someone who is at risk of significant self-harm or suicide, the detainee must be placed on suicide precautions and immediately referred to a qualified mental health professional.

The qualified mental health professional may place the detainee in a special isolation room designed for evaluation and treatment with continuous monitoring that must be documented every 15 minutes or more frequently if necessary. All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every 8 hours conducted by clinical staff, and daily mental health treatment by a qualified clinician. The isolation room must be suicide resistant, which requires that it be free of objects and structural elements that could facilitate a suicide attempt. Security staff shall ensure that the

room is inspected prior to the detainee's placement so that there are no objects that pose a threat to the detainee's safety.

If the qualified mental health professional determines that the detainee requires a special isolation room but there is either no space in the medical housing unit or a medical housing unit does not exist, the detainee may, as a last resort, be temporarily placed in an administrative segregation cell in a Special Management Unit, provided space has been approved for this purpose by the medical staff and such space allows for constant and unobstructed observation. The facility administrator shall immediately notify ICE of such placement and indicate what level of monitoring the facility is providing. The facility administrator shall also work with ICE and the medical authority to identify alternative placements, including transfer of the detainee to a facility that can provide appropriate housing.

Suicidal detainees who are temporarily placed in a Special Management Unit shall have access to all programs and services, including recreation, visitation, telephones, counsel, and other services available to the general population, to the maximum extent possible. The facility shall ensure that the decision to place a suicidal detainee in an administrative segregation cell in Special Management Unit is not punitive in nature, and, as required by "A. Placement in Administrative Segregation" in Standard 2.12 "Special Management Units", detainees in administrative segregation shall not be commingled with detainees in disciplinary segregation.

Detainees on suicide precautions who have not been placed in an isolated confinement setting by the qualified mental health professional will receive documented close observation at staggered intervals not to exceed 15 minutes (e.g. 5, 10, 7 minutes), checks at least every 8 hours by clinical staff, and daily mental health treatment by a qualified clinician."

> **Findings:** Level 1 continuous observation status (DCDF Policy #907 and 907A, Suicide Prevention and Intervention) allows for the assigned staff member to monitor up to three detainees who are on constant watch. However, this is not consistent with Standard 4.6, V.F, which requires one-to-one when a detainee is placed on continuous observation. Level 2 observation status (see DCDF Policy #907 and 907A, Suicide Prevention and Intervention) allows for observation to occur on a staggered 15-minute basis if the detainee is placed in a suicide resistant cell. However, this is not consistent with this provision, which requires constant observation whenever a detainee is placed in a special isolation room.
>
> See Standard 4.3, Medical Care.
>
> While onsite, it was observed that at least one of the two cells designated as suicide resistant contained a bed designed for using four point restraints. The structure of the bed, which includes four areas at the bottom to attach restraints to, is not suicide resistant.
>
> Suicidal detainees who are temporarily placed in a Special Management Unit do not have

access to all programs and services, including recreation, visitation, telephones, counsel, and other services available to the general population due to the conditions of confinement in the SMU.

Recommendations: (Priority) The DCDF Policy #907 and 907A, Suicide Prevention and Intervention, allows for the assigned staff member to monitor up to three detainees who are on Level 1 constant watch. However, this is not consistent with Standard 4.6, V.F, which requires one-to-one when a detainee is placed on continuous observation. Additionally, under Policy #907 and 907A, Level 2 observation status allows for observation to occur on a staggered 15-minute basis if the detainee is placed in a suicide resistant cell. However, this is not consistent with this provision, which requires constant observation whenever a detainee is placed in a special isolation room. Therefore, CRCL recommends DCDF revise its policies and practice to ensure that monitoring of Level 1 and Level 2 suicide statuses is conducted according to the standard. CRCL also recommends that DCDF ensure that if suicidal detainees are temporarily placed in the SMU, they have access to all programs and services available to the general population, which does not appear to be occurring.

4.6, V.F.1. No Excessive Deprivations

"Deprivations and restrictions placed on suicidal detainees must be kept at a minimum.

Suicidal detainees may be discouraged from expressing their intentions if the consequences of reporting those intentions are unpleasant or understood to result in punitive treatment or punishment. Placing suicidal detainees in conditions of confinement that are worse than those experienced by the general population detainees can result in the detainee not discussing his or her suicidal intentions and falsely showing an appearance of a swift recovery."

Findings: See Standard 4.6, V (Expected Practices) with specific reference to default property.

When a detainee is placed on Level 1 continuous observation, Policy #907 prohibits the detainee from receiving any property. This is not consistent with V.F.1, which requires that deprivations and restrictions placed on suicidal detainees must be kept at a minimum.

Recommendations: In accordance with the recommendation under 4.6, V., revise Attachment 1 of the Policy #907 and 907A to indicate that the default property includes a suicide blanket, suicide mattress, suicide pillow, or book; revise Policy #907 and 907A to allow level one suicide watch detainees to receive property as required by Standard 4.6, V.F.1.

4.6, V.F.2. Clothing, Hygiene, and Privacy

"The qualified mental health professional shall assess the detainee to determine whether a

suicide smock is necessary. The facility may allow suicidal detainees under constant one-to-one monitoring to wear the standard issue clothing, minus any shoe laces, belts, or other accessories that could be used by a detainee to commit suicide or self-harm. Detainees should be provided suicide smocks to wear only when clinically indicated. Such special clothing must provide the detainee with sufficient warmth and modesty. A decision whether to provide underwear to detainees in suicide smocks shall be made by the clinical medical authority. Under no circumstance shall detainees be held without clothing.

Suicidal detainees shall be allowed to shower, perform bodily functions, and change clothing with as much privacy as possible under the continuous observation of staff, and without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances.

Although staff of the opposite gender can be assigned to suicide watch, including constant observation, the facility must have procedures in place that enable a detainee on suicide watch to avoid exposing himself or herself to nonmedical staff of the opposite gender. This may be accomplished, for example, by substituting medical staff or same gender security staff to observe the periods of time when a detainee is showering, performing bodily functions, or changing clothes. It may also be accomplished by providing a shower with a partial curtain or other privacy shields. The privacy standards apply whether the viewing occurs in a cell or elsewhere.

However, any privacy accommodations must be implemented in a way that does not pose a safety risk for the individual on suicide watch. Safety is paramount when conducting a suicide watch, and if an immediate safety concern or detainee conduct makes it impractical to provide same gender coverage during a period in which the inmate is undressed, the detainee should continue to be observed, and any such incident should be documented."

Findings: See Standard 4.6, V (Expected Practices). Policy #907 and 907A, Suicide Prevention and Intervention does not appear to permit suicidal detainees under constant one-to-one monitoring to wear the standard issue clothing and/or undergarments, minus any shoe laces, belts, or other accessories that could be used by a detainee to commit suicide or self-harm.

Recommendations: (Priority) DCDF's Policy #907 and 907A, Suicide Prevention and Intervention, does not appear to permit suicidal detainees under constant one-to-one monitoring to wear the standard issue clothing and/or undergarments, minus any shoe laces, belts, or other accessories that could be used by a detainee to commit suicide or self-harm, which is inconsistent the standard. CRCL recommends DCDF revise Policy #907 and 907A to be consistent with Standard 4.6, V.F.2, which requires that the facility make case-by-case determinations regarding whether a detainee on suicide precautions may wear the standard issue clothing and undergarments.

While onsite, it was observed that at least one of the two cells designated as suicide resistant contained a bed designed for using four point restraints. The structure of the bed,

which includes four areas at the bottom to attach restraints to, is not suicide resistant. This bed should only be used for detainees requiring the use of restraints or those on suicide watch/precautions that are under constant watch. CRCL recommends that DCDF ensure that all cells designated for suicide watch are suicide resistant in accordance with Standard 4.6, V.F.

4.6, V.F.3. Transfer to an Outside Facility
"Any detainee who is believed to be in need of seclusion, and/or restraint due to self-harming or suicidal behavior should be transferred to a psychiatric facility, if deemed medically necessary to appropriately treat the needs of the detainee."

Findings: See Standard 4.3 Medical Care.

4.6, V.F.4. Post-Discharge from Suicide Watch
"All detainees discharged from suicide observation should be re-assessed within 72 hours and then periodically at intervals prescribed by the treatment plan and consistent with the level of acuity by an appropriately trained and qualified medical staff member."

Findings: Follow-up assessment following discharge from suicide watch, by policy, is to occur "within seven days from the time of discharge or sooner clinically indicated or required by the client," which is not consistent with the 72-hour follow-up required by this provision.
Recommendations: In accordance with the recommendation under 4.6, V., revise Policy #907 and 907A to require follow-up assessments within 72 hours as opposed to seven days to be compliant with Standard 4.6, V.F.4.

