Penology Expert's Report

On

LaSalle Detention Facility

This report is a general examination of conditions at the LaSalle Detention Facility with a specific examination of the issues identified in the following complaint:

- **16-03-ICE-0207**

Prepared by:

(b) (6)

Lodi, CA

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I. Summary of Review

The Department of Homeland Security, Office for Civil Rights and Civil Liberties (CRCL) received a complaint from Human Rights Watch (HRW) making the following allegations on behalf of Immigration and Customs Enforcement (ICE) detainees at the LaSalle Detention Facility (LDF), located in Jena Louisiana:[1]

- Detainees are not being afforded meaningful access to legal representation
- Detainees were mistreated by staff with threats of bodily harm and the use of derogatory language
- Conditions at the facility are unsanitary
- Detainees are subjected to retaliation

In addition to the specific complaint identified, the following aspects of the LDF facility operations were reviewed during this on-site inspection:

- Use of Force Reporting and Accountability
- Special Management Unit (Segregated Housing)
- Sexual Abuse and Assault Prevention and Intervention (SAAPI)
- Detainee Grievances
- Visiting Program
- Recreation Programs
- Mail Services
- Religious Services
- Telephone Access
- Legal Library Services

[1] Complaint No. 16-03-ICE-0207

DHS-00039-1499

II. Facility Background and Population Demographics

On the first day of our site visit[2] the ICE detainee population at LDF was 1121.[3] The LDF is owned by the GEO Corporation and is operated under a contract with the LaSalle Economic Development District which holds an Intergovernmental Service Agreement with ICE. LDF is an American Correctional Association (ACA) accredited facility.

The detainees at LDF include classification levels from low to high and are housed together in common housing units designated by classification level. The low and low-medium classification level detainees are housed in dormitory style housing units. The medium-high and high classification level detainees are housed in units that are configured with dorm style beds and one or two-person cells. All meals are delivered in carts from the main kitchen and served in the dayroom areas of the housing units. All other services such as visiting, library, religious services and recreation are provided in common areas, used by all the detainees, and are scheduled to accommodate the keeping of detainees with common classification designations together.

Throughout the site inspection process, we toured the LDF facility, reviewed records, interviewed LDF employees and interviewed ICE officials as well as several ICE detainees. All general conditions of confinement were reviewed and considered while on-site at LDF.

Overall, we found the staff to be professional, courteous and helpful and the general living areas of the facility to be clean and orderly. The LDF was not in full compliance with one PBNDS 2008 standard[4], but overall deficiencies were minimal and recommendations will be offered in this report to improve certain aspects of the operation. All opinions and recommendations contained herein are based on my background and experience in the correctional environment, ICE detention standards and generally recognized correctional standards,

[2] CRCL was on-site at LDF March 13-14, 2017.
[3] The LDF population consists of 943 ICE male detainees and 178 ICE female detainees.
[4] See discussion below in this report regarding use of force report writing.

including those of the American Correctional Association and the American Jail Association.

II. Expert Professional Information

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III. Relevant Standards

- **ICE Detention Standards**

The 2011 Performance-Based National Detention Standards (PBNDS) apply to LDF. These are the standards that were relied upon in looking at the specific allegations regarding this facility, as well as, the general review of operations.

- **Professional Best Practices**

In addition to the PBNDS 2011 this review is being conducted based on my correctional experience and nationally recognized best practices.

IV. Review Purpose and Methodology

The purpose of this review is to examine the specific allegations in the complaint cited above and to observe the overall operations of the LDF as it relates to the care and treatment of the ICE detainees. For this review, I examined detainee records; LDF policies and procedures; documentation and logs kept on-site depicting such things as detainee grievances and law library usage; interviewed ICE detainees, ICE employees, LDF employees; and, conducted an on-site tour of the LDF facility with the managers and supervisors. All the LDF personnel were professional, cordial and cooperative in facilitating our review.

Prior to the preparation of this report I specifically reviewed the following LDF documents:

- Contract/Intergovernmental Services Agreement

[5] At that time the inmate population in the CDCR was over 160,000 with approximately 120,000 parolees and 57,000 employees.

