CRCL ADELANTO ONSITE INVESTIGATION

30/60/90-DAY CORRECTIVE TIMELINES

ADA ACCESSIBILITY VIOLATION

IMMEDIATELY

- GEO must immediately inspect all ADA accessible showers at the facility, and install, repair or replace shower curtains or modesty panels where not currently present or adequate, including in the women's East 1-A housing unit.

LACK OF LANGUAGE ACCESS

30 DAYS

- ACF and ICE Staff must be trained on how to utilize the Language Line when dealing with non-English-speaking detainees and acknowledge their awareness of language assistance requirements per the PBNDS 2011 and the recent DHS Language Access Plan issued in February 2012.
- ACF must develop a Language Line logging system and require all facility staff to record its use; by date and A#.

60 DAYS

- All forms issued to detainees for informational purposes and/or for detainee signatures must be written and/or translated in a language the detainee comprehends.

INEFFECTIVE GRIEVANCE SYSTEM

30 DAYS

- ICE, ACF Management (including the Warden), and the Grievance Coordinator must:
    a. develop a regular meeting schedule to identify serious systemic grievance issues reported by the detainees and substantiated by the Grievance Coordinator.
    b. develop a reporting system to ensure that facility personnel respond to and resolve the detainee grievance issues assigned to them by the Grievance Coordinator.
    c. develop a review and trend tracking system for all grievances reporting staff mistreatment.
- The Warden must hold facility staff accountable for substantiated abusive and disrespectful treatment of the detainees, as determined by the Grievance Coordinator.

60 DAYS

- ACF/GEO must provide the Grievance Coordinator with management training relevant to interpersonal skills-building, effective communication, and dealing with difficult individuals.

INAPPROPRIATE SEGREGATION OF DETAINEES WITH MENTAL ILLNESS

30 DAYS

- ERO, IHSC and ACF must audit all Special Management Unit (SMU) cases to identity those detainees housed in the SMU, partially or wholly due to mental health conditions and,

develop a housing alternative that includes necessary and consistently delivered mental health services.

- The Mental Health Director and IHSC must ensure that ACF mental health staff conduct daily face-to-face rounds with all detainees in the SMU and provide appropriate mental health assessments and treatment.
- The Mental Health Director, ERO, and IHSC must ensure that custody staff cease determining or influencing whether or not a detainee requires medical or mental health services.
- ICE must audit all detainees held in the SMU over 30 days for protective housing reasons, and determine if transfer to another facility is more appropriate.

60 DAYS

- ERO must conduct an external audit of all detainees held in Administrative and Disciplinary Segregation over 30 days to determine if transfer to another facility could improve treatment or resolve use of the SMU for special housing.

EXCESSIVE POPULATION COUNTS

30 DAYS

- ERO and ACF must develop and implement an efficient population count process that comports with the 2011 PBNDS in order to eliminate the problematic delays that 6 daily counts cause in the delivery of meals, visitation (legal and regular), recreation, law library access, and detainee medical appointments.

INADEQUATE VISITATION CAPACITY

30 DAYS

- ERO and ACF leadership must collaborate to develop a strategy for increasing the facility's visitation capacity and to eliminate the long waits for both legal and regular visitation caused by current physical plant limitations, insufficient staffing, and population count inefficiencies.
- ACF must issue written notice to the detainee population, and post a notice in the visitation area, clarifying that large families traveling long distances for visitation are able to request special accommodations regarding the size of the visiting family and the time allotment.

INADEQUATE LEGAL ACCESS

30 DAYS

- ERO and ACF leadership must institute an attorney appointment system to decrease the current excessive wait times, and begin to consider other legal visitation options such as V-tel legal visits.

60 DAYS

- ACF should grant the female Law Librarian's transfer request and hire a Spanish Speaking Librarian.
- ACF must institute a detainee computer training class, demonstrating use of the Lexis-Nexis software and computers, and create a detainee trustee position in each housing unit in order to assist detainees with the computer system.

INSUFFICIENT STAFFING/TRAINING

30 DAYS

- ICE HQ and ACF leadership must develop a post-assignment schedule that creates a staffing plan which resolves the current staffing deficiencies that are impacting operational inefficiencies, such as excessive count times, meal delays, and limited visitation, legal access and recreation time allotments.
- ERO and ACF must provide cultural diversity training to all staff to improve staff detainee communication.
- ACF management should grant the female Law Librarian's transfer request and hire a Spanish speaking Librarian.
- ICE and GEO headquarter leadership must send a team onsite to help identify and develop a Corrective Action Plan (CAP) for those more difficult and complex needs that are not within the onsite ERO or ACF leaderships' ability to resolve.

60 DAYS

- ICE and ACF must provide gender responsive, trauma informed training to all staff working with the facility's new female population.

FOOD SERVICE MENU IMPLEMENTATION

30 DAYS

- No later than January 15, 2016, fully implement the newly revised menu that was scheduled for implementation on December 14, 2015. GEO should also Implement dietitian approved changes to medically therapeutic and religious diets and ensure that standardized recipes are implemented for all menu items. (Hunger Strike issue)

INADEQUATE MEDICAL CARE

30 DAYS

- GEO and ICE (IHSC) must conduct an audit of ***all*** medical files, starting with the detainee Chronic Care List, and take action to ensure all detainees receiving medical/mental health care are current on appointments (onsite and offsite), treatments (including surgeries), and are receiving the appropriate and timely assessments and treatments for their conditions.
- The paper-based medical record must be changed to include a separate section for medical orders (with a standard order form).

90 DAYS

- GEO must recruit an outside permanent clinical leadership team, consisting of a qualified and experienced detention Clinical Director (MD or DO), Director of Nursing and clinical Mental Health Director (psychiatrist) and have them on site and in their positions within 90 days.
- The medical record must be standardized. Only forms approved by the Clinical Director and the Medical Record Director should be used for charting.
- GEO must draft a Request for Proposals (RFP) in order to begin the process of selecting, procuring and deploying an Electronic Health Record (EHR) that is appropriate for detention health care. (Deploy the EHR within twelve months.)

- ICE HQ must immediately require a CAP be developed for all issues identified during the onsite investigation and, within 90 days, all local and headquarters CAP items must be fully corrected, and documented; signed by ICE and GEO headquarters.

INADEQUATE MENTAL HEALTH CARE

30 DAYS

- GEO and ICE (IHSC) must audit the medical files of detainees on the Mental Health Chronic Care List, prioritizing detainees who are in Segregation, and take action to ensure that all detainees are receiving appropriate mental health care. In particular, ensuring that detainees with psychotic disorders are diagnosed as such and are offered adequate antipsychotic medication, including long-acting injectable antipsychotics, especially when medication inadherence is present.

- ACF Mental Health staff must follow GEO Procedure 623-A, which calls for a complete "written comprehensive Initial Psychiatric Evaluation" (Form HS-906) that "will address current and past inpatient and outpatient psychiatric treatment and psychotropic medications." Moreover, Mental Health Staff must demonstrate an attempt to obtain collateral historical information (and not simply indicate that a detainee has "refused"). If such information is available in a transfer summary, that must be placed in the chart and referenced by the mental health provider. This procedure should be done retrospectively for all detainees on the Mental Health Chronic Care List who are in segregation.

- Detainees needing emergent transport and admission to outside acute psychiatric inpatient units should wait more than 72 hours after such a determination/request before transfer is made by a mental health clinician. Relationships with potential accepting institutions must be established and/or strengthened in order to address this need.

- The paper-based medical record must be changed to include a separate section for medical orders (with a standard order form).

90 DAYS

- GEO must recruit an outside permanent clinical leadership team consisting of a qualified and experienced Mental Health Director (a psychiatrist experienced in treating persons with serious mental disorders) and have them on site and in their positions within 90 days.

- The medical record must be standardized. Only forms approved by the Clinical Director and the medical record director should be used for charting.

- GEO must draft a Request for Proposals (RFP) in order to begin the process of selecting, procuring and deploying an Electronic Health Record appropriate for detention health care. (The goal should be to deploy an EHR within twelve months).

- All mental health staff must have access to GEO Track, where they can review and change their own appointments and those of other mental health clinicians. Each clinician should have his/her own schedule.

LEADERSHIP AND OVERSIGHT NEEDS

60 DAYS

- All actions relevant to the above recommended audits, reviews, and changes must be written into policy and procedure, with written notice provided to staff.
- ICE HQ must monitor the CAP to ensure all items are corrected by local ERO and ACF management.

90 DAYS

- ICE and GEO must address ACF staff turnover rates by comparing local correctional facility custody classifications in order to promote staff longevity, institutional knowledge and operational consistency.
- All local and headquarters CAP items must be fully addressed and implemented with a memo documenting their resolution and signed by ICE and GEO.

CORRECTIONS EXPERT'S REPORT

ON

ADELANTO CORRECTIONAL FACILITY

Prepared by:

(b) (6)

Roseville, CA

March 1, 2016

Privileged and Confidential

For Official Use Only

ADELANTO CORRECTIONAL FACILITY

I. SUMMARY OF REVIEW

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL), received a complaint on April 15, 2015 from Community Initiatives for Visiting Immigrants in Confinement (CIVIC) which was referred by Department of Homeland Security (DHS), Office of the Inspector General (OIG) regarding the April 6, 2015 death of a detainee in U.S. Immigration and Customs Enforcement (ICE) custody that was held at the Adelanto Correctional Facility (ACF) in Adelanto, California.[1] On May 12, 2015 CRCL received a complaint from CIVIC alleging retaliatory use of Segregation for conditions of confinement complaints and verbal abuse by staff. On November 2, 2015 Think Progress released an online report entitled "Why Immigrant Detainees in California Jails Just Launched a Hunger Strike". Since 2014 CRCL has received numerous other allegations from DHS Office of the Inspector General, advocacy groups and other sources. Additionally, on August 25, 2015 SIDLEY, LLP filed a written complaint alleging unlawful denial of Attorney visits at the ADF on behalf of the Co-Executive Director of CIVIC. As a result of the detainee death and multiple conditions of confinement and advocate complaints, CRCL conducted an onsite investigation of operations in the following areas: Admission and Release, classification and screening, housing (including housing capacities), segregation, counts and lockdowns, ADA accommodation, environmental health and safety, personal property, post orders, sexual abuse and assault prevention and intervention, staff detainee communication, language access, retaliation, legal access, discipline, food service, hunger strikes, religious accommodation, medical, dental and mental health care, recreation, visitation, grievances, and staff training. An additional area of this review included ICE's potential expansion of ACF's female population and the potential to expand ACF's mission to include the housing of transgender detainees. This investigation also reviewed ACF's adherence to the 2011 Performance Based National Detention Standards (2011 PBNDS).

Allegations related to the death, medical (including ADA accommodation) and mental health care are addressed by the medical and mental health experts. Allegations regarding food, environmental health and safety and personal property are addressed by the environmental health and safety expert.

Through this review, I found operational deficiencies related to some of the allegations, as well as other operational deficiencies observed during the December 9-11, 2015 onsite investigation and document review.

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

---

[1] This expert report addresses allegations contained in the following CRCL complaints: 15-08-ICE-0417, 15-09-ICE-0540, 15-11-ICE-0599, and 16-02-ICE-0013.

II. EXPERT PROFESSIONAL INFORMATION

(b) (6)

[redacted]

III. RELEVANT STANDARDS

A. ICE Detention Standards

ICE's 2011 PBNDS currently apply to ACF. This facility was covered by these standards during the entire period relevant to this investigation. Consequently, I relied on the 2011 PBNDS when looking at the specific allegations regarding conditions at the facility. Additionally, ICE's October 6, 2006 Sexual Assault Awareness Information Memorandum to All Field Office Directors by (b) (6), (b) (7)(C) Acting Director and ICE Directive 11062.1: Sexual Abuse and Assault Prevention and Intervention issued May 11, 2012 by (b) (6), (b) (7)(C) Director was in force and effect during this period. The PBNDS 2011 which include 2.11 Sexual Abuse and Assault Prevention and Intervention (SAAPI) policies was in force during the investigation period.

B. Additional Relevant Standards / Professional Best Practices

Where the PBNDS 2011 do not address a specific issue, I made recommendations based on my correctional experience, best correctional practices, and recognized correctional standards including those published by ACA.

IV. FACILITY BACKGROUND AND POPULATION DEMOGRAPHICS

ACF is located in Adelanto, California, and is operated and managed by The GEO Group, a private corrections company, under a dedicated Inter-Governmental Service Agreement (IGSA) between ICE and the City of Adelanto, California, to house only ICE detainees. ACF has a rated population count of 1940. ACF began the initial intake of detainees in August of 2011 opening East Facility with a rated bed capacity of 650. On August 1, 2012 West Facility was opened, adding 650 beds of housing capacity. Detainees have been housed at this facility since 2011. In July 2015 the GEO Group added a 650 bed expansion. ACF houses male and female detainees.

On December 9, 2015, the detainee count at ACF was 1492, 1338 male and 154 female detainees. The detainees are housed in a mix of dormitory and secure housing units. Housing units have Lower and Upper tiers. Detainees held in segregation are housed in a Special Management Unit (SMU) at the West Facility. The SMU contains 32 cells with an upper and lower tier and has a total capacity of 64. The SMU count at this facility was 64 during the December 9-11, 2015 site visit. The SMU population included a combination of detainees on disciplinary and administrative segregation status.

V. REVIEW PURPOSE AND METHODOLOGY

The purpose of this review was to examine the specific allegations made in the complaint, as well as to identify other areas of concern regarding the operation of the facility. As part of this review, I examined a variety of documents; conducted a site visit of ACF on December 9-11, 2015, along with CRCL staff and experts who examined medical and mental health care, food, and environmental health and safety; and interviewed ICE and ACF staff and detainees. Detainee names and alien numbers and staff names are omitted from this report, and instead listed in Appendix A.

The staff at ACF was helpful and cooperative during our site visit, and I appreciated their assistance. I also appreciated the cooperation and assistance provided by ICE staff before, during, and after our visit.