4.6, V.G. Communication
4.6, V.G.1. Transfer of Detainee to ICE/ERO Custody
"Upon change of custody to ICE/ERO from federal, state or local custody, ICE/ERO staff or designee shall inquire into any known prior suicidal behaviors or actions, and, if behaviors or actions are identified, shall ensure detainee safety pending evaluation by a medical provider. The patient's "medical summary report" shall be transferred in accordance with standard "7.4 Detainee Transfers."

Findings: See Standard 4.3 Medical Care.

4.6, V.G.2. Continuity of Communication Regarding Detainees in ICE/ERO Custody
"Consistent communication shall be maintained between medical, mental health and correctional staff through a variety of mechanisms, in order to mitigate the risk for significant self-harm/suicide.

Such communication shall include the following:
a. intake forms;

b. daily briefings;
c. shift change briefings;
d. medical progress notes;
e. special needs forms;
f. medical/psychiatric alerts; and
g. transfer summaries."

Findings: See findings under Standard 4.6, Section V (Expected Practices).

4.6, V.H. Intervention
"Following a suicide attempt, security staff shall initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. Arriving medical personnel shall perform appropriate medical evaluation and intervention. The CMA or designee shall be notified when a detainee requires transfer to a local hospital or emergency room."

Findings: This provision was not assessed.

4.6, V.I. Notification and Reporting
"In the event of a suicide attempt, all appropriate ICE and ICE Health Service Corps (IHSC) officials shall be notified through the chain of command. The detainee's family, if known, and appropriate outside authorities shall also be immediately notified.

In the event that a detainee dies as a result of a suicide, the Notification and Reporting of Detainee Deaths Directive shall be followed.

In both cases, medical staff shall complete an Incident Report Form within 24 hours, and all staff who came into contact with the detainee before the suicide attempt or death shall submit a statement describing their knowledge of the detainee and the incident."

Findings: The previously referenced corporate audit found that suicide alert notifications were not being sent to the appropriate chain of command.

Recommendations: (**Priority**) CRCL recommends that DCDF ensure that suicide alert notifications are being sent to the appropriate chain of command given deficiencies found in this area through reviewing the June 2018 corporate audit.

4.6, V.J. Review
"Every death that results from a suicide shall be subject to a mortality review process and the Notification and Reporting of Detainee Deaths

Directive shall be followed. ICE shall make arrangements to complete a psychological reconstruction of the suicide. The mortality review process shall include review of: circumstances surrounding the incident, facility procedures relevant to the incident, training of

staff, medical/mental health reports, identification of possible precipitating factors, recommendations for changes in response to the incident (e.g. policy, training or re-training, counseling, reprimand or discipline of staff identified as failing to follow suicide prevention procedures, physical plant, medical or mental health services and operational procedures)."

Findings: See findings under Standard 4.6, Section V (Expected Practices).

4.6, V.K. Debriefing
"A critical incident debriefing following a suicide or serious suicide attempt shall be offered to all affected staff and detainees within 24 to 72 hours after the critical incident."

Findings: See findings under Standard 4.6, Section V (Expected Practices).

4.6, V.L. Detainee Mental Health Follow-up
"Following a suicide or serious suicide attempt, the facility should offer appropriate mental health services to other detainees who may have been affected."

Findings: See findings under Standard 4.6, Section V (Expected Practices).

Appendix III

Review of Records

1. Detainee 1 (b) (6))

The health care record of this detainee was reviewed after receiving information from her that she had not received any responses to her mental health self-referrals (i.e., kites).

The health care record did not contain any record of a self-referral for mental health purposes. However, she had a positive intake mental health screening during April 10, 2018, which indicated that she was referred to mental health for an evaluation. There was no documentation in the health care record that she ever received a mental health evaluation.

The above information was conveyed to the HSA.

Assessment: This detainee did not have adequate access to mental health services.

2. Detainee 2 ((b) (6))

The health care record of this detainee was reviewed because she complained of not receiving a response to a mental health kites. Health care records did not contain documentation of such a self-referral.

This detainee did submit a medical kite during August 2, 2018 due to acne and was seen two days later.

Assessment: I am unable to determine the accuracy of this detainee's complaint of inadequate access to mental health services based on review of the health care record.

3. Detainee 3 ((b) (6))

The health care record of this detainee was reviewed due to her report of an untimely response to a mental health self-referral. This detainee was apparently admitted on July 20, 2018 and referred to mental health services on July 30, 2018. As of August 14, 2018, she still has not yet been evaluated by mental health services.

Assessment: This detainee has not had timely access to mental health services.

4. Detainee 4 ((b) (6)

This 52-year-old woman, with a history of a major depressive disorder, was initially referred to mental health services following a positive intake mental health screen on July 14, 2017. She was timely seen by a psychiatrist, who started her on Zoloft on July 20, 2017. Beginning in

November 2017, she reported experiencing auditory hallucinations. She was seen on a regular basis by telepsychiatrists, who were appropriately monitoring her report of auditory hallucinations. She eventually agreed to a trial of Risperdal on July 12, 2018. The plan was for the telepsychiatrist to see her again in four weeks. This detainee was not being seen by an on-site mental health clinician.

Assessment: I am concerned about the plan to reassess this detainee in four weeks after starting on a new medication. In addition, it is unclear why she is not been followed by an on-site mental health clinician due to her psychotic symptoms.

5. Detainee 5 (b)(6)

The health care record of this Russian-born detainee was reviewed due to her complaints about an assessment by a psychiatrist that she thought was unusual. Her initial psychiatric examination was completed during August 8, 2018. The psychiatric report appeared to be appropriate.

6. Detainee 6 (b)(6)

This detainee complained of a delay in receiving mental health treatment. His health care record was subsequently reviewed.

A June 15, 2018 intake screening form was reviewed, which was positive from a mental health perspective. A referral to mental health was not initiated because he was already on the mental health caseload. This detainee has been receiving mental health treatment since at least 2017 at the DCDF. He has been seen on a regular basis by the telepsychiatrist, who was prescribing Zyprexa and Remeron. A July 6, 2018 progress note by (b)(6) was reviewed. This assessment was comprehensive in nature and resulted in a referral to the psychiatrists that was implemented in a timely manner.

Assessment: This detainee was receiving appropriate mental health treatment.

7. Detainee 7 (b)(6)

The health care record of this detainee was reviewed because he complained of needing a change in his medications due to insomnia. The most recent intake screening form was completed during April 25, 2017. He was referred to the psychiatrist due to bizarre or abnormal behavior.

Mental health follow-up on a regular basis by both a psychologist and a telepsychiatrist was documented in his health care record. On June 29, 2017, the psychiatrist indicated that psychotropic medications were neither necessary nor indicated at that time. However, he was noted to be receiving Vistaril in July 2017. Prazosin was added in October 2017. Olanzapine was added on November 3, 2017. His medications were changed to Risperidone and Mirtazapine on January 5, 2018.

Diagnosis was posttraumatic stress disorder, chronic.

On May 4, 2018 Zyprexa was discontinued. Abilify was started on May 30, 2018.

Assessment: Although I have significant concerns regarding the use of polypharmacy with this detainee, he clearly has received timely psychiatric treatment and aggressive attempts to treat his sleep disturbance that is apparently symptomatic of his PTSD.

8. Detainee 8 (b)(6)

This detainee' s health care record was reviewed related to his complaint of lack of response to mental health kites. A June 25, 2018 intake screening form indicated a history of past mental health treatment. A mental health referral was initiated at that time.

(b)(6) evaluated this detainee during June 30, 2018. His presentation was consistent with a depressive disorder, anxiety disorder and history of amphetamine abuse. He declined a referral to the psychiatrist. The plan was to see him again in one month.

Written consent for treatment was also obtained at that time.

(b)(6) again met with this detainee during August 1, 2018. He was noted to be feeling much better. He was educated about the kite system.

I did not find any documentation of kites being initiated by this detainee in his health care record.

Assessment: This detainee was receiving appropriate mental health services.

9. Detainee 9 (b)(6)

This detainee reported that he needed an increase in his medication and thought that the facility was being nonresponsive to this need.

A May 2, 2018 intake screening was positive from a mental health perspective, which resulted in a referral to mental health services. It was unclear why a mental health referral was made based on review of the of the mental health screening questions.

(b)(6) evaluated this detainee on May 3, 2018. His presentation was consistent with the diagnosis of an adjustment disorder with anxiety and depression. (b)(6) referred this detainee to a telepsychiatrist on May 30, 2018.

This detainee was evaluated by a telepsychiatrist on June 1, 2018. He complained of symptoms of depression and anxiety that have increased during the past month. Paxil was subsequently prescribed with the plan to see him again in 30 days. Buspirone was added to his medication by the telepsychiatrist on June 29, 2018.