- Grievance logs and detainee grievances (January 2016 – March 2017, random selection)
- Law library logs showing the complete volume of law library usage, including detainees by name (January 2016 – March 2017, random selection)
- Detention Files (random selection and those associated with the complaint)
- Segregation records (records kept in the SMU)
- Incidents involving use of force and Force After-Action Reports (January 2016 – March 2017, about a dozen random selection)
- LDF and ICE National Detainee handbooks in English and Spanish
- SAAPI logs and electronic tracking system, compliance checklists and investigations (January 2016 – March 2017[6])
- Assigned personnel rosters
- LDF Post Orders
- LDF Policies on the following:
    1. Use of Force
    2. Special Management Unit
    3. Detainee Grievance Procedures
    4. Recreation Programs/Schedule
    5. Investigations
    6. Language Line
    7. Religious Programming
    8. Sexual Abuse and Assault Prevention and Intervention
    9. Detainee Legal Activity
    10. Library Services
    11. Mail Procedures

2011 PBNDS Standards relevant to this review:

1. Sexual Abuse and Assault Prevention and Intervention
2. Admission and Release

[6] There was a total of 5 SAAPI allegations and investigations during this time period. All were reviewed.

3. Use of Force and Restraints
4. Special Management Units (Segregation)
5. Telephone Access
6. Law Libraries and Legal Material
7. Grievance System
8. Visitation
9. Correspondence and Other Mail
10. Recreation
11. Classification
12. Religious Practices

In addition to the above listed activities the on-site inspection on March 13-14, 2017 included the following:

- Toured the Intake and Release
- Toured the housing units
- Toured the recreation yards
- Toured the law library
- Toured the Special Management Unit (administrative and disciplinary segregation)
- Toured the Medical Clinic
- Toured the visitation area and reviewed the rules and hours
- Toured the Mail Room
- Inspected all areas of detainee access for information postings
- Interviewed various personnel including command staff, supervisors and line staff[7]
- Interviewed various ICE detainees randomly selected

[7] These interviews included, but were not limited to, the SAAPI coordinator, the Grievance Coordinator, the Classification/Intake Coordinator, the Religious Services Coordinator, the Visiting Officer, the Mail Supervisor and the Law Library Supervisor.

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V. Findings, Analysis and Recommendations

For this report the following definitions are being observed as it relates to the "findings" for the allegations being considered:

- "Substantiated" describes an allegation that was investigated and determined to have occurred substantially as alleged;
- "Unsubstantiated" describes an allegation that was investigated and there was insufficient evidence to determine whether or not the allegation occurred[8]; and
- "Unfounded" describes an allegation that was investigated and determined not to have occurred.

Prior to making "findings" analysis will be offered to establish the evidence relied upon to make a finding. Any recommendations will be assigned a "priority" that is tied to the PBNDS 2011 or to industry "best practices."

The complaint listed above in this report will be specifically reviewed, analyzed and a finding will be opined.

Complaint No. 16-03-ICE-0207

This complaint was received by the CRCL in December 2016[9] from the HRW alleging that detainees were not being afforded meaningful access to legal representation; that detainees were not being afforded adequate medical care;[10] that detainees were mistreated by LDF staff with threats of bodily harm and the use of racially derogatory language; that the conditions at the facility were unsanitary; and, the LDF staff had retaliated against detainees who were communicating with HRW.

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[8] While "Unsubstantiated" can often be the finding because there simply is not enough tangible evidence to "Substantiate" an allegation, I may sometimes offer my expert opinion as to whether, based on other considerations and observations, it is more likely than not that the allegation either happened or did not happen.
[9] The allegations were made following a visit to the LDF by HRW on November 2-3, 2015.
[10] This allegation will be addressed by the medical professional on the CRCL team, Dr. Scott Allen, by separate report.

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Analysis:

The specific detainees involved in the allegations as presented by the HRW were not present at LDF at the time of our inspection. However, the CRCL inspection included the detainee services at issue in the complaint and efforts were made to investigate the allegations with the LDF management. The allegations are addressed individually below:

Meaningful Access to Legal Representation:

HRW alleged that during their visit to LDF on November 2, 2017, they were only allowed to speak to one of 14 male detainees who had been on a week-long hunger strike because the sole attorney visiting room at the facility had been reserved. HRW reported that one of the hunger strikers they were not able to interview called that evening and reported that his commissary and phone account had been discontinued and that he feared he was being removed as a result of the hunger strike.

The next day on November 3, 2015 HRW returned to the facility to meet with five other detainees. They were informed that one of the detainees requested had been removed and was no longer at LDF and that the other remaining detainees were unavailable because they were attending court hearings in the adjacent ICE building. HRW reported that later that day when they were able to visit with one of the detainees requested earlier, he informed HRW that he had not attended a court hearing that day.