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

- Reviewed the CIVIC complaints
- Reviewed the Think Progress Report "Why Immigrant Detainees in California Jails Just Launched a Hunger Strike"
- Reviewed the February 2009 ICE National Detainee Handbook
- Reviewed relevant ICE PBNDS 2011
    - Grievance System

    - Detainee Handbook
    - Admission and Release
    - Law Libraries and Legal Material
    - Recreation
    - Religious Practices
    - Staff-Detainee Communication
    - Special Management Units
    - Staff Detainee Communication
    - Classification System
    - Population Counts
    - Disciplinary System
    - Sexual Assault and Abuse Prevention and Intervention
    - Facility Security and Control
- Reviewed relevant ACA correctional standards

While at the ACF on December 9-11, 2015 and post visit, I did the following:

- Toured East and West Facility Housing Units
- Toured the Special Management Unit
- Toured Visiting
- Interviewed housing officers
- Reviewed the Intergovernmental Service Agreement between ICE and the City of Adelanto
- Reviewed institutional operational policies
- Reviewed law library access at ACF
- Interviewed the law librarian and officer
- Inspected the law library for general population (East and West) and the SMU
- Interviewed detainees in the law library
- Reviewed the facility schedule for the law library
- Inspected the recreational yards for East and West Facilities and the SMU
- Reviewed the recreation schedule for East and West Facilities and the SMU
- Reviewed the religious service schedules for East and West
- Reviewed the religious service area
- Interviewed the Chaplain
- Interviewed custody and program personnel regarding PREA, disciplinary system, law library access, religious services, recreation programs, language access, and telephone access
- Inspected the SMU
- Inspected telephone pro bono number postings in East and West housing units and SMU
- Reviewed detainee grievances logs for 1/1/2015-12/09/2015
- Reviewed specific detainee grievances and responses
- Interviewed Grievance Officer
- Reviewed detainee disciplinary reports
- Reviewed disciplinary segregation orders
- Interviewed male and female detainees in East and West Facilities

- Interviewed randomly selected detainees in the SMU
- Spoke with various facility staff and management during the course of the review
- Met with various ICE staff during the course of the review
- Reviewed detainee housing rosters
- Reviewed detainee files
- Reviewed the ACF supplemental detainee handbook
- Reviewed Administrative Segregation and Disciplinary Segregation hearing notices, reports, and detention files
- Reviewed detainee requests made to ICE
- Reviewed the Daily Activity Schedule
- Reviewed ACF policies on:
    - Classification
    - Detainee Programs-Recreation
    - Special Management Detainees/Special Management Unit Operations
    - Use of Force
    - Detainee Services and Programs, Religious Programming
    - Detainee Grievance Program
    - Grievance Procedures
    - Detainee Rules and Disciplinary Procedures
    - Reception and Orientation, Admission and Release
    - Reception and Orientation, Detainee Handbook Supplement
    - Staff and Detainee Communication
    - Legal Rights of Detainees
    - Detainee Rights

In the context of this report, a finding of "substantiated" refers to an allegation that was investigated and determined to have occurred; a finding of "not substantiated" refers to an allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred; and a finding of "unfounded" means an allegation that was investigated and determined not to have occurred. Detainee's name and A#'s referred to in this report are listed in Appendix A.

VI. CORRECTIONS FINDINGS AND RECOMMENDATIONS

A. Admission and Release, Intake Screening and Classification

The 2011 PBNDS protects the Community, detainees, staff, volunteers and contractors by ensuring secure and orderly operations when detainees are admitted to or released from a facility. The 2011 PBNDS protects these same individuals and contributes to orderly facility operations by requiring a formal classification process for managing and separating detainees that is based on verifiable and documented data. As part of this investigation I was asked by CRCL to investigate the efficacy of TLF's admission and release, intake screening and classification system and compliance with the Detention Standards. I interviewed staff in Receiving who are responsible for the intake screening, admission and release of detainees. I

also interviewed ACF/ICE staff knowledgeable of the classification process. I also reviewed intake screening and classification documents in detention files as part of my investigation. ACF did not conform to the Admission and Release Standard. ACF does conform to Classification Detention Standards.

FINDING: ACF PRACTICE DOES NOT CONFORM TO THE PBNDS ON ADMISSION AND RELEASE STANDARD. ACF DOES CONFORM TO THE CLASSIFICATION SYSTEM STANDARD

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

1. ACF fails to meet the Admission and Release, Intake Screening Standard as interpreters or language lines are not consistently used during the intake screening process and completion of the numerous intake forms. The facility must correct their intake and admission process by consistently utilizing interpreters during the intake screening and admission process and ensuring detainees are signing documents in a language he/she understands or is provided oral assistance in order to comply with the detention standard. (PBNDS 2011, Admission and Release)

B. Special Management Units

The 2011 PBNDS protect detainees, staff, contractors, volunteers, and the community from harm by segregating certain detainees from the general population in Special Management Units (SMUs) with an Administrative Segregation section for detainees segregated for administrative reasons and a Disciplinary Segregation section for detainees segregated for disciplinary purposes. Because of the risks associated with the isolation of a detainee in segregation, the detention standards mandate specific requirements for any detainee held in segregation to protect their rights.

Special Management Units (SMU) A and B at ACF housed approximately 64 detainees at the time of this investigation. ACF's SMU log identifies 29 cases with serious mental illness. The mental health conditions noted on the log were not accurately diagnosed. Healthcare staff were making daily rounds but a majority of cases were not seen due to refusals and custody staff were relied upon to determine whether the detainee wanted to be seen or not. Custody should not be interpreting for Healthcare, medical or mental health if detainees want to be seen. This is a violation of the Detention Standard. Additionally, 17 detainees have been in SMU for 100-372 days and the majority of all of the long term detainees held in SMU is due to detainee requests for safety reasons. Gang, prior criminal history, mental health condition, and detainee concerns about being housed with general population detainees all contribute to the long stays in SMU. There were seriously mentally ill detainees housed in the SMU who were not receiving adequate mental health care. The mental health expert will speak to the specific cases. No current strategy exists to address the long term detainees held in SMU. If strategies are not developed, the mental health and other long term detainee cases will continue to decompensate and the population of the SMU will continue to grow.

FINDING: ACF SMU PRACTICE DOES NOT CONFORM TO THE PBNDS ON SPECIAL MANAGEMENT UNITS STANDARD.

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

Recommendations

2. ERO, IHSC and ACF must audit all Special Management Unit (SMU) cases to identify those detainees housed in the SMU, partially or wholly due to mental health conditions and, develop a safe housing alternative with more intensive mental health services including mental health groups in a non-SMU setting for detainees with mental health conditions. that includes necessary and consistently delivered mental health services. (PBNDS 2011, SMU)
3. The Mental Health Director and IHSC must ensure that ACF mental Health staff conduct daily face-face round with all detainees in the SMU and provide appropriate mental health assessment and treatment. (PBNDS 2011, SMU)
4. The Mental Health Director, ERO and IHSC must ensure that custody staff cease determining or influencing whether or not a detainee requires medical or mental health services. (PBNDS 2011, SMU)
5. ICE must audit all detainees held in the SMU over 30 days for protective housing reasons and determine if transfer to another facility is more appropriate. (PBNDS 2011, SMU)
6. ERO must conduct an external audit of all detainees held in Administrative and Disciplinary Segregation over 30 days to determine if transfer to another facility could improve treatment or resolve use d of the SMU for special housing. (PBNDS 2011, SMU)

C. Population Counts

The PBNDS 2011 requires three and encourages more custody counts of the detainee population daily; however, the Detention Standard also requires the count system to be effective. The count system at ACF is not effective. There are six counts daily at the East and West Facility. Count can take up to 2 hours to clear. All movement must cease during counts per PBNDS 2011. The number of counts was increased to six several years ago due to a detainee escape and was based upon a Corrective Action Plan agreement between ICE and ACF. The six counts at ACF creates extended delays in feeding, visiting (legal and regular), recreation, law library, and healthcare appointments. These extended delays impact all programming. In discussions with the Chief of Security, he does not have a concern with eliminating the 1100 daily count. The Warden and AFOD are also open to discussing revising the count process at ACF, but will need support from ICE Headquarters.

FINDING: ACF POPULATION COUNT PRACTICE DOES NOT CONFORM TO THE PBNDS ON POPULATION COUNTS STANDARD.

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

Recommendation

7. ERO and ACF must develop and implement an efficient population count process that comports with the 2011 PBNDS in order to eliminate the problematic delays that six daily counts cause in the delivery of meals, visitation (legal and regular), recreation, law library access, and detainee medical appointments. (PBNDS 2011, Population Counts)

D. Grievance System, Staff Misconduct, Retaliation,

The 2011 PBNDS protects detainees' rights and ensure they are treated fairly by providing a procedure for them to file both informal and formal grievances and receive timely responses relating to any aspect of his/her detention, including medical care. One important aspect of the Grievance System Standard is detainees are protected from harassment, discipline, punishment or retaliation for filing a complaint or grievance. CIVIC filed a complaint[2] on behalf of Detainee #1 alleging that Detainee #1 was wrongly placed in administrative segregation for organizing other detainees to complain about conditions of the facility. Detainee #1 also alleged the Lieutenant failed to document the reason for the detainee's placement in segregation and failed to give a reason for the placement. I reviewed the detainee's file and the paperwork associated with the placement in segregation. The appropriate placement order for inciting other detainees which could jeopardize the safety of the facility was written, and the detainee refused to sign his copy of the order. Staff appropriated noted the detainee's refusal to sign the order on the document. This complaint is unfounded. Detainee #2[3] alleged that the facility Warden wrongfully denied his grievances. I reviewed numerous Detainee #2 grievances and the responses. Based on the document review, I did not substantiate that the Warden had wrongfully denied Detainee #2's grievances. Detainee #2 submitted a significant number of grievances which were responded to in accordance with the Detention Standards.

I also reviewed the Grievance system as part of this investigation. The facility had 483 grievances logged for 2015 which is a significant number. In 2015 42% of the approximately 483 ACF detainee grievances were healthcare related. This large number of healthcare related grievances is not typical in a correctional setting, and is a key indicator that the healthcare needs of the detainee population is not being met. The medical expert will provide the expert opinion on medical care; however, grievance systems are designed to act as am important indicator or early warning system to assist leadership of both ICE/ACF to identify significant issues within the facility. Heath care concerns were one of the major issues raised by detainees during detainee interviews that CRCL staff and I conducted at this facility. Detainees also raised concerned that an officer, staff #1, was rude and disrespectful to the detainees. This staff name was provided to facility leadership during the onsite investigation for follow-up action.

Twelve (12%) of the grievances filed by detainees were related to staff misconduct. Alleged misconduct includes verbal disrespect and harassment of detainees by healthcare, program, and custody staff, discrimination based on race and sexual identity, retaliation when detainees voice grievances, and excessive use of force. Six grievances were filed against the Grievance coordinator. During detainee interviews CRCL staff and I conducted, female and male detainees voiced numerous concerns regarding the grievance system and the Grievance Coordinator.

---

[2] CRCL complaint No. #15-08-ICE-0417

[3] CRCL complaint No. 15-11-ICE-0599

The Grievance Coordinator, staff #2 is conscientious; however, her interpersonal skills create difficulties communicating with the detainees. Detainees on both East and West Facility during interviews and in documented grievances report disrespectful treatment by the Grievance Coordinator. Female and male detainees reported feeling bullied to agree to withdraw appeals or agree with the finding. Detainees also report having no faith in the grievance system due to a lack of responsiveness by staff and the grievance system being ineffective. Adding to the communication difficulty is the Grievance Coordinator reports she is frustrated by a lack of management support to follow through and correct reported system issues, lack of staff accountability for correcting individual detainee grievances that have been granted, and failure to address issues of staff disrespect toward detainees. The lack of management and supervisory follow through on correcting grievances generates additional detainee hostility towards the Grievance Coordinator. The Grievance Coordinator also requests additional training on how to effectively communicate with detainees and how to deal with difficult people.

While onsite I interviewed two separate groups of detainees. One female groups and one male group. Detainees were interviewed on both East and West Facilities. During both groups of detainee interviews the detainees reported they are verbally harassed and disrespected by ACF staff in healthcare, program, and custody staff, discriminated against based on race and subjected to retaliation when they voice grievances. These reports mirror the staff misconduct formally documented in grievances. Adult Local Detention Facility Performance Based Standard 4-ALDF-6A-07 mandate that detainees [Inmates] are not subjected to personal abuse or harassment.

FINDING: ACF GRIEVANCE SYSTEM FAILS TO CONFORM TO THE PBNDS. DETAINEES SUFFER RETALIATION, VERBAL HARASSMENT AND TREATED WITH DISRESPECT BY ACF STAFF

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

Recommendations:

8. ICE/ACF Management (including the Warden), and the Grievance Coordinator must develop a regular meeting schedule to identify serious systemic grievance issue reported by the detainees and substantiated by the Grievance Coordinator. (PBNDS 2011, Grievance System)
9. ICE/ACF Management (including the Warden), must develop a reporting system to ensure that facility personnel respond to and resolve the detainee grievance issues assigned to them by the Grievance Coordinator. (PBNDS 2011, Grievance System)
10. ICE/ACF Management must develop a review and trend tracking system for all grievances reporting staff mistreatment. (PBNDS 2011, Grievance System)
11. ACF Warden must hold facility staff accountable for substantiated abusive and disrespectful treatment of the detainees, as determined by the Grievance Coordinator and or other facility personnel. (PBNDS 2011, Grievance System)

12. ACF/GEO must provide the Grievance Coordinator with management training relevant to interpersonal skills-building, effective communication, and dealing with difficult individuals. (PBNDS 2011, Staff-Detainee Communication, Grievance System)

E. Staff-Detainee Communication, Training and Turnover

ICE and ACF management cite staff communication, turnover and medical as the three largest problems at this facility. The medical expert will speak to the medical issues in his report. Both ICE and ACF management attribute the high staff turnover to the pay level of the officers. There are several other contract correctional facilities in close proximity to ACF. ACF staff hires and trains custody staff but cannot retain them as they accept jobs in other facilities that provide higher pay. This creates a constant instability in the workforce, a constant need for close supervision and ongoing basic training, and an inconsistent application of policy and practice. Constant staff turnover can impact their performance of conducting basic duties such as count and contribute to the delays. Lower pay levels than the surrounding facilities can also negatively impact the quality of the staff hired and the staff who choose to remain at ACF.