Appropriate consent forms were present in his health care record.

Assessment: This detainee was receiving timely and appropriate mental health care.

10. Detainee 10 (b)(6)

The health care record of this detainee, who was receiving psychotropic medications, was reviewed as part of a targeted random sample.

A June 22, 2018 intake screening form was positive from a mental health perspective, which resulted in a referral to the psychiatrist.

This detainee was evaluated by (b)(6), MSW, LCSW on June 29, 2018. His presentation was consistent with PTSD. His appointment with the psychiatrist was noted.

(b)(6) prescribed Remeron to this detainee on July 7, 2018. Appropriate written consent was obtained at that time. The plan was to see him again and 90 days.

Assessment: This detainee initially received timely mental health treatment. The scheduled 90-day follow-up after starting a new medication was not timely.

11. Detainee 11 (b)(6)

The health care record of this 19-year-old male detainee was reviewed because he was identified as having been on suicide watch during his current detention. The June 14, 2018 mental health intake screening was negative from a mental health perspective.

A July 5, 2018 initial suicide risk assessment form was reviewed. He presented with history of depression and anxiety. Impulsive and acting out behavior was noted while he was in the RHU. He was threatening to bang his head. He reported to the evaluating psychologist that he was just angry because he thought he was getting out of the RHU and did not. He denied suicidal thinking or self-harming ideation. There was a history of inpatient psychiatric hospitalization at the Colorado Mental Health Institute at Pueblo. The assessment was that he did not need to be on suicide alert at that time. Follow-up was planned for one month.

A July 5, 2018 PREA mental health incident report was reviewed. There was a history of being charged with sexual assault in the past but charges were dropped around 2017.

A July 5, 2018 mental health initial segregation evaluation report was reviewed. There was a history of a suicide attempt via hanging during 2016. He had a recent altercation in general population. This diagnosis was anxiety and depressive disorders unspecified and polysubstance dependence.

(b)(6) provided a comprehensive assessment in his typed July 5, 2018 progress

note. This detainee, who had been living in the United States since the age of two, was facing deportation related to his apparent criminal history.
An August 8, 2018 progress note indicated that this detainee refused his schedule follow-up appointment with Dr. (b) (6) . The plan was to see this detainee upon request.

Assessment: Related to this detainee's initial presentation, a cell front follow-up would have been indicated following his refusal.

12. Detainee 12 (b)(6)

The health care record of this 22-year-old man, who was on the mental health caseload and housed in the SHU, was reviewed. His March 9, 2018 intake mental health screening was negative.

A March 15, 2018 initial mental health evaluation indicated a history of being seen by a psychologist in 2016 possibly due to ADHD. Based on review of the mental health evaluation form, it was unclear why this detainee was being evaluated by (b)(6) He was feeling scared, sad and depressed about his current incarceration. He was subsequently referred to the psychiatrist apparently due to these symptoms in addition to a sleep disturbance. His presentation was consistent with the diagnosis of adjustment disorder with anxiety and depression and a history of ADHD. The plan was to see him for two weeks for counseling.

There was no documentation that subsequent counseling sessions occurred. There was no documentation that he was ever evaluated by the psychiatrist.

A May 9, 2018 initial segregation evaluation form was reviewed that was consistent with the March 15, 2018 assessment. The plan was to follow-up in 30 days while in segregation housing.

An urgent kite submitted by this detainee, dated June 6, 2018, described a sleep disturbance and experiencing "unbelievable amount of stress… I am losing my hair I can't stop thinking… ." The June 6, 2018 response indicated that appointment "is made with M.D.… ."

As previously referenced, there was no documentation that this detainee has been seen by a psychiatrist during his current incarceration.

I found the documentation that 30-day SHU reviews occurred.

Assessment: This detainee has not received planned follow-up by psychologist or psychiatrist. His access to mental health care was inadequate.

13. Detainee 13 (b)(6)

The health care record of this 24-year-old man, who was in the SHU and on the mental health caseload, was reviewed. His June 28, 2018 intake mental health screening was positive and he

was subsequently referred to mental health.

A June 28, 2018 PREA risk assessment indicated that this detainee had been the victim of sexual assault in the past. He subsequently refused his appointment with the psychologist. The plan was to see him again in one week to be evaluated.

On July 18, 2018 he indicated to the psychologist that he did not feel safe in general population and preferred being in the RHU. A PREA investigation had been initiated due to his allegations that his roommates were making inappropriate sexual comments and gestures towards him. There was a history of a prior inpatient psychiatric treatment as well as a suicide attempt.

His presentation was consistent with major depressive disorder, recurrent, moderate, posttraumatic stress disorder, neurocognitive disorder unspecified and gender dysphoria, unspecified. The plan was to see him again in a week for follow-up and referral to the psychiatrist for medication assessment.

The Montréal cognitive assessment resulted in a total score of 23/30 with the normal range being greater than 26/30.

(b)(6) psychiatrically evaluated this detainee on July 24, 2018. A major depressive disorder, severe, recurrent was diagnosed. He was started on Zoloft with a planned psychiatric follow-up in 14 days.

A July 18, 2018 mental health initial segregation evaluation form was present in the chart.

The detainee refused follow-up with (b)(6) on July 20, 2018. The plan was to see him again in two weeks. He again refused to see (b)(6) on July 28, 2018. He was again scheduled for follow-up again in two weeks.

An August 13, 2018 detentions/segregation mental health 30 day review form was completed. However, there was no reference to his prior reported refusals. He was assessed to be functioning well with no further action being necessary although continued follow-up with mental health was planned.

Assessment: This detainee was receiving inadequate follow-up despite the plan to see him on a more regular basis. For example, the plan to be followed-up by psychiatrist two weeks after his initial assessment never occurred. Although (b)(6) made follow-up appointments, attempts were not made to see this detainee at the cell front following his reported refusals even though a neurocognitive disorder unspecified was considered in the differential diagnosis. The above is partially mitigated based on the August 13, 2018 detentions/segregation mental health 30 day review.

14. Detainee 14 (b)(6)

This 51-year-old man, who was reportedly on the mental health caseload and currently housed in SHU, had a negative mental health intake screening on July 20, 2018. His health care record was disorganized.

An August 13, 2018 detention/segregation mental health 30-day review form was reviewed. He was assessed to be functioning well with no further action necessary.

An August 13, 2018 mental health evaluation/MH 30-day RHU review written by (b)(6) Ph.D. was reviewed. His clinical presentation was consistent with no mental disorder.

Assessment: This detainee was not currently in need of mental health treatment.

15. Detainee 15 (b)(6)

This 49-year-old man, who reportedly was on the mental health caseload and currently housed in the SHU, had a positive intake mental health screening on July 11, 2018. A PREA mental health incident report, dated July 21, 2018 indicated that he was recently charged/accused of sexual assault.

(b)(6) evaluated this detainee on July 12, 2018. The clinical assessment was consistent with no diagnosis. This assessment was consistent with an August 13, 2018 30-day RHU review.

Assessment: Similar to other health care records reviewed of detainees reportedly on the mental health caseload, this detainee was not on the mental health caseload. This issue was indicative of the tracking problems experienced by the mental health staff.

16. Detainee 16 (b)(6)

The health care record of this 21-year-old man, who had a history of having been on suicide watch, was reviewed. His January 9, 2018 intake mental health screening was positive, which resulted in a referral to the psychiatrist.

(b)(6) Psy.D. evaluated this detainee on January 9, 2018 due to his request for sleep medications and history of anger and acting out behaviors. The mental health assessment was not completed due to lack of cooperation from the detainee.

On Monday, June 18, 2018 this detainee was placed on level 1 suicide watch. Property included a safety smock, 10 sheets of toilet paper at a time, no sharp/metal items and use of hygiene items under direct and constant supervision. He was not allowed any clothing, undergarments, or personal items.

(b)(6), Ph.D. changed the suicide alert to level 2 on June 20, 2018 following completion of an initial suicide risk assessment. It was unclear why the mental health evaluation occurred

two days following the initial placement on suicide watch.
Suicide watch log and notes were present in the chart, which were consistent with the relevant policy and procedure. However, even when on level 2, documentation frequently occurred every five minutes although other observations occurred exactly 15 minutes apart.

A June 21, 2018 mental health evaluation by (b)(6) indicated a diagnosis of adjustment disorder with anxiety and depression. His mental health watch/suicide alert-level 2 was discontinued with the plan for daily follow-up. He was cleared for housing in the RHU. The plan was to see him again in one week.

(b)(6) M.D. evaluated this detainee on June 22, 2018. No medications were indicated or at that time. A behavioral management plan was completed on June 22, 2018. Intervention included daily rounds by mental health staff each day staff members were on site and a seven day follow-up assessment related to discontinuation of the suicide alert status as well as weekly counseling sessions.

(b)(6) subsequently assessed this detainee on June 22, 23, 27, and 28, 2018 as part of the behavioral management plan. Although the plan was for follow-up on June 29, 2018, such follow-up did not occur. The next and last mental health progress note was dated July 27, 2018 by (b)(6) The plan was again to see him in one week as part of his behavior management plan.

Assessment: The initial psychiatric referral on January 2018 never occurred or was significantly delayed until June 2018. The behavioral management plan was only partially followed. This detainee did not receive adequate access to mental health care services.

17. Detainee 17 (b)(6)

The health care record of this 22-year-old man was reviewed because he had been identified as previously being on suicide watch status. His June 22, 2018 intake mental health screening was positive from a mental health perspective. The screening form did not indicate that he was referred to mental health.

An initial suicide risk assessment was completed by (b)(6) on July 7, 2018. He was assessed to not require suicide watch at that time. The plan was to follow-up in one week. He had been placed on suicide watch after making a statement that he would kill himself after being placed in the RHU. A July 7, 2018 mental health initial segregation evaluation indicated a diagnosis of PTSD.

(b)(6) evaluated this detainee on July 17, 2018. Remeron was prescribed with a planned follow-up in one month.

(b)(6) again assessed this detainee on July 21, 2018. He was to be seen again as part of his 30-day RHU follow-up, which occurred on August 2, 2018. The plan was to see him again in one

month.
I did not find suicide watch logs but it is possible that he was being constantly observed until his mental health assessment.

Assessment: It was unclear why the intake mental health screening did not result in a mental health assessment. The planned one week followed by (b)(6) was late by one week.

APPENDIX A

Non-Priority/Best Practices Recommendations

Denver Contract Detention Facility (DCDF)

Complaint Nos. 17-12-ICE-0463, 18-03-ICE-0036
18-06-ICE-0155, and 18-09-ICE-0352

Mental Health

1. The telepsychiatrists have not come onsite at DCDF, and the telepsychiatry coordinator spends much of her time trying to locate and scan records to the telepsychiatrists. CRCL recommends that DCDF revise their Policy #627-A (Telehealth) to require a telepsychiatrist to be on site at least once every six months. The Policy should also be revised to specify which health care records should be scanned to the telepsychiatrist prior to the appointment to avoid spending an extraordinary amount of time scanning records to the file that are not necessary. Furthermore, CRCL recommends that DCDF evaluate whether it has adequate telepsychiatry staffing since detainees are reportedly only scheduled for a 20-25 minute initial psychiatric examination; such assessments usually require 45-60 minutes.

2. The medical clinic area has two suicide resistant rooms that are used for suicide watch purposes and restraint for mental health purposes. DCDF should consider moving the beds in these units to prevent a detainee from standing on them and tampering with the sprinkler head.

Corrections

3. DCDF should consider revising the 14-day time frame to respond to detainee request to more effectively align with the ICE time frame of 72 hours to respond to detainee requests.

4. DCDF should provide additional training to their staff on providing adequate responses to detainee requests and grievances.

5. The Law Library Officer Post Order should be reviewed and revised to reflect the actual duties of the post.

6. Additional training should be provided to detention officers on the importance of reading post orders when assuming a post each day and signing the acknowledgement sheet.

7. Law Library Officers should not be pulled to work other DCDF posts during hours the law library is to be open except during emergencies.

8. Based on the June 2018 Corporate Audit Special Management Unit findings, DCDF should consider conducting a Special Management Unit staffing analysis to determine if existing

Special Management Unit staffing is sufficient to perform required duties and responsibilities.

9. DCDF should develop policies, procedures, and practices to address Use of Force allegations. The existing DCDF Use of Force policy does not address Use of Force allegations.

10. DCDF officials should review the Detention Handbook and address all contradictory information and sections that need additional information, specifically, the visits and personal hygiene sections.

11. All DCDF staff training should be recorded in the LMS software program.

CONDITIONS OF DETENTION EXPERT'S REPORT

ON

DENVER CONTRACT DETENTION FACILITY

Prepared by:

(b) (6)

Olive Branch, Mississippi

August 18, 2018

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DENVER CONTRACT DETENTION FACILITY

I. SUMMARY OF REVIEW

The United States Department of Homeland Security Office for Civil Rights and Civil Liberties (CRCL) received several complaints alleging United States Immigration and Customs Enforcement (ICE) violated the civil rights and civil liberties of detainees at the Denver Contract Detention Facility (DCDF) in Aurora, Colorado. The allegations raised were concerns regarding medical care, mental health care, and conditions of confinement. The complaints were:

- On September 26, 2017,[1] CRCL received correspondence from the American Civil Liberties Union American Immigration Council, American Immigration Lawyers Association, Center for Gender and Refugee Studies, Northwest Immigrant Rights Project, Refugee and Immigrant Center for Education and Legal Services and the Women's Refugee Commission on behalf of 10 women who were pregnant while detained by ICE. Specifically, one of the pregnant detainees referenced in the letter, Detainee #1, was being held at the DCDF. In the letter, Detainee #1 alleged she was six weeks pregnant and required to work one day a week. This, coupled with the fact she had complications with a previous pregnancy caused her great concern about the health of her unborn baby.
- On December 4, 2017,[2] CRCL received notification from ICE of the death of Detainee #2, an ICE detainee at DCDF from November 17, 2017 to December 2, 2017. According to ICE, on November 28, 2017, the DCDF on-site physician placed Detainee #2 on "level 1 suicide watch" requiring visual inspection at 5-minute intervals while Detainee #2 was in the medical isolation unit. This suicide watch was ordered after Detainee #2 had wrapped a bed sheet over his head and around his neck. The physician ordered that the suicide watch continue until Detainee #2 could be evaluated by mental health professionals at the facility. On December 2, 2017, DCDF contract staff and one nurse attempted to place Detainee #2 in a wheelchair for a scheduled on-site mental health appointment. Detainee #2 could not sit in the wheelchair and was laid back down on the mattress within the medical isolation/suicide watch cell. Just after 11:00 a.m. MST, Detainee #2 began vomiting and DCDF contract staff contacted emergency medical services (EMS). After he vomited, Detainee #2 was placed in a recovery position (on his side) and the vomit was taken out of his mouth. He was breathing and responsive to questions and statements when EMS arrived at 11:20 a.m. MST. Detainee #2 then stopped breathing while EMS was attending him. EMS began Cardiopulmonary Resuscitation (CPR) and transported Detainee #2 to the University of Colorado Medical

[1] CRCL Complaint No. 17-12-ICE-0463
[2] CRCL Complaint No. 18-03-ICE-0036

Center (UCMC) at 11:34 a.m. MST where he was later pronounced dead on December 2, 2017 at 12:02 p.m. MST.

- On March 23, 2018,[3] CRCL received email correspondence from Robert Lang, American Bar Association (ABA), on behalf of Detainee #3, an ICE detainee at DCDF. Detainee #3 alleged that he received inadequate medical care following a physical assault on March 7, 2018. Detainee #3 alleges he was unable to seek immediate medical attention because he had an asylum hearing. Upon evaluation by the attending doctor, Detainee #3 was reportedly told that he needed additional medical care but was only prescribed Tylenol and sleeping pills. Detainee indicated he had an x-ray appointment but did not know the date and was in desperate need of immediate medical help. On March 26, 2018, CRCL sent this complaint to ICE as a medical referral.
- On June 4, 2018,[4] the American Immigration Council (Council) and American Immigration Lawyers Association (AILA) submitted a complaint to ICE and CRCL on behalf of current and formerly detained individuals at the DCDF alleging dangerously inadequate medical and mental health care at the facility which threatened the health and well-being of affected detainees, as well as their ability to lawfully pursue immigration and asylum claims.
- On April 25, 2018,[5] the Department of Homeland Security, Office of Inspector General opened Case: C18-ICE-SEA-26820. Detainee #4 reported a Detention Officer from the DCDF wanted him to forcibly sign Detainee #4's deportation against his will. Detainee #4 claimed deportation was not an option since his life was threatened in his home country. In addition, Detainee #4 claimed the Detention Officer physically hurt his arm and gave him scratch marks.
- CRCL determined the DCDF operations areas of segregation, grievances, sexual assault and abuse prevention and intervention, the disciplinary system, law libraries and legal materials, telephone access and language access would also be reviewed because these areas potentially raise important civil rights and civil liberties issues.