Detainees reported during interviews, and complaints, grievances (as previously discussed) and staff interviews substantiate that some staff at ACF treat detainees with disrespect and make disrespectful comments. Also, when ACF began housing women detainees in July no gender responsive or trauma informed training was provided to staff who work with the women detainees adding to communication problems with the women detainees.

Staffing levels at the East and West facilities was impacted by GEO cutting over 20 officer positions. The positions were cut due to the population levels at the facility; however, the positions that were cut directly impacted the movement of the detainees to medical, feeding, visiting (legal and regular), etc. Some positions are now being hired on overtime to reduce the movement delays; however, a permanent resolution to the number of custody staff needed to operate the facility needs to be developed as workload can also impact staffing turnover as well as the safe and efficient operation of the facility.

FINDING: ACF FAILS TO HIRE AND MAINTAIN A WORKFORCE OF QUALIFIED PERSONNEL. ACF'S CURRENT POST ASSIGNMENT SCHEDULE RESULTS IN OPERATIONAL DELAYS TO COUNT, FEEDING, VISITING, LEGAL ACCESS, AND RECREATION AND DOES NOT CONFORM TO THE PBNDS. DETAINEES SUFFER RETALIATION, VERBAL HARASSMENT AND TREATED WITH DISRESPECT BY ACF STAFF

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

Recommendations:

13. ICE HQ and ACF leadership must develop a post-assignment schedule that creates a staffing plan which resolves the current staffing deficiencies that are impacting operational inefficiencies, such as excessive count times, meal delays, and limited visitation, legal access and recreation time allotments. (PBNDS 2011, Facility Security and Control)

14. ERO and ACF must provide cultural diversity training to all staff to improve staff detainee communication comply with the Detention Standard requirement that training shall be consistent with the duties and function of each individual. (PBNDS 2011, Staff Detainee Communication, Staff Training)
15. ICE/ACF must address pay inequity with other local correctional facility custody classifications to reduce high turnover and stabilize the custody workforce to ensure essential security posts and positions will be staffed with qualified personnel and comply with Detention Standards. (PBNDS 2011, Facility Security and Control)
16. ICE and ACF must provide gender responsive, trauma informed training to staff working with women detainees to comply with the Detention Standard requirement that training shall be consistent with the duties and function of each individual. (PBNDS 2011, Staff Training)

F. Legal Access

Law Library

During onsite interviews Detainees in East and West facilities voiced significant complaints regarding the disrespectful and ineffective services provided by the female Law Librarian, staff #3. These complaints were also substantiated in inmate requests and grievances/complaints. Complaints of detainees include being treated disrespectfully by the Law Librarian, not receiving legal copies timely and in some cases, not at all, and lack of knowing how to operate a computer and the Lexis-Nexis software. Management is aware of detainee concerns regarding the Law Librarian and recently moved her from the West to East facility. Detainees in the East facility now voice the same concerns. While interviewing the Law Librarian, she became frustrated, agitated, at times did not listen to what was being asked, and made assumptions that were not accurate about which detainees were complaining about her. The Law Librarian is not bi-lingual which also contributes to the communication difficulties with LEP detainees. The Law Librarian previously asked for a transfer to another position out of the Law Library but was denied due to a pending investigation. The investigation is now over and that barrier to transfer no longer exists.

FINDING: ACF FAILS TO PROVIDE LEGAL ACCESS TO DETAINEES IN COMPLIANCE WITH PBNDS

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

Recommendations

17. ACF should grant the female Law Librarian's transfer and hire a Spanish Speaking Librarian. (PBNDS 2011, Law Library and Legal Material)
18. ACF must institute a computer training class, demonstrating use of the Lexis-Nexis software and computers, and create a detainee worker position in each housing unit in order to assist detainees with utilizing the computer system. (PBNDS 2011, Law Library and Legal Material)

G. Visitation

The physical plant at ADF limits the visiting space available. The limited visiting space contributes to long wait times for visitors including adults and minor children. The detainees complain of unequal treatment as it relates to families of detainees who come from long distances and have over three children. Families are inconsistently provided with longer visits and allowed to visit more than three at a time which is the set limit by facility policy. The limited space in the general visiting room and the increasing detainee population contributes to the lengthy visitor waits. The count process also impacts the amount of time available for visiting. If count is delayed, so is visiting. Visitors may come to visit and not be able to due to capacity limits and count delays.

Legal Visits

Attorney visits on the West and East facilities are impacted by the limited number of attorney interview rooms. On the West side seven attorney interview rooms exist; however, one was turned into a storage room. During the investigation I pointed this out to ICE/ADF leadership who immediately gave staff direction to remove storage items and to return the interview room to its intended use. Detainees and attorneys are frustrated about the long wait times for attorney visits. Grievances and complaints by detainees, advocates and attorneys report up to a four hour wait time. The long wait time and the remote area of ACF acts as a disincentive for attorneys to provide pro-bono services and legal representation in immigration proceedings at this facility. Freezing movement of the detainee population during count and feeding delays also impact attorney wait times. As part of this investigation I also reviewed the policies regarding attorney access and the complaint filed by SIDLEY alleging that Ms. Fialho, the Co-Executive Director of CIVIC and attorney of record, was denied access to a client in retaliation for her participation in a vigil outside of the ACF and her advocacy for detainees. I found no evidence to substantiate this allegation; however, attorney-client visits are clearly impacted by capacity issues. The systemic changes that I have recommended should result in improved access, less wait time and less frustration for attorneys and detainees.

FINDING: ADF'S LIMITED VISITING CAPACITY RESULTS IN UP TO FOUR HOUR DELAYS FOR FAMILY VISITS AND VISITING RULES ARE INCONSISTENTLY APPLIED. RETALIATION FOR ATORNEY-CLIENT ADVOCACY IS NOT SUBSTANTIATED.

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

Recommendation

19. ERO and ACF leadership must collaborate to develop a strategy for increasing the facility's visitation capacity and to eliminate the long waits for both legal and regular visitations caused by current physical plant limitations, insufficient staffs and population count inefficiencies. (PBNDS 2011, Visitation, Legal Access)
20. ERO and ACF leadership must institute an attorney appointment system to decrease the current excessive wait times, and begin to consider other legal visitation options such as V-tel legal visits. (PBNDS 2011, Visitation, Legal Access)

21. ACF must issue written notice to the detainee population, and post a notice in the visitation area, clarifying that large families traveling long distances for visitation are able to request special accommodations regarding the size of the visiting family and the time allotment. (PBNDS 2011, Visitation)

H. Limited English Proficiency-Language Access

ACF and ICE do not currently comply with providing language access to Limited English Proficient (LEP) detainees. Under federal civil rights law and DHS policy, LEP detainees must be provided meaningful access to information, programs and services within ICE detention. Title VI of the Civil Rights Act of 1964 (Title VI); Executive Order 13,166, Improving Access to Services for Persons with Limited English Proficiency, 65 Fed. Reg. 50,121 (Aug. 11, 2000); Department of Homeland Security Language Access Plan, February 28, 2012 mandate LEP access for individuals held in detention. This obligation includes providing access to competent interpretation (oral) and translation (written) services for a wide range of interactions and programs covered by the ICE standards, e.g., Admission and Release, Custody Classification, Sexual Abuse and Assault Prevention and Intervention, Special Management Units, Staff-Detainee Communication; Disciplinary System; Medical and Mental Health Care; Suicide Prevention; Detainee Handbook; Grievance Systems. Further, not only is this a legal requirement, but a failure to provide appropriate language services can impact the safety of detainees and staff, and undermine the facility's compliance with detention standards and its own processes and procedures. Karnes and ICE's contractual obligations require them to provide meaningful language access for residents.

In non-medical settings, ICE and ADF staff does not routinely use language line and some bi-lingual Spanish speaking ICE/ADF staff do not speak to Spanish speaking detainees in Spanish or translate official documents from English to Spanish. LEP detainees are required to sign documents that they do not understand which invalidates the content of the documents and purpose of having detainees sign documents. ICE/ADF management does not believe they can mandate staff that is Spanish speakers to use bi-lingual skills.

FINDING: ADF DOES NOT COMPLY WITH THE DHS 2012 LANGUAGE ACCESS PLAN AND DOES NOT COMPLY WITH PBNDS LANGUAGE ACCESS FOR LIMITED ENGLISH PROFICIENT DETAINEES STANDARDS

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

Recommendations:

22. ACF/ICE Staff must be trained on how to utilize the Language Line when dealing with non-English speaking detainees and acknowledge their awareness of Language assistance requirements per the PBNDS 2011 and the DHS Language Access Plan issued in February 2012. (DHS Access Plan 2012) (PBNDS 2011, Multiple)
23. ACF must develop a Language Line logging system and require all facility staff to record its use; by date and A#. (DHS Access Plan 2012) (PBNDS 2011, Multiple)

24. ICE/ADF must ensure all forms issued to detainees for informational purposes and/or for detainee signatures must be written and/or translated in a language the detainee comprehends. All written material provided to detainees shall generally be translated into Spanish to comply with the Detention Standards. (DHS Language Access Plan 2012) (PBNDS, Multiple)

I. Management Team Assistance

ICE and GEO leadership at ADF expressed frustration at many Detention Standard deficiencies as ICE/ACF felt they needed further direction or support of Headquarter ICE/GEO to resolve. Developing a SMU long term placement and mental health placement case strategy, staffing issues and count are three of the primary areas.

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

Recommendation

25. ICE and GEO Headquarter leadership must send a team onsite to help identify and develop a Corrective Action Plan (CAP) for those more difficult and complex needs that are not within the onsite ERO or ACF leadership 's ability to resolve.
26. All actions relevant to the above recommended audits, reviews and changes must be written into policy and procedure, with written notice provided to staff.
27. ICE must monitor the CAP to ensure all items are corrected by local ERO and ACF management
28. ICE and GEO must address ACF staff turnover rates by comparing local correctional facility custody classifications in order to promote staff longevity, Institutional Knowledge and operational consistency.
29. All local and Headquarter CAP items must be fully addressed and implemented with a memo documenting their resolution, providing proof of practice, and signed by ICE and GEO.

J. Hunger Strike

The PBNDS 2011 protects detainees' health and well-being by monitoring, counseling and providing appropriate treatment to any detainee who is on a hunger strike. The Adelanto Detention Facility has experienced ongoing complaints from detainees and NGO's regarding the treatment and conditions at this facility. The November 2, 2015 online report, entitled "Why Immigrant Detainees in California Just Launched a Hunger Strike"[4], published by Think Progress contained allegations of mistreatment, inadequate medical and mental health care, inappropriate treatment of visitors, long waits for scheduled visits, inadequate Prison Rape Elimination Act responses (PREA), forced fingerprinting inadequate denial of food, limited access

[4] CRCL complaint 16-01-ICE-0037

to the grievance process, retaliatory denial of legal access, inadequate telephone access, inappropriate and abusive staff-detainee communication and general claims of verbal mistreatment of detainees by ACF corrections officers; inappropriate use of segregation, and excessive use of force. I did not substantiate inadequate PREA, forced fingerprinting, inadequate telephone access, or excessive use of force. I did substantiate as previously discussed allegations of mistreatment, inadequate medical and mental health care in the Special Management Unit (medical and mental health experts will opine on care), inappropriate treatment of visitors, long waits for scheduled visits, limited access to the grievance process, retaliatory denial of legal access (law library), inappropriate and abusive staff-detainee communication and general claims of verbal mistreatment of detainees by ACF corrections officers; and inappropriate use of segregation. During the onsite investigation, CRCL, the medical expert and I met with a group of detainees who had decided on the day we met with the group to end their hunger strike. The detainees had been moved into a single housing unit for monitoring. Detainees reported they had been on a Hunger Strike to protest conditions of confinement, disrespectful treatment and the length of time the detention proceedings take. The medical expert will opine on the ACF's compliance with the medical aspect of the Hunger Strike and compliance with the Detention Standard; however, it is important that ICE/ACF take action to ameliorate the conditions discussed in this expert report to prevent further hunger strikes from occurring.

FINDINGS: ACF CONDITIONS OF CONFINEMENT AND DISRESPECTFUL TREATMENT CONTRIBUTE TO HUNGER STRIKES

Recommendations: No further recommendations. Correct identified issues. It is not recommended that any mission expansions including the housing of transgender detainees or a population expansion of the female detainee population occur until the numerous identified deficiencies are corrected.

K. Detainee #3 Death Review (Name listed on Appendix A)

As Part of this investigation I was asked by CRCL to review from a correctional practice perspective any significant factors regarding Detainee #3's detention at ACF. I reviewed the detainee's detention file and found Detainee #3 was housed in disciplinary segregation on two occasions: 1) September -22-24, 2014, and 2) March 31-April 1, 2015 for fighting with and assault of a detainee. There are two grievances in the file both dated February 6, 2015. The detainee grieves "To who is in charge, I saw the nurse on 2/3/15 and she gave me Ibuprofen…..". Detainee #3 further states he needs medical attention so they can give me medicine for my sickness but these dumb brutes don't care about my health. Let's see if you can help me." The Grievance Officer responds" Your Grievance states that medical staff has not cared for you and that you did not see the MD as you were told. You are requesting medical attention. You have been scheduled to see a provider on February 10-, 2015." The grievance is denied due to the detainee's request being medical in nature, but a medical appointment was made for the detainee. From a correctional perspective the detainee sought assistance through the grievance process and although his grievance was denied, he was scheduled for an appointment. Based on the records that are contained in Detainee #8's detention file, I did not find any conditions of detention information that contributed to or was related to the detainee's death.