To examine the allegations in the complaints and review DCDF operations' for the areas of segregation, grievances, sexual assault and abuse prevention and intervention, the disciplinary system, law libraries and legal materials, telephone access and language access, CRCL conducted an onsite investigation on August 14 – 16, 2018. The investigation reviewed DCDF's adherence to the Performance-Based National Detention Standards 2011 (PBNDS 2011) and U.S. ICE 11065.1 Directive: Review of the Use of Segregation for ICE Detainees, Issue and Effective Date September 4, 2013.

[3] CRCL Complaint No. 18-06-ICE-0155
[4] CRCL Complaint No. 18-09-ICE-0352
[5] CRCL Complaint No. 18-08-ICE-0301

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

II. EXPERT PROFESSIONAL INFORMATION

(b) (6)

III. Relevant Standards

a. ICE Detention Standards

The ICE PBNDS 2011 with the 2016 modifications currently apply to DCDF. The facility was covered by these standards during the relevant period to this investigation. I relied on PBNDS 2011 and DCDF policies and procedures when investigating the specific allegations and the conditions of confinement areas that potentially raise important civil rights and civil liberties issues.

b. Additional Relevant Standards / Professional Best Practices

For issues not specifically addressed by PBNDS, recommendations were made based on my correctional experience, best correctional practices, and recognized correctional standards including those published by the ACA.

IV. Facility Background and Population Demographics

The DCDF is privately owned and operated by the GEO Group, Inc. (GEO) of Boca Raton, Florida. The facility holds ICE detainees and the United States Marshall Service inmates. My review focused solely on the conditions of detention of ICE detainees. On August 14, 2018, the total ICE population at DCDF was 823 detainees including 106 females.

DCDF was accredited by the National Commission of Correctional Health Care (NCCHC) in August 2015. Facility officials reported the next NCCHC survey is scheduled during the next month. DCDF is accredited by the American Correctional Association with the last re-accreditation in January 2017. The ICE Prison Rape Elimination Act (PREA) Audit is scheduled for DCDF in September 2018.

Staffing for DCDF consists of:

Department	# of Positions
Executive Office	(b) (7)(E)
Business	
Maintenance	
Health Care	
Education/Programs	
Food Service	
Supervisory	
Detention Officers	
Transportation	
USMS	
Total Detentions Officers	**146.0**
Total Staff	**226.05**

DCDF houses ICE male detainees in (b) (7)(E) housing general population units and (b) (7)(E) (b) (7) bed Restrictive Housing Unit (RHU). The ICE females are housed in (b) (7)(E) general population units. One of the female housing units only has (b) cells and can be utilized for high custody or RHU female detainees. It was reported female high custody and RHU detainees are never held in the housing unit at the same time. The DCDF classification custodies for detainees are: low, medium-low, medium, medium-high and high.

V. Review Purpose and Methodology

The purpose of this review was to examine the specific allegations made in the complaints, and identify other areas of concern regarding the operation of the facility. Medical and Mental Health Experts examined the complaints related to medical and mental health care. My responsibility was to examine the complaints related to facility operations and corrections and additional areas of segregation, grievances, sexual assault and abuse prevention and intervention, the disciplinary system, law libraries and legal materials, telephone access and language access. The review was conducted by examining documents prior to and during the DCDF August 14 through 16, 2018 Site Visit. DCDF was toured and interviews were conducted with ICE and DCDF staff and detainees during the site visit. Detainees' names and alien numbers are omitted from this report and are listed in Appendix A.

DCDF staff were cooperative and provided requested assistance during the August 14, through 16, 2018 Site Visit. The assistance and cooperation of ICE staff was beneficial to conduct the investigation.

The following was performed to prepare for the DCDF August 14 through 16, 2018 Site Visit and compile my expert report:

- Reviewed the complaints received by CRCL;
- Reviewed the April 2016 ICE National Detainee Handbook
- Reviewed the ICE 2017 Denver Contract Detention Facility Annual Review
- Reviewed DCDF Detainee Grievances and Grievance Logs for 9.1.17 through 7.13.18
- Reviewed DCDF Special Management Unit (RHU) and Medical Observation Rosters for September 2017 through July 9, 2018
- Reviewed DCDF 2017 and 2018 UOF Reports
- Reviewed DCDF Alpha Roster with Classification and Detainee Housing Rosters for 7/17/18
- Reviewed the DCDF Building Floor Plan and Housing Classification Document
- Reviewed DCDF 2018 Staffing Analysis
- Reviewed Detainee #2 Death Summary
- Reviewed Detainee #3 Security File
- Reviewed PBNDS 2011 Standards for:
    - Detention Files
    - Staff – Detainee Communication
    - Sexual Abuse and Assault Prevention and Intervention
    - Law Libraries and Legal Material
    - Grievance System
    - Medical Care
    - Medical Care (Women)
    - Significant Self-Harm and Suicide Prevention and Intervention
    - Disability Identification, Assessment, and Accommodation
    - Use of Force and Restraints
    - Disciplinary System
    - Custody Classification System
    - Special Management Units
    - Voluntary Work Program
    - Telephone Access
    - Visitation
    - Personal Hygiene
    - Facility Security and Control
    - Emergency Plans
    - Searches of Detainees
    - Food Service

- Religious Practices
- Recreation

- Reviewed relevant ACA Detention Standards
- August 14 through 16, 2018 Expert Activities
  - Toured DCDF
  - Reviewed the Facility Detainee Activity Schedule
  - Interviewed Housing Detention Officers
  - Interviewed male and female detainees
  - Reviewed detainee housing rosters
  - Reviewed detainee files
  - Reviewed the DCDF Detainee Handbook
  - Inspected the Law Library
  - Interviewed the Program Coordinator/Grievance Officer and Law Library Officer
  - Interviewed detainees regarding the Law Library
  - Reviewed the DCDF Law Library Schedule
  - Reviewed the DCDF Law Library Detainee Sign Up List
  - Reviewed the DCDF Approved Volunteer List
  - Reviewed DCDF Detainee request to ICE staff
  - Reviewed DCDF Detainee electronic and paper requests to facility staff
  - Interviewed the DCDF PREA Coordinator and PREA Investigator
  - Interviewed the DCDF Associate Warden for Operations
  - Interviewed the DCDF Chief of Security
  - Interviewed the DCDF Administrative Captain
  - Interviewed the DCDF Compliance Officer
  - Inspected the Special Management Unit
  - Interviewed the DCDF 7/15/18 Day Shift Special Management Unit Officer
  - Interviewed the designated Intake/Classification Officer
  - Interviewed detainees in the Special Management Unit
  - Reviewed Special Management Unit Detainee Activity Records
  - Reviewed random DCDF Weekly RHU Review Committee Forms
  - Met and interviewed various ICE staff during the review
  - Reviewed Telephone Language Line Telephone Billing Records
  - Reviewed the June 2018 DCDF Corporate Audit
  - Reviewed the DCDF December 2017 to May 2018 DCDF Monthly Reports to ICE
  - Reviewed selected DCDF Detainee UOF Files and Videos
  - Reviewed DCDF UOF statistics
  - Reviewed DCDF PREA statistics
  - Reviewed DCDF PREA Certified Investigator Certificates
  - Reviewed selected DCDF PREA Investigations
  - Reviewed DCDF Electronic Tele-Staffing Roster (identifies the post each detention officer is trained to work)

- Reviewed DCDF Alpha Roster with Classification and Detainee Housing Rosters for 8/14/18
- Reviewed the DCDF ICE Custody Classification Worksheet Form
- Reviewed the DCDF Detainee Work Detail Application
- Reviewed the DCDF Food Service 2018 Cycle 6 Menu

- Reviewed DCDF Policies for:
  - Corporate Staff Misconduct Reporting Procedure
  - Corporate Staff Misconduct
  - Restricted Housing Unit for ICE
  - Use of Force
  - Detainee Disciplinary Hearing Board and Attachment A
  - Detainee Grievances
  - ICE Intake Procedures
  - ICE Classification Procedures
  - Detainee Handbook
  - Training Requirements
  - General Training Standards
  - Supplementary Training
  - Suicide Recognition and Prevention
  - DCDF Law and Leisure Officer Post Order

VI. CONDITIONS OF DETENTION FINDINGS AND RECOMMENDATIONS

A finding of "substantiated" refers to an allegation that was investigated and determined to have occurred or is present. 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 or is present. A finding of "unfounded" means an allegation that was investigated and determined not to have occurred or was not present.

a. Complaint No. 17-12-ICE-0463

On September 26, 2017, CRCL received correspondence from the American Civil Liberties Union American Immigration Council, American Immigration Lawyers Association, Center for Gender and Refugee Studies, Northwest Immigrant Rights Project, Refugee and Immigrant Center for Education and Legal Services and the Women's Refugee Commission on behalf of 10 women who were pregnant while detained by ICE. Specifically, one of the pregnant detainees referenced in the letter, Detainee #1, was being held at the DCDF. In the letter, Detainee #1 alleged she was six weeks pregnant and required to work one day a week. This, coupled with the fact she had complications with a previous pregnancy caused her great concern about the health of her unborn baby.

Analysis and Findings:

Detainee #1 is no longer detained at DCDF; therefore, she could not be interviewed. To investigate her complaint she was required to work one day a week while six weeks pregnant, I interviewed staff, detainees, and reviewed DCDF records and electronic databases. Through the investigation, I was able to surmise Detainee #1 was referring to

the DCDF general use cleanup program in the housing units. This program has inmates placed on a list to perform general area cleaning in the detainee's housing unit. Detainees are not required to perform the work assignments according to DCDF staff. A review of the DCDF grievance and detainee request records found no complaints from detainees regarding being required to work in the general use cleanup program. Staff denied detainees were required to work in the general use cleanup program and could decline assigned work. Detainees did not voice any complaints about being required to work in the general use cleanup program during interviews. **Based on the available information the complaint is unsubstantiated.**

Recommendations:

None.

b. Complaint No. 18-08-ICE-0301

On April 25, 2018, the Department of Homeland Security, Office of Inspector General opened Case: C18-ICE-SEA-26820. Detainee #4 reported a Detention Officer from the DCDF wanted him to forcibly sign Detainee #4's deportation against his will. Detainee #4 claimed deportation was not an option since his life was threatened in his home country. In addition, Detainee #4 claimed the Detention Officer physically hurt his arm and gave him scratch marks.

Analysis and Findings:

Detainee #4 is no longer detained at DCDF; therefore, he could not be interviewed. To investigate the complaint, DCDF use of force and grievances records were reviewed, DCDF staff and an ICE Senior Deportation Officer were interviewed. No documentation of a Use of Force or complaint was discovered in the review of DCDF records. ICE nor DCDF have staff by the name identified by the Department of Homeland Security Office of Inspector General as involved in the incident with Detainee #4. DCDF and ICE officials also reported that DCDF staff have no detainee fingerprinting responsibilities. Detainee fingerprinting is an ICE responsibility. DCDF and ICE staff interviewed had no knowledge of a use of force incident involving Detainee #4. **Based on the available information the complaint is unsubstantiated.**

Recommendations:

None.

c. Grievances

ICE PBNDS 2011 with the 2016 modifications, 6.2 Grievance System – Protects a detainee's rights and ensures that all detainees are treated fairly by providing a procedure for them to file both informal and formal grievances, which shall receive timely responses relating to any aspect of their detention, including medical care.

Analysis and Findings:

I reviewed DCDF's grievance system as a whole; reviewed grievances; interviewed the DCDF Program Coordinator (responsible for managing the DCDF Grievance System); and detainees. The DCDF maintains and processes detainee grievances and logs the grievances electronically and in paper format. On a weekly basis, DCDF provides ICE officials copies of all grievances and the grievance log. A review of grievances found they

are being responded to within the five day time requirement. My review found a high number of detainee grievances are rejected and DCDF is not responsive to detainee grievances with a significant number having inadequate responses, i.e. "your complaint has been addressed". A number of detainees complained that their formal grievances were not adequately responded to by DCDF. The DCDF Electronic Staff Request System (the tablet) is also problematic. DCDF has 14 days to respond to detainee paper or electronic requests. ICE has 72 hours to respond to paper requests. ICE does not utilize the DCDF Detainee Electronic Request System. The DCDF Medical Department utilized both paper and electronic requests until August 13, 2018. This created confusion for detainees on which system they should utilize to submit a medical request. Detainees complained that their electronic and paper requests were frequently unanswered and that provided responses did not adequately address their request. A random sample of electronic requests reviewed during the onsite visit verified the detainees' complaints were legitimate. DCDF officials acknowledged that the electronic detainee request system does not have a quality improvement component with a designated staff member responsible for monitoring the efficiency and effectiveness of the program. **The DCDF Grievance System does not conform to the ICE PBNDS 2011 with the 2016 modifications, 6.2 Grievance System due to the high number of rejected grievances and inadequate responses.**

Recommendations:

1. DCDF should enhance their Quality Improvement Program to address the high number of rejected grievances and inadequate grievance responses.
2. DCDF should include the Electronic Detainee Request Program in the existing Quality Improvement Program and designate a staff member to provide oversight of the program.
3. DCDF should consider revising the 14 day time frame to respond to detainee requests to more effectively align with the ICE time frame of 72 hours.
4. DCDF should provide additional training to their staff on providing adequate responses to detainee requests and grievances.

d. Law Libraries and Legal Materials

ICE PBNDS 2011 with the 2016 modifications, 6.3 Law Libraries and Legal Material – protects detainees' rights by ensuring their access to courts, counsel and comprehensive legal materials.

Analysis and Findings:

The DCDF Law Library and Legal Material area was inspected and the Day Shift Law Library Officer was interviewed. The Library Officer advised he had only been in the position since July 2018. The Law Library was found to have the required access to courts, counsel and comprehensive legal materials and is scheduled to be open from 7:00 a.m. until 11:00 p.m. Monday through Friday. The Library Officer reported he has not been trained on the law library operations, does not know how to assist detainees needing legal assistance and would not know where to refer detainees. He also did not know how to assist detainees with limited English proficiency (LEP) and/or low intellectual functioning. A review of the Law Library Logbook revealed in July 2018 the Law Library Officers on both

the day and evening shift were pulled to work other DCDF posts when the law library was scheduled to be open. A review of the Law Library Officer Post Order revealed it is not consistent with the actual post duties, (example-the post order identifies the law library officer is to retrieve legal mail from the housing units, in practice this is a mailroom staff responsibility). There were several days the Library Officer had not signed the sheet acknowledging reading and understanding of the law library post order. DCDF requires this to be done daily when assuming a duty post. The Law Library Officer advised he was unaware if the telephone language line was accessible in the law library. **The DCDF Law Libraries and Legal Material System does not conform to the ICE PBNDS 2011 with the 2016 modifications, 6.3 Law Libraries and Legal Materials. The Law Library Officer was not trained on DCDF law library and legal material operations and did know how to assist or refer detainees needing law library and legal material assistance including detainees with limited English proficiency and low intellectual functioning.**

Recommendations:

1. The Law Library Officer should immediately be trained on how to assist or refer detainees needing law library and legal material assistance including detainees with limited English proficiency and low intellectual functioning.
2. The Library Officer should be trained on procedures to provide detainees access to the telephone language line that are utilizing the Law Library.
3. Law Library Officers should not be pulled to work other DCDF posts during hours the law library is to be open except during emergencies.
4. The Law Library Officer Post Order should be reviewed and revised to reflect the actual duties of the post.
5. Additional training should be provided to detention officers on the importance of reading post orders when assuming a post each day and signing the acknowledgement sheet.

e. Telephone Access

ICE PBNDS 2011 with the 2016 modifications 5.6 Telephone Access- ensures that detainees may maintain ties with their families and others in the community, legal representatives, consulates, courts and government agencies by providing them reasonable and equitable access to telephone services.

Analysis and Findings:

Detainees have access to telephones in their housing units. Interviews with detainees revealed no complaints regarding access to telephones. During the site visit, there were no issues identified regarding detainee telephone access. As identified in VI.d telephone language line should be accessible in the DCDF Law Library. **DCDF conforms to the ICE PBNDS 2011 with the 2016 modifications, 5.6 Telephone Access.**

Recommendations:

1. See VI.d. The telephone language line should be available in the Law Library.

f. Language Access

ICE PBNDS 2011 with the 2016 modifications, 2.13 Staff-Detainee Communication – Enhances security, safety and orderly facility operations by encouraging and requiring

informal direct and written contact among staff and detainees, as well as informal supervisory observation of living and working conditions. The standard also requires the posting of hotline informational posters from the Department of Homeland Security (DHS) Office of the Inspector General (OIG). II. Expected outcome (6) of this detention standard (specific requirements are defined in "V. Expected Practices") – Requires the facility to provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP). The facility will provide detainees with disabilities with effective communication, which may include the provision of auxiliary aids, such as readers, materials in Braille, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters, and note-takers, as needed. The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities. All written materials provided to detainees shall generally be translated into Spanish. Where practicable, provisions for written translation shall be made for other significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate.