L. Detainee #4- Lockdown Allegation

As Part of this investigation I was asked by CRCL to review a complaint DHS-15-0792 from Detainee #4 regarding an incident that occurred on March 22, 2015 involving detainees that the detainee alleged resulted in a lock down of the facility for four days. I reviewed the documentation related to the incident. Housing Unit H-3A was locked down due to gang related violence, southerners and a southern drop out. The unit was appropriately locked down by custody staff until the assailants could be identified and the security risk resolved. Detainee #5 also alleged that many detainees were not eating because they were on lockdown. This allegation is unfounded as documentation was provided that detainees were offered meals at every meal cycle. It is unfortunate, but sometimes necessary to lock a unit down until security risks can be resolved in order to maintain the safety and security of the detainees, staff and facility.

FINDING: ALLEGATION IS UNFOUNDED

M. Detainee #5-Prison Rape Elimination Act-Sexual Abuse and Assault Prevention and Intervention Complaint

As part of this investigation I was asked by CRCL to review a complaint from Detainee #5 that on September 4, 2015, he was sexually assaulted inside the bathroom/shower. Detainee #5 alleges he was forcibly raped. Detainee #5 reported the alleged assault and the facility appropriately implemented the PREA/SAPPI protocol and followed all policy and detention requirements. Medical mental health care was offered and the detainee was placed on medical observation. The detainee was also provided with support information. The alleged assailant was placed in administrative segregation pending the investigation. The San Bernardino Sheriff's Office investigated and did not find any evidence to support criminal charges and did not substantiate the complaint.

FINDING: ICE/ADF FOLLOWED ALL PREA/SAAPI PROTOCOLS AND THE ALLEGATION OF SEXUAL ASSAULT IS NOT SUSTAINED.

VII. SUMMARY OF ACF RECOMMENDATIONS

Regarding the specific deficiencies I found as part of my inquiry into these complaints, I have recommended the following based on the PBNDS 2011.

1. ACF fails to meet the Admission and Release, Intake Screening Standard as interpreters or language lines are not consistently used during the intake screening process and completion of the numerous intake forms. The facility must correct their intake and admission process by consistently utilizing interpreters during the intake screening and admission process and ensuring detainees are signing documents in a language he/she understands or is provided oral assistance in order to comply with the detention standard. (PBNDS 2011, Admission and Release)

2. ERO, IHSC and ACF must audit all Special Management Unit (SMU) cases to identify those detainees housed in the SMU, partially or wholly due to mental health conditions and, develop a safe housing alternative with more intensive mental health services including mental health groups in a non-SMU setting for detainees with mental health conditions. that includes necessary and consistently delivered mental health services. (PBNDS 2011, SMU)
3. The Mental Health Director and IHSC must ensure that ACF mental Health staff conduct daily face-face round with all detainees in the SMU and provide appropriate mental health assessment and treatment. (PBNDS 2011, SMU)
4. The Mental Health Director, ERO and IHSC must ensure that custody staff cease determining or influencing whether or not a detainee requires medical or mental health services. (PBNDS 2011, SMU)
5. ICE must audit all detainees held in the SMU over 30 days for protective housing reasons and determine if transfer to another facility is more appropriate. (PBNDS 2011, SMU)
6. ERO must conduct an external audit of all detainees held in Administrative and Disciplinary Segregation over 30 days to determine if transfer to another facility could improve treatment or resolve use d of the SMU for special housing. (PBNDS 2011, SMU)
7. ERO and ACF must develop and implement an efficient population count process that comports with the 2011 PBNDS in order to eliminate the problematic delays that six daily counts cause in the delivery of meals, visitation (legal and regular), recreation, law library access, and detainee medical appointments. (PBNDS 2011, Population Counts)
8. ICE/ACF Management (including the Warden), and the Grievance Coordinator must develop a regular meeting schedule to identify serious systemic grievance issue reported by the detainees and substantiated by the Grievance Coordinator. (PBNDS 2011, Grievance System)
9. ICE/ACF Management (including the Warden), must develop a reporting system to ensure that facility personnel respond to and resolve the detainee grievance issues assigned to them by the Grievance Coordinator. (PBNDS 2011, Grievance System)
10. ICE/ACF Management must develop a review and trend tracking system for all grievances reporting staff mistreatment. (PBNDS 2011, Grievance System)
11. ACF Warden must hold facility staff accountable for substantiated abusive and disrespectful treatment of the detainees, as determined by the Grievance Coordinator and or other facility personnel. (PBNDS 2011, Grievance System)
12. ACF/GEO must provide the Grievance Coordinator with management training relevant to interpersonal skills-building, effective communication, and dealing with difficult individuals. (PBNDS 2011, Staff-Detainee Communication, Grievance System)
13. ICE HQ and ACF leadership must develop a post-assignment schedule that creates a staffing plan which resolves the current staffing deficiencies that are impacting operational inefficiencies, such as excessive count times, meal delays, and limited visitation, legal access and recreation time allotments. (PBNDS 2011, Facility Security and Control)
14. ERO and ACF must provide cultural diversity training to all staff to improve staff detainee communication comply with the Detention Standard requirement that training shall be consistent with the duties and function of each individual. (PBNDS 2011, Staff Detainee Communication, Staff Training)

15. ICE/ACF must address pay inequity with other local correctional facility custody classifications to reduce high turnover and stabilize the custody workforce to ensure essential security posts and positions will be staffed with qualified personnel and comply with Detention Standards. (PBNDS 2011, Facility Security and Control)
16. ICE and ACF must provide gender responsive, trauma informed training to staff working with women detainees to comply with the Detention Standard requirement that training shall be consistent with the duties and function of each individual. (PBNDS 2011, Staff Training)
17. ACF should grant the female Law Librarian's transfer and hire a Spanish Speaking Librarian. (PBNDS 2011, Law Library and Legal Material)
18. ACF must institute a computer training class, demonstrating use of the Lexis-Nexis software and computers, and create a detainee worker position in each housing unit in order to assist detainees with utilizing the computer system. (PBNDS 2011, Law Library and Legal Material)
19. ERO and ACF leadership must collaborate to develop a strategy for increasing the facility's visitation capacity and to eliminate the long waits for both legal and regular visitations caused by current physical plant limitations, insufficient staffs and population count inefficiencies. (PBNDS 2011, Visitation, Legal Access)
20. ERO and ACF leadership must institute an attorney appointment system to decrease the current excessive wait times, and begin to consider other legal visitation options such as V-tel legal visits. (PBNDS 2011, Visitation, Legal Access)
21. ACF must issue written notice to the detainee population, and post a notice in the visitation area, clarifying that large families traveling long distances for visitation are able to request special accommodations regarding the size of the visiting family and the time allotment. (PBNDS 2011, Visitation)
22. ACF/ICE Staff must be trained on how to utilize the Language Line when dealing with non-English speaking detainees and acknowledge their awareness of Language assistance requirements per the PBNDS 2011 and the DHS Language Access Plan issued in February 2012. (DHS Access Plan 2012) (PBNDS 2011, Multiple)
23. ACF must develop a Language Line logging system and require all facility staff to record its use; by date and A#. (DHS Access Plan 2012) (PBNDS 2011, Multiple)
24. ICE/ADF must ensure all forms issued to detainees for informational purposes and/or for detainee signatures must be written and/or translated in a language the detainee comprehends. All written material provided to detainees shall generally be translated into Spanish to comply with the Detention Standards. (DHS Language Access Plan 2012) (PBNDS, Multiple)
25. ICE and GEO Headquarter leadership must send a team onsite to help identify and develop a Corrective Action Plan (CAP) for those more difficult and complex needs that are not within the onsite ERO or ACF leadership 's ability to resolve.
26. All actions relevant to the above recommended audits, reviews and changes must be written into policy and procedure, with written notice provided to staff.
27. ICE must monitor the CAP to ensure all items are corrected by local ERO and ACF management

28. ICE and GEO must address ACF staff turnover rates by comparing local correctional facility custody classifications in order to promote staff longevity, Institutional Knowledge and operational consistency.
29. All local and Headquarter CAP items must be fully addressed and implemented with a memo documenting their resolution, providing proof of practice, and signed by ICE and GEO.

APPENDIX A

Detainee Name and A Numbers

(b) (6)

#1:

Detainee #2:

Detainee #3:

Detainee #4:

Detainee #5:

Staff Name and Classification

(b) (6), (b) (7)(C)

Staff #1:

Staff #2:

Staff #3:

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

Adelanto Detention Facility, Adelanto, California

(b) (6), RD, LD, RS, CLLM

(b) (6)

Prepared By:
MCJ, R.D., L.D., R.S., CCHP, CLLM
3/2/2016

Confidential
For Official Use Only

Protected by Deliberative Process Privileges

Table of Contents

Introduction

On December 9-11, 2015, I assessed the environmental health and safety conditions at the Adelanto Detention Facility (ADF) in Adelanto, California, to investigate complaints made by U.S. Immigration and Customs Enforcement (ICE) detainees who alleged violations of civil rights and civil liberties at ADF. This onsite investigation was conducted under contract with the United States Department of Homeland Security, Office for Civil Rights and Civil Liberties (CRCL). Accompanying me on this investigation were (b) (6) Senior Policy Advisor, CRCL, and (b) (6) Policy Advisor, CRCL, as well as three other subject matter experts who examined ADF's medical care, mental health care, and correctional operations.

Qualifications

(b) (6)

Methodology

The basis of this report includes document reviews, tour of the facility, interviews with facility staff and detainees, visual observations, and environmental measurements. The findings and recommendations contained in this report are solely those of the author. The report cites specific examples of conditions found during this investigation, however, they should not be considered as all inclusive of the conditions found during the investigation. Consideration was given to national and state standards including the 2011 Performance Based National Detention Standards (PBNDS 2011) and Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, published by the American Correctional Association (ACA).

Facility Overview

ADF is operated by The GEO Group, Inc., under contract for Immigration and Customs Enforcement (ICE). The facility population was 1,304 male and 153 female detainees on December 9, 2015. The 2011 Performance Based National Detention Standards (PBNDS 2011) are applicable to this facility.

Findings

Allegation No. 1 – Think Progress Complaint

It is alleged by Think Progress that detainees are served bland food that is not prepared and served in accordance with health and safety codes. The group also purports that detainees should be served larger food portions, actual desserts instead of fresh fruit, fewer processed meat products, and hot main courses instead of cold, sliced turkey. Additionally, it is alleged that detainee kitchen workers should be treated more respectfully.

Findings: The allegation that the food served at ADF does not comply with applicable food safety standards is **partially substantiated**. The allegation that the meals are nutritionally inadequate is **partially substantiated**. The allegation that detainee kitchen workers are treated disrespectfully is **unsubstantiated**.

Applicable Standard: The PBNDS 2011 Food Service standard is applicable.

Analysis:

An inspection of the kitchen was conducted on December 10, 2015. Two significant violations of the PBNDS 2011 Food Service standard were found. First, what appeared to be mouse droppings were observed along the floor and wall juncture beside the Vulcan ovens. The droppings were easily spotted and in a location that should be routinely cleaned on a daily basis. Upon bringing this finding to the attention of the kitchen supervisor, the area was immediately cleaned and before noon the following day, the contracted licensed pest control company was contacted and rodent specific service was performed. Rodent droppings are of significant health importance. Rodents are reservoirs and vectors of disease. Therefore the presence of droppings in the kitchen justifies a finding of partial compliance with the PBNDS 2011 Food Service standard, specifically the standard requiring, "No pests or infestations may be present."

Additionally, detainee workers were observed using cloth towels dipped in a bucket of a watery solution to wipe the dining tables between the first and second meal seating. However, when the contents of the bucket were tested for the type and concentration of chemical sanitizer, it was discovered that the bucket contained only water. Properly concentrated sanitizing solution is important to kill the microorganisms that spread disease that may be transmitted between detainees via the dining tables. Proper sanitizing solution was available in the kitchen. However, failure to adhere to the PBNDS 2011 Food Service standard requiring, "Moist cloths used for non-food-contact surfaces like counters, dining table tops and shelves shall be clean, rinsed frequently in sanitizing solution and used solely for wiping food spills. These cloths shall soak in the

sanitizing solution between uses," places detainees at risk of disease. Once the deficiency was brought to the attention of the kitchen supervisor, the situation was immediately corrected and the tables were wiped down with sanitizing solution before the next dining session.

The menu plans have been approved by a registered dietitian and are adequate to meet the diverse nutritional needs of most, but not necessarily all detainees. The current menu was last certified by a dietitian in June 2015 and provides an average of 2,200 to 2,300 calories per day. Calorie needs vary from person to person based on the factors of age, body composition, gender, and activity level. The current calorie level may not be sufficient for all detainees, particularly younger, very active males. However, CRCL's medical expert (b) (6) did not report findings of weight loss. Furthermore, ADF administration advised that a newly revised dietitian certified menu is scheduled for implementation on December 14, 2015. The new menu provides 2,600 to 2,700 calories per day and should be sufficient to meet the needs of most detainees except those requiring a medically prescribed high calorie diet. An interviewed cook supervisor stated that standardized recipes are not used at ADF, which may lead to inconsistent preparation of foods impacting flavor and nutritional value, particularly sodium and fat content.

The detainee criticisms that sweet desserts should be served in place of fresh fruits and that the facility should serve fewer processed meat products are assertions of personal preference. However, meal periods are highly anticipated events in a detention environment and the taste, appearance, and presentation of meals can impact the health and general mood of the facility, as indicated by the PBNDS 2011 Food Service standard stating, "The food service program significantly influences morale and attitudes of detainees and staff, and creates a climate for good public relations between the facility and the community." The food is a serious concern because it is one of the complaints cited by the hunger strikers and the majority of interviewed detainees report that the foods served are repetitive and poor quality. The new, revised menu incorporates the detainee requests and includes desserts such as fruit crisps, cobblers, and cake, as well as an increase in the variety and frequency of chicken entrees.

Observation of the kitchen operation revealed that volunteer detainee workers were acting under direction of the GEO kitchen staff. The kitchen complies with the PBNDS 2011 Food Service standard requiring, "Before starting work in the department, the detainee shall sign for receipt of the applicable job description. A copy of the detainee's job description shall remain on file for as long as the detainee remains assigned to the food service department." Additionally, many of the signed job descriptions and

training forms were in Spanish and kitchen employees were verbally communicating with detainees in both English and Spanish. Random interviews with detainee kitchen workers did not reveal any problems. Detainees stated that they are paid in a timely manner and that the GEO kitchen employees treat them fairly. Interactions between the kitchen staff and detainees were observed to be professional in nature.

Conclusion: The presence of rodent droppings and failure to properly sanitize the dining tables between uses is placing detainees at potential risk of illness. Furthermore, the newly revised menu should be fully implemented along with standardized recipes, as soon as possible, to ensure that the food service program meets the diverse nutritional needs of the detainees.

Recommendations:

1. Strict adherence to the PBNDS 2011 Food Service standard is needed to ensure the kitchen is maintained in a sanitary and pest-free manner. (Applicable standard: PBNDS 2011 Food Service)

2. Implementation of the new, revised menu and standardized recipes should bring ADF into compliance with the PBNDS 2011 Food Service standard requiring, "Food service personnel shall provide nutritious and appetizing meals." (Applicable standard: PBNDS 2011 Food Service)

Allegation No. 2 – Supplemental Complaint

It is alleged that detainees are shivering and crying due to "freezing cold" temperatures in the dormitories because the facility does not turn on the heat when the outside temperatures are in the thirties.

Findings: The allegations that the ambient air temperatures in the dormitories are "freezing cold" and that the facility does not utilize a heating system are **unsubstantiated**.

Applicable Standards: The PBNDS 2011 Environmental Health and Safety and Personal Hygiene standards are applicable.

Analysis:

Ambient air measurements were taken throughout the housing units. Temperatures in the West facility ranged from 66.7°F (near an open door leading to the outside mini-recreation area with an outdoor temperature of 65°F) to 80.6°F on December 10, 2015.

Temperatures in the East facility ranged from 68.6°F to 73.7°F and temperatures in the West facility Segregation Unit ranged from 71.6°F to 76.5°F on December 11, 2015.

The PBNDS 2011 does not specify an ambient air temperature requirement, however, it does indicate that "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene" and further specifies, "The standards include those from the American Correctional Association." ACA Housekeeping standard 4-ALDF-1A-20 stipulates, "Temperature and humidity are mechanically raised or lowered to acceptable comfort levels." The Centers for Disease Control (CDC) and the National Institute for Occupational Safety and Health (NIOSH) recommend indoor temperature ranges of 68.5°F to 75°F in the winter and 75°F to 80.5°F in the summer.

The Adelanto Maintenance Supervisor reported that the facility is equipped with heating, air conditioning, and ventilation systems that comply with California Title 24, energy efficiency standards. The system operates at a set point and maintains temperatures within plus or minus four degrees. During the warmer months the system was set at 72°F and was raised to 74°F approximately one month prior to the onsite to compensate for the lower seasonal outdoor temperatures.

Furthermore, ADF issues two blankets to each detainee in compliance with the PBNDS 2011 Personal Hygiene standard stating, "Additional blankets will be issued, based on local indoor-outdoor temperatures." ADF also issues each detainee a long sleeved sweatshirt during the period of October through April.

Conclusion: The factors that constitute comfortable and preferable living conditions are subjective and some individuals, especially those in a sedentary environment may feel cold at the common set point temperatures utilized in institutional environments. However, the general conditions found during the onsite investigation met the environmental health standards and generally accepted practices applicable to detention facilities.

Allegation No. 3 – ADA Accessibility (Complaint 15-08-ICE-0413)

Complaint 15-08-ICE-0413 alleges that detainee who uses a wheelchair experienced falling out of his wheelchair due to a lack of staff assistance with toileting and bathing. Although the primary complaint is being addressed by other members of the CRCL team, the allegations in the complaint also prompted an environmental safety review of the ADA accessible areas in the detainee housing units.

Findings: The lack of privacy curtains or panels in ADA accessible showers creates a barrier to their use and an environment in which detainees with disabilities utilize non-accessible showers, placing them at increased risk of injuries from falling.

Applicable Standard: The PBNDS 2011 Personal Hygiene standard is applicable.

Analysis: Time constraints did not allow for a comprehensive inspection of every accessible cell, toilet, lavatory, and shower. However, spot checks indicate that the physical layout and design of the accessible areas are compliant with ADA/Section 504 Design Guide: Accessible Cells in Correctional Facilities. Furthermore, the Maintenance Supervisor reports that the facility is less than five years old and meets modern construction standards.

During the initial tour on December 9, 2015, it was pointed out by the tour guide that the ADA accessible shower in the east 1-A female housing unit was missing a shower curtain, while the other showers had curtains. The shower is situated in the middle of a large dormitory style housing unit, across from the officer station and the door used for entering and exiting the unit. Therefore, use of the shower without a curtain or modesty panel will likely leave the detainee exposed to staff members and other detainees. On December 11, 2015, the east 1-A housing unit ADA accessible shower still lacked a curtain or modesty panel. A detainee housed in the unit that requires the use of a wheelchair reported to CRCL's medical expert (b) (6) that because the accessible shower lacks a curtain, she uses a non-accessible shower with a curtain for modesty. However, the use of a non-accessible shower places the detainee at serious risk of injury from falling.

Conclusion: The lack of a reasonably private environment due to the absence of a shower curtain in the east 1-A accessible shower is placing detainees with disabilities at risk of serious injury.

Recommendation:

3. A shower curtain or modesty panel, at least equivalent to the curtains on the other showers, should be immediately installed in the lower accessible shower in the women's East 1-A housing unit and all ADA accessible showers should be inspected to ensure that modesty curtains or panels, at least equivalent to those found in the other showers throughout the facility, are in place or immediately installed, repaired, or replaced in compliance with the PBNDS 2011 Personal Hygiene standard pertaining to Bathing and Toilet Facilities stating, "Detainees shall be provided with a reasonably private environment in accordance with safety and security needs" and "Detainees with disabilities shall be provided the

facilities and support needed for self-care and personal hygiene in a reasonably private environment in which the individual can maintain dignity." (Applicable standard: PBNDS 2011 Personal Hygiene)

Other Observations

Water Quality

Numerous detainees report that the tap water at ADF is sometimes brown and they are concerned that it is not safe to drink.

Applicable Standards: The PBNDS 2011 Food Service and Staff-Detainee Communication standards are applicable.

Analysis: The 2014 annual water quality report for Adelanto was published in July 2015. The report indicates that the water is safe for human consumption in compliance with the PBNDS 2011 Food Service standard requiring, "Clean, potable drinking water must be available." Although safe, the water supply is naturally high in Iron and Manganese, which may produce brown, discolored water. The Adelanto Utility Authority performs routine maintenance by periodically flushing hydrants which dislodges sediment in the lines and may cause water discoloration, as well as changes in the taste, odor, and pressure. Copies of a flyer, printed in English, published by the city of Adelanto regarding "Notice Hydrant Flushing" were posted on the bulletin boards in the housing units. The flyer states, "Discolored water is not harmful. These conditions will subside in a few hours after flushing is complete" and "If your water is discolored, it poses no threat to your health."

Conclusion: Although the discolored water may be unappealing to detainees, it is safe for consumption.

Recommendation:

4. The City of Adelanto Hydrant Flushing notices posted in the housing units were only in English. Therefore, ADF should ensure that the posting complies with the PBNDS 2011 Staff-Detainee Communication standard requiring, "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." (Applicable standard: PBNDS 2011 Staff-Detainee Communication)

Summary of PBNDS 2011 Recommendations

1. Onsite, I observed rodent droppings in the kitchen and food service employees wiping the dining tables with plain water instead of a proper chemical sanitizing solution that is necessary to kill the bacteria and viruses that cause illnesses. Therefore the facility must strictly adhere to the PBNDS 2011 Food Service standard to ensure that the kitchen is maintained in a sanitary and pest-free manner. (Applicable standard: PBNDS 2011 Food Service)

2. Based on my previous review and this recent onsite, I found that ADF has not been in full compliance with the PBNDS Food Service Standard. The current menu provides as average of 2,200 to 2,300 calories per day. Although calorie needs vary from person to person based on the factors of age, body composition, gender, and activity level, the current calorie level may not be sufficient for all detainees, particularly younger, very active males. Furthermore, food service employees report that the kitchen does not utilize standardized recipes, which can detrimentally impact the nutritional value of the dietitian planned menu. However, implementation of the new, revised menu and standardized recipes should bring ADF into compliance with the PBNDS 2011 Food Service standard requiring, "Food service personnel shall provide nutritious and appetizing meals." (Applicable standard: PBNDS 2011 Food Service)

3. While onsite, I observed that the lack of privacy curtains or panels in ADA accessible showers creates a barrier to their use and an environment in which detainees with disabilities utilize non-accessible showers, placing them at increased risk of injuries from falling. Therefore, a shower curtain or modesty panel, at least equivalent to the curtains on the other showers, should be immediately installed in the lower accessible shower in the women's East 1-A housing unit and all ADA accessible showers should be inspected to ensure that modesty curtains or panels, at least equivalent to those found in the other showers throughout the facility, are in place or immediately installed, repaired, or replaced in compliance with the PBNDS 2011 Personal Hygiene standard pertaining to Bathing and Toilet Facilities stating, "Detainees shall be provided with a reasonably private environment in accordance with safety and security needs" and "Detainees with disabilities shall be provided the facilities and support needed for self-care and personal hygiene in a reasonably private environment in which the individual can maintain dignity." (Applicable standard: PBNDS 2011 Personal Hygiene)

4. While onsite, I found that the City of Adelanto Hydrant Flushing notices posted in the housing units were only in English. This is a violation of the PBNDS 2011 standard stating, "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." Therefore, ADF should review and revise the posting to ensure compliance with the PBNDS 2011 Staff-Detainee Communication standard. (Applicable standard: PBNDS 2011 Staff-Detainee Communication)

List of Documents Reviewed

1. GEO, Adelanto Detention Facility, Supplemental Detainee Handbook, v2.17.15
2. National Institute for Occupational Safety and Health (NIOSH), Indoor Environmental Quality, retrieved from: http://www.cdc.gov/niosh/topics/indoorenv/temperature.html
3. GEO Menu Specifications, 12-14-15
4. Menu Template Reports, Weeks 1-6, Friday, June 05, 2015
5. Menu Template Reports, Weeks 1-6, Monday, December 07, 2015
6. Adult Menus, 12-14-15
7. Vegetarian Menu, 12-14-15
8. ADF – West Chow Rotation
9. Meal Rotation Schedule, Rev. 10/25/2012
10. Therapeutic Diet Order Form, HS-127
11. Form: Appendix 4.1.A: Authorization for Common Fare Participation
12. Performance-Based National Detention Standards 2011 Inspection Worksheet for Over 72 Hour Facilities, Start Date: 12/10/2013, End Date 12/11/2013
13. Performance-Based National Detention Standards 2011 Inspection Worksheet for Over 72 Hour Facilities, Start Date: 12/10/2013, End Date 12/12/2013
14. ADA/Section 504 Design Guide: Accessible Cells in Correctional Facilities. Retrieved from: http://www.ada.gov/accessiblecells.htm
15. City of Adelanto Annual Water Quality Report 2014, Adelanto Water Authority Consumer Confidence Report, July 1, 2015
16. Notice: Hydrant Flushing, Adelanto Public Utility Authority

On-site Investigation Report – Adelanto, December 2015

(b) (6)
MD, FACP
(b) (6)

December 28, 2015

Introduction

This report responds to a request by the Office for Civil Rights and Civil Liberties (CRCL) to review and comment on the medical care provided to detainees at the Adelanto by the contractor GEO under the authority of the Immigration and Customs Enforcement (ICE). My opinions are based on the materials provided and reviewed and an on-site investigation of the facility on December 9-11, 2015. My opinions are expressed to a reasonable degree of medical certainty. ICE and GEO personnel were most pleasant and cooperative during my investigation.

Overview of Findings

Overall, the medical care at the Adelanto facility is inadequate and does not meet the 2011 Performance Based National Detention Standards (PBNDS) standards[1]. While problems were identified in a number of areas, almost all problems can be linked to one fundamental problem: a lack of medical leadership. The consequence of the void in medical leadership in the medical program is that the care is uneven, uncoordinated, lacking in continuity, and lacking in provision. Documentation is not standardized and the medical records are in disarray. Medical care moves forward slowly and inefficiently and things fall through the cracks. There are significant delays and denials of care for medical conditions. The management of hunger strikes was incompetent and negligent resulting in significant risk of harm to the health and safety of the recent striking detainees, and any future hunger-strikers at Adelanto.

Specific Findings

1. ***Medical Leadership*** – Adelanto has had critical vacancies in key medical leadership for months, which violates the PBNDS. Key medical leadership positions including a Clinical Medical Authority (CMA, as required by PBNDS V.B) and Director of Nursing are vacant and have been for a prolonged period of time. Administrative support for medical, including the designated Health Services Administrator (HSA, as required by PBNDS V.B), have only recently

[1] Specific examples with citation to relevant standards will follow in the body of this report.

arrived at the facility and they do not yet have a good handle on the medical program. The Acting Medical Director has no understanding of his role and lacks the experience and judgment that the position requires. As an example, the Acting Medical Director's handling of the hunger strikes was negligent and raises questions about his fitness as a clinician, let alone as a Clinical Medical Authority for a detention facility.