Analysis and Findings:
Language access was reviewed at DCDF as part of the investigation. Inmate interviews with detainees revealed no complaints regarding language access. The telephone language access telephone bills revealed the language line is used frequently with the exception of in the Law Library. Intake staff demonstrated how the telephone language line functioned and reported it was utilized during the detainee intake process. As identified in VI.d. Law Library and Legal Materials, the language line should be accessible in the DCDF Law Library. **DCDF Language Access conforms to the ICE PBNDS 2011 with the 2016 modifications, 2.13 Staff-Detainee Communication.**
Recommendations:

1. See VI.d. The telephone language line should be available in the Law Library.

g. Detainee Disciplinary System
ICE PBNDS 2011 with the 2016 modifications, 3.1 Disciplinary System – promotes a safe and orderly living environment for detainees by establishing a fair and equitable disciplinary system, requiring detainees to comply with facility rules and regulations, and imposing disciplinary sanctions to those who do not comply.
Analysis and Findings:
The DCDF Assistant Warden of Operations, Chief of Security, and Administrative Captain were interviewed regarding the Detainee Disciplinary System. Detainee disciplinary records were reviewed during the onsite investigation. During interviews with DCDF officials it was discovered DCDF does not conform with:

II. Expected outcome (9) of the 3.1 Disciplinary System standard (specific requirements are defined in "V. Expected Practices") that requires when a detainee has a diagnosed mental

illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior. DCDF does not have a practice implemented to conform with this part of the standard although their 14.2.1 Hearing Board and Disciplinary Procedures includes the requirement. The policy, procedure, and practice for other requirements of the standard are being followed. **The DCDF Detainee Disciplinary System does not conform to the ICE PBNDS 2011 with the 2016 modifications, 3.1 Disciplinary System- When a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability a mental health professional is not consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior. The DCDF 14.2.1 Hearing Board and Disciplinary Policy and Procedure includes the requirement; however, DCDF has not implemented the policy and procedure in practice.**

Recommendations:

1. DCDF should implement the practice of their DCDF 14.2.1 Hearing Board and Disciplinary Policy and Procedure requiring when a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior.

h. Sexual Assault and Abuse Prevention and Intervention

ICE PBNDS 2011 with the 2016 modifications, 2.11 Sexual Abuse and Assault Preventions and Detention – Facilities that house ICE/ERO detainees act affirmatively to prevent sexual abuse and assaults on detainees; provide prompt and effective intervention and treatment for victims of sexual abuse and assault; and control, discipline and prosecute the perpetrators of sexual abuse and assault.

Analysis and Findings:

The DCDF PREA Coordinator and Investigator were interviewed and records were reviewed. DCDF has four (4) staff members trained to investigate sexual abuse in correctional settings. All detainees received at DCDF receive a Prison Rape Elimination Act (PREA) screening. Detainees at risk are entered in a confidential database and are monitored by management. The Intake PREA screening conducted in the DCDR Intake Common Area is not in a confidential setting to ensure accurate reporting occurs and a detainee's confidential information is not compromised. All staff, including contractors and volunteers, receive training on sexual assault and abuse prevention and intervention. When a PREA allegation is made against a staff member, the staff member is placed in a

non-contact detainee post until the investigation is completed. DCDF is scheduled for an ICE PREA Audit in September 2018. An initial ICE PREA Audit was performed in May 2018; however, due to PREA Auditor issues a re-audit was required. The re-audit was not based on DCDF performance. **DCDF Sexual Assault and Abuse Prevention and Intervention does not conform to the ICE PBNDS 2011 with the 2016 modifications, 2.11 Sexual Assault and Abuse Prevention and Intervention, the DCDF Intake PREA screening conducted in the Intake Common Area is not in a confidential setting to ensure accurate reporting occurs and a detainee's confidential information is not compromised.**

Recommendations:

1. Intake PREA Screening should be performed in a confidential setting to ensure accurate reporting occurs and a detainee's confidential information is not compromised.

i. Segregation

ICE PBNDS 2011 with the 2016 modifications, 2.12 Special Management Units – Protects detainees, staff, contractors, volunteers and the community from harm by segregating certain detainees from the general population in Special Management Units with an Administrative Segregation section for detainees segregated for administrative reasons and a Disciplinary Segregation section for detainees segregated for disciplinary reasons.

Analysis and Findings:

DCDF Segregation records were reviewed prior to and during the onsite investigation. Random Special Management Unit (SMU) detainees and the assigned Special Management Unit Officer were interviewed while on site. Detainees interviewed in the SMU voiced no complaints and reported receiving required services. Most detainees confined in the SMU are on protective custody status. A review of SMU records reflected activities are not always accurately recorded. This same finding was identified in the June 2018 Corporate Audit. The male DCDF SMU has 48 beds and the female SMU has 2 beds. The female SMU is alternatively utilized for housing high custody females and the populations cannot be mixed. DCDF Management officials reported that Medical Observation beds are utilized if there are no beds available for female high custody or special management detainees. Officials admitted there was no formalized plan if high custody and special management bed needs exceeded capacity. The male SMU is staffed by one officer and the female Special Management/High Custody Unit does not have an assigned officer. The housing unit is monitored with irregular 30 minute rounds by the officer from the adjacent low/medium housing unit. The male and female Special Management Unit staffing makes it essential that staff are well trained on emergency response. A review of DCDF records revealed an emergency drill is conducted quarterly on each shift. The conducted after action reviews

of the emergency drills were insufficient to adequately assess if staff were properly trained in emergency response (i.e. the after action reviews did not always include if the four minute response time was met). **DCDF Special Management Units conform to the ICE PBNDS 2011 with the 2016 modifications, 2.12 Special Management Units.**

Recommendations:

1. DCDF should develop an action plan for if the female high custody/special management population exceed bed capacity.
2. DCDF should provide additional training to management staff on performing emergency drill after action reviews.
3. DCDF should provide additional training to special management unit officers on accurately documenting services provided detainees.
4. Based on the June 2018 Corporate Audit Special Management Unit findings, DCDF should consider conducting a Special Management Unit staffing analysis to determine if existing Special Management Unit staffing is sufficient to perform required duties and responsibilities.

j. Use of Force

ICE PBNDS 2011 with the 2016 modifications, 2.15 Use of Force and Restraints – authorizes staff to use necessary and reasonable force after all reasonable efforts to otherwise resolve a situation have failed, for protection of all persons; to minimize injury to self, detainees, staff and others; to prevent escape or serious property damage; or to maintain the security and orderly operation of the facility. Staff shall use only the degree of force necessary to gain control of detainees and, under specified conditions, may use physical restraints to gain control of a dangerous detainee. This detention standard does not specifically address the use of restraints for medical or mental health purposes, which is addressed by standard "4.3 Medical Care." Canine units, where available, may be used for contraband detection, but their use for force, control, or intimidation of detainees is prohibited.

Analysis and Findings:

Use of Force Reports and Reviews were analyzed before and during the onsite investigation. DCDF had seven (7) use of force incidents (five minor and two major) in 2017 and six thus far in 2018 (three minor and three major). The DCDF Use of Force Policy defines minor use of force as physical contact with a detainee in a confrontational situation to control behavior or to enforce order, including the placement of hands on the detainee in an effort to cause him/her to do anything involuntary. Major use of force is: 1) restraints are applied in order to restore or preserve order unless restraints are routinely required to assure control of an individual or group, 2) chemical agents, firearms, water, batons, or other instruments are used, and 3) if any offensive or defensive physical contact or hold is employed including the following; one or more physical blows, hard pushes, come along holds, defensive holds or if in the opinion of medical staff an injury has occurred during a minor use of force, such as a bruise or wound.[6] A review of the use of force incidents for 2017 and 2018 did not reveal any incidents with unnecessary or excessive use of force. A review of staff use of force reports reveal lack of necessary detail. Likewise, use of force reviews lack the necessary

[6] DCDF Use of Force 11.2.15-AUR.

information to meet the criteria for a quality review. The DCDF 11.2.15 Use of Force Policy and Procedure does not address the procedures for use of force allegations. **DCDF Use of Force policy, procedure, and practice does conform to the ICE PBNDS 2011 with the 2016 modifications, 2.15 Use of Force and Restraints.**

Recommendations:

1. Additional training should be provided DCDF staff on Use of Force Reporting and performing After Action Use of Force Reviews.
2. DCDF should develop policies, procedures, and practices to address Use of Force allegations.

k. Intake Admission and Release

ICE PBNDS 2011 with the 2016 modifications, 2.1 Admission and Release - protects the community, detainees, staff, volunteers and contractors by ensuring secure and orderly operations when detainees are admitted to or released from a facility.