2. ***Complaints*** – The Office for Civil Rights and Civil Liberties received a high number of complaints about medical care prior to our on-site investigation including eight cases cited in the retention memo (see cases 1-7 and 22 in Appendix II) and a number of complaints filed after that memo was finalized. The onsite investigation team also identified a number of additional cases through on-site interviews (cases 8-21). A high number of the CRCL complaints were either confirmed (cases 7, 11, 14 and) or partially confirmed (cases 1, 9, 15, 18, 21 and 21). Complaints typically involved the failure to provide care, failure to provide care in a timely manner, and inadequacy of the care that was provided.

   C*ases cited in the retention memo:*

   a. Complaint No. 15-07-ICE-0478 (Case 22) involves a detainee death. Some aspects of the complaint were **substantiated**. This case will be discussed in greater detail in its own section later in this report.
   b. Complaint No. 15-12-ICE-0673 (Case 7) alleged that there was an interruption in his medications for chronic medical conditions resulting from failure of the staff to anticipate an order renewal. The medical record supported the complaint and therefore the complaint was **substantiated**.
   c. In the remaining six complaints cited in the retention memo (Cases 1-6), I did not find evidence to substantiate the allegations.

3. ***Grievances*** – Adelanto does have a grievance process and that process does include complaints or grievances on medical care. An abnormally high number of all Adelanto grievances involved medical care. In fact, the majority of all grievances were related to medical care. For Calendar year 2015, there were more than 200 grievances about medical care. Most of those complaints involved delays or denials of care. The *majority* of the complaints about delays or denials of care *were substantiated* by the grievance process. There is no evidence that either the high number of grievances or the high number of substantiated grievance complaints led to any systematic review of policies, procedures or practices by leadership at the facility.

4. ***Medical Records*** – Adelanto's Medical records are in disarray. Adelanto still uses a paper based medical record. The medical record is not standardized, and staff have taken it upon themselves to develop and use many unofficial and unapproved forms. The charts are extremely difficult to read, and it is often impossible to reconstruct a medical timeline or determine what care was and was not provided based on a review of the medical record. Medical orders are not

placed in a designated section for medical orders (a best practice to ensure practitioners can easily find the information they need to see history and make accurate current medical decisions); rather, they are buried in any of variety of places in the progress notes and are not always clearly labeled as orders. This increases the chances that medical orders will go unnoticed and makes it difficult to for both outside authorities and program administrators to audit the quality of care.

5. ***Access to Care –*** A review of medical records and interviews with detainees supported the allegations that access to medical care was slow, and in some cases never happened. For example, Case 11 involves a detainee who, during his March 2015 intake screening, was noted to have a one-centimeter growth on his scalp . In spite of his repeated documented complaints that the mass was growing quickly and causing him pain, and despite the notations in the medical record that the mass had grown to seven centimeters in size by November of 2015, no definitive surgical treatment or biopsy of the lesion has been provided. Case 9 involves a detainee with a spinal cord injury, and who had a legitimate need for urinary catheters. Based on my review of the medical record, the medical staff appeared to be confused as to the proper catheters to be ordered, and struggled to order and provide a reasonable number of catheters. As a result, the detainee was forced to reuse catheters, which increased the risk of a bladder infection. This detainee did develop a bladder infection that required hospitalization, which may have been preventable if he had been provided appropriate and timely medical care. Case 20 involves a woman who reported a very prolonged absence of menstruation. However, she received little or no medical evaluation for this significant complaint. These three cases are merely representative examples. Delays, failure to follow up, and denials of care were found throughout my review of the medical records. In addition, when I made an attempt to review the timeliness of access to outside specialty medical care, the facility log lacked dates of referral or dates of service. Relevant to that lapse in record keeping, the HSA and Deputy Warden over Health Services confirmed that they currently lacked a way of auditing for timely access to outside specialty care because the key data was not being collected on their log.

6. ***Management of Hunger Strikes –*** The most egregious failure to provide care involves the management of the recent and past hunger strikers. The facility has been confronted with group hunger strikes on at least two occasions within the last year. Onsite I found evidence which demonstrates that medical staff has no understanding of the proper role of medical professionals in the management of hunger strikes. Interviews with a group of nine hunger strikers (who ended their strike during our on-site), facility staff and a review of the medical records demonstrate medical staff's complete failure to deliver proper care to the detainees who were on hunger strikes. In the most recent hunger strike, there was no evidence in the striking detainees' medical records that a physician *had ever met with any of them* or made an attempt to examine, interview or counsel them,

including one detainee who has diabetes,[2] *during the entire 11 days* they were on their hunger strike. Nursing assessments consisted of forms with almost no meaningful individualized charting. These forms commonly had a single diagonal line across the form with the word "refused" written on the form. In a previous hunger strike involving 26 detainees, the nursing intake assessment was an identical photocopy of a single generic note that was placed in all of the striking detainees' medical charts. In the recent hunger strike that concluded while the CRCL team was on-site, the Medical Director wrote a single re-feeding order that was photocopied and placed on all nine charts without any evaluation, consultation, patient education, or physical exam. Management of hunger strikes at Adelanto is negligent and poses a significant risk to the health and the safety of the detainees. Medical staff do not follow the PBNDS or GEO Policy in this significant medical area.

7. ***Detainee Interviews -*** In the course of the on-site investigation, I interviewed eleven detainees individually (seven men and four women), and also interviewed the nine hunger strikers as a group on the day they ended their hunger strike. While a minority of detainees interviewed were satisfied with their medical care, the majority reported that medical providers often dismissed their complaints, or told them they would have to wait until they were in the facility for a longer period of time in order to have their medical needs addressed. Several said that while they trusted one physician whom they believe was ultimately let go from the facility, they were distrustful of the current physicians whom they felt minimized their concerns and dragged their feet in providing a meaningful evaluation and treatment of their medical complaints. Opinions of the nursing staff were generally more positive. The issue of the hunger strike is discussed in its own section of this report, but the hunger-striking detainees told us that while they were seen and counseled by mental health providers on most days, no medical doctor or nurse practitioner ever saw them during the entire course of their hunger strike.

8. ***Detainee Death –*** Case 22 involves a detainee who had previously been detained at the Theo Lacy facility in Orange County. During his time there, he presented with bowel problems including bleeding from his rectum. The Theo Lacy medical staff referred him for a consultation with a gastroenterologist and for a colonoscopy, but the facility never followed through with this plan, and he was ultimately transferred to Adelanto without ever having received the appropriate work up for his medical problems. Unfortunately, there is no evidence that the medical record arrived with the detainee at Adelanto, and I found no evidence that the Adelanto staff ever requested the record. According to my review of his Adelanto medical file, his conditions subsided for a short time after his arrival but, by the time the detainee was symptomatic again at Adelanto and the proper work-up was initiated, a two-year delay in appropriate care had resulted. During

[2] Diabetes is a significant medical condition that complicates a hunger strike and is associated with high risk of bad outcome.

his colonoscopy at an off-site facility, when he was finally diagnosed with an advance colon cancer, he developed a complication of bleeding. He was emergently transported from that off-site facility to the hospital in a regular vehicle instead of an ambulance. He ultimately died at that hospital. It is likely that an earlier diagnosis might have prolonged his life and the delay in diagnosis is a serious deviation from an acceptable standard of care. The main responsibility for the failure to follow through in evaluating the early symptoms lies with Theo Lacy, but Adelanto medical staff were remiss in not taking a thorough history on intake and in not requesting or securing his prior records. Adelanto also violated the PBNDS by not using an ambulance for the emergency transport. In conclusion, it is at least partially substantiated that inadequate medical care more than likely contributed to an earlier death, based on my review of the available evidence.

Summary of Key Findings

Overall, I found the medical care at this facility to be inadequate and not compliant with the 2011 PBNDS. Key deficiencies are as follows:

1. Medical leadership and oversight **DOES NOT meet the 2011 PBNDS**(V. B, V. BB. 2)[3]

2. Adelanto's failure to provide timely access to care for both acute and chronic problems **DOES NOT meet the 2011 PBNDS.** (II.1, II.4, II.5, II.6, II.7, II.8, II.12, II. 16, V.A.2, V.A.3, V.A.5, V.S.4).

3. Adelanto's medical records **DO NOT meet the 2011 PBNDS .** (II. 23, V.Y.1.a.)

4. Adelanto's management of hunger strikes **DOES NOT meet the 2011 PBNDS** (4.2 subsections II.1, II.3, II.9, V. B.2, V.C.1, V.C.8, E.1 and V.F) or **GEO's Policy and Procedures.**

5. Transportation procedures for detainees – specifically the requirement for the medical record to accompany the detainee (1.3. subsection V.G.2) and that transportation for medical emergencies should be by ambulance (4.3 subsection II.7) – are not being adhered to at Adelanto, and **DOES NOT meet the 2011 PBNDS.**

Discussion

At the time of our on-site investigation, the medical care at Adelanto was seriously deficient and did not meet the 2011 PBNDS. At the same time, the facility has some

[3] Unless otherwise specified, all citations to 2011 PBNDS Standards are formatted to reference subsections of the 4.3 Medical Care chapter, so, for example V. B refers to 4.3 subsection V. B.

important strengths, including a reasonable staffing plan, detainee trust in the nursing staff, and acceptable, appropriately designed medical facilities. The newly arrived Deputy Warden brings a background in appropriate health care administrative experience and insight that may help the facility start to address the leadership void.

So, while I believe the deficiencies are significant and pressing, they could be corrected by addressing the clinical leadership void and by addressing the medical record issues. But given the seriousness of the deficiencies, ICE and GEO must act quickly. To that end, I have made the following recommendations for a corrective action plan. If the facility cannot correct these deficiencies within the timeline proposed, I would recommend that ICE pull detainees from this facility.

Recommendations for a Corrective Action Plan (provided to ICE on December 16, 2015)

To be completed within 30 days:

1. Based on my onsite findings, including failures to follow through on both acute and chronic care, I strongly recommend that GEO and ICE (IHSC) must audit all medical files, starting with the Chronic Care List of detainees, and take action to ensure all detainees receiving medical/mental health care are current on appointments (onsite and offsite), treatments (including surgery), and are receiving the appropriate medications for their conditions.

2. I found the facility's practice of allowing clinicians to write medical orders in multiple areas of the chart and on multiple different forms to be dangerous. This places the ICE detainees at extreme risk for receiving in appropriate treatment or no treatment for medical needs, I recommend that the paper based medical record must be changed to include a separate section for medical orders (with a standard order form).

3. Due to the alarming lack of care and oversight of the hunger-strikers, I recommend that all medical staff must undergo training, preferably by an outside expert, regarding the medical management of hunger strikes.

To be completed within 90 days:

1. Based on my finding that the medical unit's failures are largely due to the lack of appropriate and involved leadership, I recommend that GEO must recruit an outside permanent clinical leadership team consisting of a qualified and experienced detention Clinical Director (MD or DO), Director of Nursing and clinical Mental Health Director (psychiatrist or psychologist) and have them on site and in their positions within 90 days.

2. Based on my findings that medical staff were improvising medical forms, which resulted in various unapproved and unrecognized forms in the detainee files, and the resulting danger to detainees as a result of that practice, I strongly recommend that the

medical record must be standardized. Only forms approved by the Clinical Director and the medical record director should be used for charting.

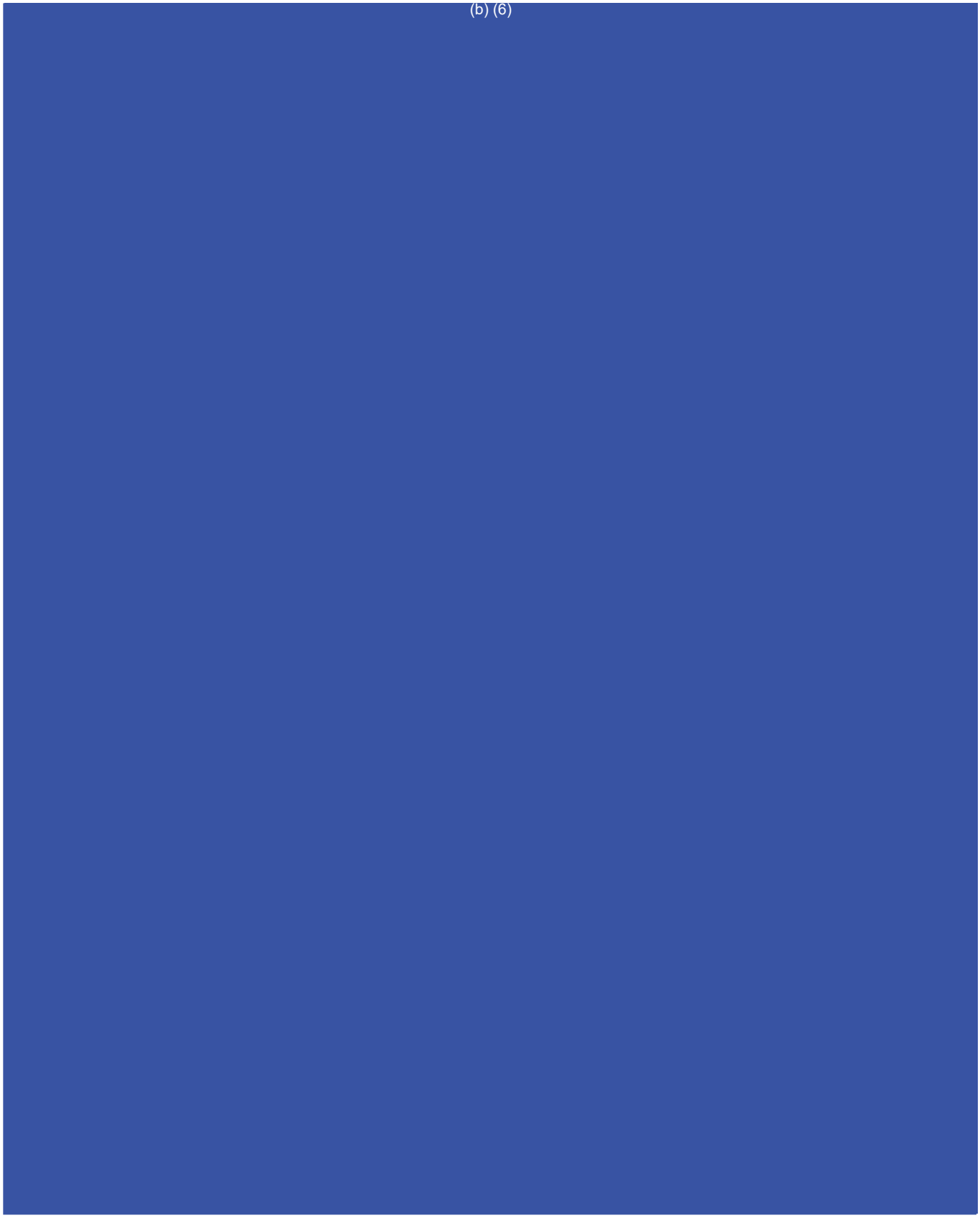
3. Understanding that the process for selecting, procuring, and deploying an Electronic Health Record takes time, I strongly recommend that GEO must swiftly work to draft a Request for Proposals (RFP) in order to provide appropriate detention health care. The goal should be to deploy an EHR within twelve months.

Sincerely,

(b) (6)

Appendix I

(b) (6)



Methods of Review

In advance of the on-site investigation, I reviewed documents provided by the Office for Civil Rights and Civil Liberties (CRCL) of the Department of Homeland Security. During the on-site investigation, I toured the facility including dormitories, pill lines and the medical clinic, reviewed documents and medical records, and interviewed staff and detainees. I did focused reviews of medical records for those detainees who had chronic medical conditions such as asthma or high blood pressure. Clinical performance was measured by a focused review of medical records using a standardized methodology. (The full methodology for the review is described in the document entitled Assessment of Quality of Medical Care in Detention Facilities, and its accompanying Reviewer Pocket Guide.) The measures are based on nationally published accepted clinical guidelines, or consensus guidelines where there are no published clinical guidelines. I reviewed more than 40 individual detainee medical records in total. I conducted 11 individual interviews with detainees (seven men and four women) and I participated in a group interview with all nine of the detainees on hunger strike. I also reviewed the care of detainees who raised medical care issues with me or with other members of our site review team during interviews. Where relevant to findings, reference is made to the 2011 Performance Based National Detention Standards (PBNDS).

Appendix II

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

Identity of Cases Cited in this Report

My Case No.	A #	Name	ICE Com laint #
		(b) (6)	
1.			15-09-ICE-0522
2.			15-09-ICE-0552
3.			15-12-ICE-0620
4.			15-12-ICE-0635
5.			15-12-ICE-0630
6.			15-12-ICE-0672
7.			15-12-ICE-0673
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			15-07-ICE-0478

On-Site Investigation Report – Adelanto Correctional Facility, December 2015

(b) (6)
MD, MPH
(b) (6)

April 4, 2016

Introduction

This report responds to a request by the Office for Civil Rights and Civil Liberties (CRCL) to review and comment on the mental health care provided to detainees at Adelanto by the contractor GEO under the authority of the Immigration and Customs Enforcement (ICE). My opinions are based on the materials provided and reviewed and an on-site investigation of the facility on December 9-11, 2015. My opinions are expressed to a reasonable degree of medical certainty. ICE and GEO personnel were helpful and welcoming throughout the investigation.

Overview of Findings

Overall, the mental health care at the Adelanto facility for those with serious mental illnesses needs significant improvement in the area of Mental Health Care and currently does not fully meet the 2011 Performance Base National Detention Standards (PBNDS). There are several current practices and the absence of practices that must be in place that either lead to or can resolve the problems found onsite.. Hands-on mental health leadership is key to comprehensively solving failures to provide adequate mental health care to the ICE detainees. There is an overall lack of knowledge of the histories of patients with serious mental illnesses in the facility and little evidence that staff pursued acquiring those histories for treatment purposes. Also, persons with serious mental disorders were in alarming high numbers in the segregation unit, obviating the need for specific mental health housing rather than readily placing seriously mentally ill detainees in segregation as the default. Furthermore, the mental health unit had limited psychiatric pharmacological capability available to them for the appropriate treatment of detainees with serious mental illnesses who would benefit from those medications and treatments that Adelanto does not have or utilize. Due to lack of diagnostic understanding and the patient's history, several patients were going without care, without appropriate care, were misdiagnosed, or were receiving suboptimal care. There was also a delay in access to acute care for those in need of involuntary treatment. Additionally, many of the detainees' mental health evaluation appointments are hindered because the corrections officers are required to escort the detainee to the appointment, though they are not always available at the time needed. Mental health staff are also hindered by lack of private space in which to evaluate detainees close to or within their dorms. Improving technology, such as allowing mental health staff to use laptops connected to an intranet, would greatly improve efficiency. The follow-up appointment system, GEO Track, was not accessible to all mental health providers, and therefore, not all providers were able to schedule their own detainee follow-up appointments or detainee follow-up appointments with other providers when there was a critical need.The paper chart with handwritten orders is inefficient and sometimes unreadable, which is problematic for all mental health staff and

detainees with mental health problems. More problematic is that the Master Problem List that was typically left blank, indicating the detainee received no mental health diagnosis, even for those detainees with serious mental disorders. An electronic health record would greatly improve these deficiencies if staff could access the system throughout the facility via laptops, allowing staff mobility for face-to-face encounters with detainees and access to patient data and scheduling.

Specific Findings

1. ***Mental Health Leadership*** - I found it very alarming that Adelanto does not have on-site facility mental health leadership. The only mental health leader is (b) (6) M.D., who is a Corporate Mental Health Director rather than an onsite leader or provider of mental health care and oversight. In multiple interviews with mental health staff at the Adelanto facility, they reported that (b) (6) was not present at the site and was not "hands-on." The staff never have regular meetings or conference calls with (b) (6) One mental health staff member said it best, "There is not really a particular leader." Though mental health staff wish to confer and collaborate with one-another on treatment plans for patients there is no process in place for them to do so in an organized fashion. Especially with growing numbers of detainees with mental disorders to treat within the Adelanto facility, a total lack of on-site mental health leadership is a violation and does not meet the 2011 PBNDS.

2. ***Improved Care and Housing for Persons with Serious Mental Disorders*** - During the onsite visit, the facility's mental health staff stated that the number of detainees with serious mental disorders is growing. (This is also the case with the general opoulation of incarcerated individuals, and so it would make sense to apply it to the population of individuals detained in dacilities for immigration violations.)[1] Therefore, the need for a mental health staff knowledgeable and experienced in working with this high-needs and difficult to treat population is critical. This is a population where safety issues and acute clinical issues are not uncommon, and diagnostic accuracy is critical for keeping patients stable and keeping patients and staff safe. Each of the staff members I interviewed during the onsite reported that the numbers of persons with serious mental disorders were growing at the Adelanto facility, while staff had not been provided with any particular training or leadership surrounding this growing population's serious mental health needs. Furthermore, most staff members had limited work experience with this population prior to working in Adelanto's mental health unit. Most concerning, I found a large number of detainees with serious mental disorders are being housed in Administrative Segregation, obviating Adelanto's need for a dedicated and appropriate mental health housing unit. At the time of the onsite , 29 of 64 detainees in segregation had serious mental disorders. Staff explained that those detainees' mental health-related behavioral and/or safety concerns necessitated the need for higher observation or single person housing, however, at Adelanto, the only way to accomplish that is to place seriously mentally ill patients in segregation.

[1] See: http://www.jaapl.org/content/38/3/392.full

3. ***Obtaining Adequate Patient History and Collateral Information*** - An essential cornerstone of psychiatric care for persons with serious mental disorders includes obtaining what is frequently referred to as "collateral information." This term refers to a patient's historic mental health information, typically that the patient himself or herself would or could not provide secondary to having a serious mental disorder and a lack of insight and/or judgment. Obtaining collateral information is considered a standard of care in the U.S. for all mental health professionals treating persons with serious mental disorders. Collateral information can be obtained in the form of medical records, phone calls with former treatment providers, or family members. In my review of 19mental health charts, I did not see any evidence that collateral information had been collected. Again, not even for one patient was there documentation of even an attempt to obtain collateral history. This is absolutely out of the basic standard of care for the practice of mental health treatment, and especially psychiatric treatment for persons with serious mental disorders. Though some mental health staff reported verbally in my interviews with them that they had received transfer summary information on some detainees, there was not one instance where I found a summary in the paper chart.Collateral information is critical to building an accurate diagnosis and treatment plan. When I met with and reviewed the charts of detainees with mental disorders, I observed several cases where diagnoses and treatment plans were inaccurate and this could have been avoided by obtaining a collateral history. Overall, the pervasive lack of collateral information resulted in persons with serious mental disorders receiving incorrect diagnoses, suboptimal care and, in particular, they were not receiving the appropriate psychotropic (and specifically, antipsychotic) medications.

4. ***Appropriate Standard of Psychiatric Care (Treatment with Psychotropic Medication)*** - In large part due to the lack of collateral information as described above, I observed that detainees were receiving treatment with psychotropic medications that were often suboptimal. When treatment with psychotropic medication is suboptimal, the detainees remained needlessly unstable, were more likely to be in segregation, and were more likely in need of acute hospitalization. I also found many cases of persons with serious mental disorders who were not taking any medication. Though notations were made of medication "refusals", there was little evidence that psychiatric staff had worked to build rapport with the detainee and use all the tools available to them in order to effectuate their medication adherence. Though the ICE Health Service Corps National Formulary includes several atypical and typical antipsychotic agents, these agents were often not prescribed in appropriate or robust dosing. Furthermore, long-acting antipsychotics (LAI's) were not being used at Adelanto, though they are on the formulary (28:16.0 8.08 haloperidol decanoate and 28:16.0 8.24 fluphenazine decanoate), even though they represent a cornerstone of care at most correctional facilities nationally. Use of long-acting antipsychotics increases the likelihood of patient stability, decreases safety concerns and the need for acute care, and in the case of Adelanto, their use would decrease the need for so much segregation housing of the seriously mentally disordered population. Training for psychiatrists in the use of decanoate medications and training for nursing staff in administering these injections would bring Adelanto mental health care into the current standard of care for treating persons with serious mental disorders.

5. ***Medical Records*** - The paper medical charts used at the Adelanto facility are problematic for several reasons. Most importantly, medical orders are not standardized.In fact, orders are sometimes written on a progress note which may be located in various sections of the chart, and each order is written in an idiosyncratic fashion according to practitioner. This is a dangerous practice, causing orders to be missed. Furthermore, in a quick review of 10 charts of detainees with serious mental disorders, I only found two instances where that serious mental disorder was listed on the Master Problem List in the paper chart. Overall, I found the medical charts were incomplete in some aspects, inconsistently organized, did not appear to be standardized, and overall lacked information needed to ensure safety and continuity of care.

6. ***Access to Care*** - There are several barriers to appropriate access to care for detainees with serious mental disorders in the Adelanto facility. One major barrier is that mental health staff personnel must often go through officers in order to see particular patients face-to-face. Because of the nature of serious mental illness, often times patients will refuse visits if approached by officers, but would accept a visit directly from a mental health practitioner. At Adelanto, this resulted in a high refusal rate for those detainees who needed care the most. Furthermore, there was little opportunity to see patients directly where they were housed, making needed care slow and inefficient. Mental health providers reported that they lacked office space inside the dormitories, and did not have the technological support or flexibility to use laptops that they could carry from patient to patient and document their notes. Furthermore, when a patient would need a follow-up visit, or a subsequent visit for a medication review with the psychiatrist, not all mental health providers had access to GEO Track; the medical unit's scheduling system for patient appointments. As described above, follow-ups were contingent upon a rudimentary hand notation system at the bottom of a progress note, which causes a high probability for error. Additionally, there was a very concerning delay in access to acute care for detainees in mental health crisis. I found several instances of detainees meeting criteria for acute inpatient psychiatric hospitalization who waited, for weeks in some cases, for psychiatric hospital admission and, in the meantime at Adelanto, they went weeks without appropriate psychiatric treatment; most notably, treatment with antipsychotic medication.

7. **Detainee Interviews** - I conducted seven individual interviews with detainees (five men and three women). The overall theme that resulted from the detainee interviews was that adequate mental health histories were not obtained and, therefore, diagnoses were not made or were incorrect, and psychiatric treatment plans were either lacking or incorrect, and resulted in the detainee receiving an appropriate psychotropic medication, or no medication, which further caused decompensation, or destabilization and, in some cases, the need for housing in segregation. In one illustrative case (Case 6), a man with a long history of a primary psychotic disorder, Schizoaffective Disorder, was documented by his psychiatrist as refusing multiple visits. One note from the psychiatrist stated, "Once more refused to see me per Officer (b) (6), (b) (7)(C) This statement makes clear that mental health staff must go through officers for these visits, creating likelihood of refusals, as stated previously. This particular psychiatrist, in fact, discontinued the patient's medication because of the visit refusals via the officer. In the chart, the psychiatrist states, "As I

stated in last month's note, the medication has to be stopped due to multiple visit refusals." The psychiatrist totally discontinued the patient's antipsychotic medications. Subsequently, in one final note months before I met this detainee, the psychiatrist wrote, "No further appointments." This particular patient, in fact, had a history of receiving a long-acting injection of an antipsychotic prior to his immigration detention, and was seriously in need of treatment, demonstrated by some notes describing, "observed by staff barking, talking to the devil on the dorm." Upon my face-to-face interview with the detainee for the purpose of the onsite investigation, he consented to medication saying, "Yes, I will take it." In another detainee interview in segregation, (Case 21), I observed him to have active signs of psychosis, however, his medications had been discontinued because he had been refusing them. Another detainee housed in segregation (Case 16), was receiving a very low, very suboptimal dose of an antipsychotic, though he had been psychiatrically hospitalized four times since arriving to the Adelanto facility. Another detainee (Case 4) in segregation was described as continuing to present with "psychosis and impaired functioning," but was not receiving any psychotropic medication, even though he . had an extensive history of serious mental illness (Schizophrenia). He had alse been receiving treatment in intensive community programs in Los Angeles County with robust dosing of antipsychotic medication, however, I found little evidence during my interview with him or in the chart demonstrating that different measures were tried to gain his adherence. One note written by the mental health provider, stated, "We have tried several times to engage him in treatment, this is enough."