Analysis and Findings:

The DCDF Intake Admission and Release area was inspected. The area has holding cells where detainees can receive orientation information via closed circuit televisions in the language of the detainee. The telephone language line is available in Intake for limited English proficient detainees. The interviewed classification officer demonstrated she was proficient in using the telephone language line. **DCDF Admission and Release does conform to the ICE PBNDS 2011 with the 2016 modifications, 2.1 Admissions and Release.**

Recommendations:

1. DCDF Classification staff interviews with detainees received at the facility should be conducted in a private and confidential correctional setting.

l. Detention Handbook

ICE PBNDS 2011 with the 2016 modifications, 6. 1 Detention Handbook – Requires that, upon admission, every detainee be provided comprehensive written orientation materials that describe such matters as the facility's rules and sanctions, disciplinary system, mail and visiting procedures, grievance system, services, programs and medical care, in English, Spanish and other languages and that detainees acknowledge receipt of those materials.

Analysis and Findings:

Interviews with staff and detainees identified the DCDF Handbook and ICE National Detainee Handbook (April 2016) are issued to detainees during admission at the facility. The DCDF and ICE National Detainee Handbooks are also available in Spanish. Detainees complained that the DCDF Handbook had contradictory and misleading information for certain sections. Specifically, the DCDF Handbook in the visits section provides all social visits are non-contact and then in a subsequent section proceeds to describe the procedures to request a contact visit by contacting ICE staff. The personal hygiene section provides insufficient information on the personal hygiene product types and frequency that are issued to detainees. These issues do not prevent DCDF from meeting the standard. **DCDF and ICE Detention Handbooks conform to the ICE PBNDS 2011 with the**

2016 modifications, 6.1 Detention Handbook.

Recommendations:

1. DCDF officials should review the Detention Handbook and address all contradictory information and sections that need additional information, specifically, the visits and personal hygiene sections.

m. Detainee Personal Hygiene

ICE PBNDS 2011 with the 2016 modifications, 4.5 Personal Hygiene – Ensures that each detainee is able to maintain acceptable personal hygiene practices through the provision of adequate bathing facilities and the issuance and exchange of clean clothing, bedding, linens, towels and personal hygiene items.

Analysis and Findings:

Interviews with DCDF and detainees were conducted regarding detainees being able to receive adequate personal hygiene items. DCDF provides detainees basic personal hygiene items. Detainees complained that the frequency and amount of personal hygiene items issued did not meet their needs. Indigent detainees complained they were not issued deodorant. The DCDF Detainee Handbook has a personal hygiene section that outlines personal hygiene items are exchanged every other Monday and to receive a new bottle of shampoo or lotion the detainee must exchange his/her empty bottles. The handbook does not clearly identify what personal hygiene items are issued detainees or when new items are issued. The information only addresses exchanges. Interviews and observations confirm detainees do receive personal hygiene items and the intent of the standard is being met by DCDF. **DCDF detainee personal hygiene issue conforms to the ICE PBNDS 2011 with the 2016 modifications, 4.5 Personal Hygiene.**

Recommendations:

1. The DCDF Detainee Handbook Personal Hygiene Section should be revised to clearly identify the type and frequency of all personal hygiene items that are issued to detainees.

n. Staff Training

ICE PBNDS 2011 with the 2016 modifications, 7.3 Training – ensures that facility staff, contractors and volunteers are competent in their assigned duties by requiring that they receive initial and ongoing training. Other detention standards may include additional training requirements specific to each standard.

Analysis and Findings:

The DCDF Training Policies and Procedures were reviewed and the Training Coordinator was interviewed. All DCDF staff completed their required training in 2017. The majority of staff training is recorded in the Learning Management System (LMS) software program. The only exception is Special Management Unit Officer specialized training is manually maintained and monitored in the Security Department utilizing Corporate Tele Staff Program software. **DCDF Staff Training does not conform to the ICE PBNDS 2011 with the 2016 modifications, 7.3 Training, due to staff only receiving 2.5 hours of initial training and 1.5 hours of annual training on suicide recognition and prevention. The required training is eight hours initial and thereafter two hours annually.**

Recommendations:

1. All DCDF staff training should be recorded in the LMS software program.
2. The DCDF Training Plan should be revised and all staff required to receive eight hours of initial training on suicide recognition and prevention and thereafter two hours annually.

VII. Summary of DCDF Recommendations

Positive aspects of DCDF Operations include the following:

- The Facility was quiet and clean;
- Low UOF numbers (seven incidents in 2017 and eight incidents thus far in 2018)
- Low number of detainees in the Special Management Unit for disciplinary reasons;
- Sound corrections policies and procedures;
- Experienced management team.

Problematic aspects of the DCDF Operations include the following:

- Practice was found inconsistent with DCDF Policies and Procedures in certain areas;
- Staff are not responsive to detainee grievances, electronic and paper detainee requests;
- High number of detainees in the Special Management Unit on request for protective custody;
- Lack of program space for detainees;
- An inadequate quality improvement system for identified areas.

A summary of my recommendations are as follows:

1. There are a high number of detainee grievances that are rejected and DCDF is not responsive to detainee grievances with a significant number having inadequate responses. CRCL recommends DCDF enhance their Quality Improvement Program to address the high number of rejected grievances and inadequate grievance responses. Additionally, DCDF should include the Electronic Detainee Request Program in the existing Quality Improvement Program and designate a staff member to provide oversight of the program *(ICE PBNDS 2011 with the 2016 modifications, 6.2 Grievance System)*.

2. Records revealed the language line was infrequently used in the Law Library. Additionally, the officer assigned to the Law Library indicated that he was not familiar with the language line nor has he ever used it to assist LEP detainees. CRCL recommends that DCDF ensure that the language line is used in the law library and that any officer assigned to the Law Library Officer is trained on how to assist or refer detainees needing law library and legal material assistance including detainees with

limited English proficiency and low intellectual functioning *(ICE PBNDS 2011 with the 2016 modifications, 6.3 Law Libraries and Legal Material).*

3. CRCL recommends that DCDF implement the practice of their DCDF 14.2.1 Hearing Board and Disciplinary Policy and Procedure, requiring when a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior (*ICE PBNDS 2011 with the 2016 modifications, 3.1 Disciplinary System).*
4. Intake PREA Screening should be performed in a confidential setting to ensure accurate reporting occurs and a detainee's confidential information is not compromised (*ICE PBNDS 2011 with the 2016 modifications, 2.11 Sexual Abuse and Assault Prevention and Intervention).*
5. Currently, DCDF houses high custody females in the same space utilized for the female SMU. In the event, DCDF's high custody females exceeds capacity, CRCL recommends DCDF develop an action plan for situations where the female high custody/special management population exceeds bed capacity (*ICE PBNDS 2011 with the 2016 modifications, 2.12 Special Management Units).*
6. DCDF should provide additional training to management staff on performing emergency drill after action reviews (*ICE PBNDS 2011 with the 2016 modifications, 1.1 Emergency Plans).*
7. A review of SMU records reflected activities are not always accurately recorded. CRCL recommends DCDF provide additional training to the officers assigned to the SMU on accurately documenting access to programs and services provided to the SMU detainees (*ICE PBNDS 2011 with the 2016 modifications, 2.12 Special Management Units).*
8. There were instances where the use of force reports were lacking detailed information. CRCL recommends DCDF provide additional training on properly documenting Use of Force incidents and After Action Use of Force Reviews (*ICE PBNDS 2011 with the 2016 modifications, 2.15 Use of Force and Restraints).*

DENVER CONTRACT DETENTION FACILITY

APPENDIX A

Detainee Names and Alien Numbers

(b)(6)

DENVER CONTRACT DETENTION FACILITY

APPENDIX B

Best Practice Recommendations

1. DCDF should consider revising the 14 day time frame to respond to detainee request to more effectively align with the ICE time frame of 72 hours to respond to detainee requests.
2. DCDF should provide additional training to their staff on providing adequate responses to detainee requests and grievances.
3. The Law Library Officer Post Order should be reviewed and revised to reflect the actual duties of the post.
4. Additional training should be provided to detention officers on the importance of reading post orders when assuming a post each day and signing the acknowledgement sheet.
5. Law Library Officers should not be pulled to work other DCDF posts during hours the law library is to be open except during emergencies.
6. DCDF should include the Electronic Detainee Request Program in existing Quality Improvement Program and designate a staff member to provide oversight of the program.
7. DCDF should develop an overflow contingency plan for when the female Special Management, High Custody and Medical Observation beds are at maximum capacity.
8. Based on the June 2018 Corporate Audit Special Management Unit findings, DCDF should consider conducting a Special Management Unit staffing analysis to determine if existing Special Management Unit staffing is sufficient to perform required duties and responsibilities.
9. DCDF should develop policies, procedures, and practices to address Use of Force allegations. The existing DCDF Use of Force policy does not address Use of Force allegations.
10. DCDF officials should review the Detention Handbook and address all contradictory information and sections that need additional information, specifically, the visits and personal hygiene sections.
11. All DCDF staff training should be recorded in the LMS software program.