8. ***Complaints*** - The Office for Civil Rights and Civil Liberties received many medical complaints, and fewer mental health complaints. However, the majority of the mental health complaints involve the failure to provide care or to provide timely care. Most were not substantiated or were partly substantiated. Two are substantiated as described below.

    a. Complaint relates to Case 1 and involves multiple requests on the part of the detainee for treatment for insomnia, none of which appeared to be addressed. These four complaints from the same detainee were made in June 2015 and the patient left the facility in August 2015. There was no evidence in the chart that he had been seen by a mental health provider or any other provider for his specific complaint and therefore, this complaint is **substantiated**.

    b. Complaint relates to Case 12 and involves a detainee's report that he had been raped. Facility staff, including mental health staff, were conscientious in their approach to this case and performed evaluations in a timely and appropriate manner. Staff performed an investigation and the accusations of rape were determined to be unfounded. This complaint is **not substantiated**.

    c. Complaint relates to Case 14 and involves a detainee requesting a medication change who has a history of Bipolar Disorder. There were several visits with this detainee from the psychologist and psychiatrist. The detainee was offered various medications which appeared to be appropriate. However, the detaineepreferred certain medications above the others that were offered. It appears that mental health staff

attempted to work with the patient appropriately. This complaint is **not substantiated**.

d. Complaint relates to Case 15 and involves a detainee who garnered concern due to active psychosis. In my review of this detainee's complete chart and in my brief visit with him at his cell door in segregation, this case was illustrative of the problems previously described where staff's understanding of serious mental disorders was lacking, their ability to appropriately diagnose and medicate detainees was insufficient, and their inability to get detaineesaccess to acute care in a timely manner is apparent. This detainee was listed on the "7 Day Tracking Sheet" as having the diagnosis of "Rule-Out PTSD, "Rule-Out Intermittent Explosive Disorder," however, this detainee had a clear history of Schizoprehnia and treatment with a well-known agency in Los Angeles County for persons with serious mental disorders, though there was no eividence that any collateral history was obtained on his behalf from his former providers. In this particular case, the detainee was not eating due to his active psychosis. In a note written on 7/31/15, mental health staff stated, "not eating because the voices have told him not to eat for 31 days or someone would die." At that point, the detainee met criteria for inpatient hospitalization. However the request was not made for inpatient care until 8/3/15 and the detainee did not get to the hospital until 8/9/15. He was subsequently released from the hospital on 8/26/15 and began to refuse medications again. On 9/3/15 the psychiatrist at Adelanto discontinued all of his medications. On 9/14/15, the psychiatrist wrote that the follow-up would be distant, even though this was detainee with serious mental health concerns. The Adelanto psychiatrist's note states, "See again in four weeks." While the patient was in the hospital, California law allows a Riese Petition, in which this patient could have been given a long acting antipsychotic injection to ensure treatment of his psychosis and refusal to eat. This would've helped stabilize the patient, and Adelanto facility staff could have continued the long-acting injection, but this opportunity was missed. I did not see any documentation of the treatment staff's attempts to liaison or work with inpatient hospital staff in order to effectuate a treatment plan. Furthermore, in my interviews with Adelanto Mental Health staff, they did not make any efforts to work with or contact treatment staff at the inpatient hospitals in order to create treatment plans for their most acute patients. This complaint is **substantiated**.

e. Complaint relates to Case 22 and involves a detainee dually diagnosed with both a psychotic disorder and a seizure disorder, who was housed in segregation. Upon review of this patient's complete chart, it is clear that he was likely experiencing catatonia, which was not diagnosed by the Adelanto mental health staff, and therefore not treated. This is a potentially dangerous condition as it can result in an inability for self-care, including feeding. It can also result in muscle breakdown, leading to renal failure. Despite clinical urgency, which is clearly documented in the chart, this patient was documented as a medication refuse or and repeatedly not provided with psychotropic medications. Because this patient was refusing medication and was either not seen as a suicide risk or was not reporting suicidal ideation, he was consistently untreated and unmedicated. He was hospitalized at an acute psychiatric inpatient facility on 3/17/15, but returned the very next day because he refused to take

medications at the outside hospital. This is illogical clinically and illogical with regard to involuntary commitment law in California, as there is a common mechanism to treat patients who refuse medications when they are in need of acute care (as mentioned above, the Riese Petition iscommonly used in inpatient hospitals across the state). This patient received poor and inadequate care. This complaint is **substantiated**.

9. Grievance - Only one mental health grievance was reviewed during the onsite, this is Case 13, and involves requests for mental health help that were not appropriately addressed at Adelanto. It does appear that this patient's initial mental health assessment took place at Adelanto, and he received ongoing mental health care. However, two common problems occurred in the course of his mental health treatment: one is that he had both depression and psychosis, but neither problem was listed on his Master Problem List in his chart; the other problem was that this particular patient was not listed on the facility's SERIOUS Mental Illness list tEven though he had been prescribed an antipsychotic medication, it appears the facility erred in only considering him as a detainee with depression for purposes of the list. Though this grievance highlights systemic issues at Adelanto, the grievance issue itself is **not substantiated**.

Summary of Key Findings

Overall, I found the mental health care at the Adelanto facility for those with serious mental illnesses inadequate and not compliant with the 2011 Performance Base National Detention Standards (PBNDS) standards.

1. Mental health leadership and oversight is absent at Adelanto. The lack of leadership and oversight is a violation and **DOES not meet the 2011 PBNDS (4.3 V. B)**

2. Adelanto's medical records are in poor shape, leading to missed and overlooked mental health care needs for detainees with serious mental health problems. Mental Health record keeping at Adelanto **DOES NOT meet the 2011 PBNDS (4.3 II 23, 4.3 V.Y.1.a)**

3. Adelanto's practice of not obtaining adequate patient histories is a violation of the PBNDS and leads to inadequate and inappropriate mental health care for detainees with all levels of mental health disorders. **DOES NOT meet the 2011 PBNDS (4.3 V. N.3.b)**

4. Adelanto has inadequate and delayed access to care for persons in mental health crisis in need of acute inpatient psychiatric hospitalization which **DOES NOT meet the 2011 PBNDS (4.3 V. N.3.j.4).**

5. Adelanto houses persons with serious mental disorders inappropriately in segregation, rather than an appropriate mental health housing arrangement, which leads to inadequate mental health care, and increased likelihood of poorer mental health outcomes , which **DOES NOT meet the 2011 PBNDS (4.3 V. N.3.j.3).**

6. Adelanto Medical Unit staff do not make use of and/or advocate on behalf of the detainee-patient to invoke involuntary commitment and medication administration law that is approved in California, in order to treat detainees' serious mental health disorders and needs. There was no evidence in any patient chart or during any interview with patients or staff that demonstrates that attempts were made to liaison with hospital staff to obtain a Reese Petition, Court Order, or any other options to medicate patients involuntarily when patient safety was at stake, which **DOES NOT meet the 2011 PBNDS (4.3 V. N.6).**

Discussion

Overall, though Adelanto's mental health team demonstrated caring and strengths during the onsite investigation, overall they are poorly equipped to treat the growing number of persons in the facility with serious mental disorders. A lack of leadership is the primary cause for the systemic problems I found onsite that lead to inadequate care. Furthermore, thefacility barriers I observed onsite such as: poor access to patients (largely because access to the detainees for appointments and other mental health services had to be coordinated with the correctionsofficers, who were often unavailable or not immediately available); the lack of offices in or near the housing units; and, the inability of staff to use laptops at the dorm sites, are all major shortcomings that lead to inefficiency and blocks in care. Very concerning is the culture that seems to have developed at Adelanto where obtaining a detainee's mental health history is rarely undertaken is particularly concerningthe population of detainees at Adelanto with serious mental disorders who commonly cannot provide histories for themselves.. This practice is so critical to adequate mental health care for detainees with serious mental disorders, that it is commonly considered a basic standard of care, howeverthere was little evidence that this ever occurs at Adelanto. As a result, diagnoses were incorrect or delayed, as was mental health treatment. Furthermore, I observed a pattern of repeated documentation demonstrating that whena patient "refuses" medication or "is not suicidal," aggressive mental health treatment is not pursued by mental health staff for those detainees who need it most. This clearly resulted in several people being housed in segregation needlessly. Mental Health leadership at the Adelanto facility would bring an immense improvement to mental health care at the facility, especially if the leader is a psychiatrist who specializes in treating people with serious mental disorders and is skilled at providing appropriate doses of antipsychotic medication, especially long-acting antipsychotic medication via injection.. A culture change in approach to mental health care is also vitally necessary. Instead of leaving mentally ill detainees to languish untreated because of the seemingly accepted staff attitude that nothing is possible, the current culture could be overhauled by a good mental health leader through staff motivation and inspitation who, in turn would more likely do everything possible within their means to ensure quality mental health care, including thinking creatively, building rapport with patients to influence them to betteraccept treatment, eliminate the use of officers as escorts and instead get the mental health providers efficient face-to-face access to patients as often needed, and use robust dosing and long-acting medications as often as possible (as most correctional facilities do in the U.S.). These changes would substantially improve the mental health care at Adelanto.

<u>Summary of Recommendations</u> (Many of these were already provided to ICE and IHSC as CRCL's initial recommendations, immediately after the conclusion of the December 2015 onsite investigation)

1. GEO and ICE (IHSC) must audit the medical files of detainees on the Mental Health Chronic Care List, prioritizing those detainees who are in Segregation and take action to ensure that all are receiving adequate mental health care and, in particular, that detainees with psychotic disorders are diagnosed as such and are offered appropriate antipsychotic medication, including long-acting injectable antipsychotics. This is especially critical when medication non-adherence is present. Additionally, all detainees who have requested mental health care, or have been seen in the mental health unit, should have their files audited to ensure they have been properly diagnosed and are being appropriately treated.

2. Mental Health staff must follow GEO Procedure 623-A, which calls for a complete "written comprehensive Initial Psychiatric Evaluation" (Form HS-906) that "will address current and past inpatient and outpatient psychiatric treatment and psychotropic medications."

- Particular to this recommendation, Mental Health Staff must demonstrate an attempt to obtain collateral historical information (and not simply record that a detainee has "refused" care).If such information is available in a transfer summary, it must be placed in the detainee's chart and referenced by the mental health provider. This procedure should be done retrospectively for all detainees on the Mental Health Chronic Care List who are currently in segregation, as well as for detainees who staff did not appropriately place on the Mental Health Chronic Care List, but are discovered during the needed audit of detainee mental health care files.

3. Detainees needing emergent transport and admission to outside acute psychiatric inpatient units should not wait for transfer more than 72 hours after such a determination/request for transfer is made by a mental health clinician. Relationships with potential accepting institutions must be established and/or strengthened whether through a written MOU or another formal agreement.

4. While waiting for an electronic record system to be installed at Adelanto, the paper-based medical records must undergo a required system change where medical orders must be placed in a separate designated section, and with the use of a standardized order form.

5. GEO must recruit an outside permanent clinical leadership team consisting of a qualified and experienced Mental Health Director (a psychiatrist experienced in treating persons with serious mental disorders) and bring them onsite and in their positions.

6. The medical record must be standardized. Only forms approved by the Clinical Director and the medical record Director should be used for charting.

7. GEO must draft a Request for Proposals (RFP) in order to begin the process of selecting, procuring and deploying an Electronic Health Record appropriate for detention health care. (The goal should be to deploy an EHR by the end of 2016).

4. All mental health staff must have access to GEO Track, allowing them to make, review and change their own appointments and those of other mental health clinicians. Each clinician should maintain his/her own schedule.

Sincerely,

(b) (6)

Assistant Clinical Professor
Department of Psychiatry and Biobehavioral Sciences
UCLA David Geffen School of Medicine

Appendix I

Expert Qualifications and Methods

Expert Qualifications

(b) (6)

[redacted]

(b) (6)

7. I've published in peer-reviewed journals on the topics of persons with serious mental disorders and the immigration detention system. I am a member of the University of California Criminal Justice and Health Consortium, the Human Rights Committee and Law Enforcement Liaison Committee of the American Academy of Psychiatry and the Law.

8. A more detailed listing of my experience and publications are included in my curriculum vitae, which is attached.

9. I am familiar with the degree of care and skill ordinarily exercised by members of the medical and mental health professions involving the care and treatment of inmates and pre-trial detainees in correctional facilities.

Methods of Review

In advance of the on-site investigation, I reviewed the documents provided by the Office for Civil Rights and Civil Liberties (CRCL) of the Department of Homeland Security. During the on-site investigation, I toured the facility including dormitories, pill lines and the medical clinic, review documents and medical records and interviewed staff and detainees. I performed focus reviews of medical records for those detainees who had mental health conditions, and particular those who were on the Chronic Care List and/or the Serious Mental Illness List. I reviewed 19 individual detainee paper medical charts, I conducted seven individual interviews with detainees (five men and three women) and I interviewed four staff members of the mental health treatment team.

Appendix II

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

Identity of Cases Cited in this Report

My Case No.	A#	Detainee Name	CRCL Complaint #
1.		(b) (6)	15-09-ICE-0522
2.			15-12-ICE-0625
3.			
4.			
5.			
6.			16-02-ICE-0072
7.			
8.			
9.			
10.			
11.			
12.			16-03-ICE-0070
13.			Grievance
14.			17-02-ICE-0071 18-02-ICE-0073
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			16-03-ICE-0101