The visitation areas were inspected.[11] The Warden at LDF was interviewed regarding the allegations by HRW. Although the allegations date back over a year ago, the Warden remembered generally the issues related to the HRW complaint. The Warden explained (and we verified) that the attorney visitation area has two visitation stations separated by a half wall.[12] All visits are non-contact, conducted

[11] The phones used to talk through the glass visitation enclosure were tested and operational.
[12] The half wall makes one unable to see who is sitting in the adjacent visitation station, but it is not sound proof, so conversations can be potentially overheard by attorneys visiting simultaneously. Consequently, some attorneys do not use the attorney visitation area while another attorney is in the adjacent attorney visitation station.

through glass. Attorneys may have more than one detainee on the detainee side of the glass to participate in a group discussion.[13]

The attorney visits are scheduled on a first come, first served basis. When attorney visitation is pre-scheduled, conflicts are avoided by not scheduling multiple attorney visits during the same timeframe. Attorney visitation is open and available for attorneys from 7:00 am – 11:00 pm, seven days a week. According to the Warden and the Major in charge of the visitation program, there are rarely scheduling conflicts that cause attorneys to wait for more than 15 minutes.[14] The Warden reports, however, that advocacy organizations such as HRW often come to the facility without prescheduling visitation with specified detainees and sometimes have to wait due to scheduling conflicts with other attorneys who have pre-scheduled the visitation. This was the case with HRW in November 2015.

The Warden also recalled that when the HRW requested visitation with the five detainees on November 3, 2015, staff initially thought all of them were at court in the ICE building and reported this to the HRW. Shortly thereafter, it was discovered that only three of the requested detainees were at court and the one who was not at court was escorted to the visitation area for the visit with the HRW. This is consistent with the HRW account of getting to visit with one of the requested detainees.

The HRW complaint that attorney visits are restricted to the one attorney visiting area is correct, with the caveat that there are two phones that attorneys can use to conduct visits simultaneously if confidentiality is not an issue between their clients.[15] For this reason, visits must be pre-scheduled to ensure conflicts don't interfere with visits.

After reviewing the visitation logs, it is clear that there is a higher volume of attorney visitation Monday through Friday during normal business hours.

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[13] This type attorney visit would require detainees passing the phone to participate in the conversation.
[14] After reviewing the visitation logs, 15 minutes is generally the time it takes to locate and escort the detainee to the visitation area once the attorney arrives on site.
[15] The visitation log included entries where attorneys had interviewed multiple clients with two attorneys present in the attorney visitation area simultaneously.

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Additional visitation space and capacity would help alleviate any congestion and waiting periods that may be caused when groups like the HRW come to interview large numbers of detainees. However, the LDF has attempted to mitigate any limits on space by allowing the pre-scheduling of attorney visits and extending attorney visitation to 16 hours a day, seven days a week. The visitation program as currently operated by LDF meets the standards for visitation as required by the PBNDS 2011, 5.7, Visitation, V., J.

Threats of Bodily Harm and Use of Derogatory Language:

HRW reported threats of bodily harm, use of racial slurs and derogatory language. The information presented by HRW was nonspecific and vague in terms of being able to review documented accusations or events that support the allegation. Accordingly, it is not possible a year and a half later to identify or verify events or information that support or refute the allegations. However, in inspecting the facility in the present, impressions can be rendered as to the likelihood of such interactions based on the general environment and culture at the facility.

Observed staff and detainee interactions appeared to be healthy. The interaction between staff and detainees appeared to be positive and detainee requests and grievances are answered in a timely manner. The interactions observed were respectful exchanges between staff and detainees and did not appear to be strained. Detainees were randomly interviewed and replied that staff were generally respectful with detainee interactions. After at least eight random detainee interviews only one detainee identified an officer who had been disrespectful in her interactions with detainees.[16]

While there clearly could have been inappropriate language or threats used by some staff member(s) in 2015 as alleged, we observed no evidence of such interaction in the present. The allegation appears unlikely to have happened as alleged, but cannot be ruled out.

[16] This detainee indicated that a female officer in her housing unit had a "bad attitude" towards her and on several occasions spoke to her in a disrespectful manner in an effort to embarrass her in front of the other detainees. This officers' name was given to the Warden who indicated that the issue would be promptly addressed.

Unsanitary Conditions:

HRW reported allegations of unsanitary conditions at the facility in late 2015. In addition to the general conditions, they reported an incident in October 2015 in which the water at the facility reportedly smelled and tasted bad and that detainees reported developing rashes after showering.

The Warden was interviewed regarding these allegations and remembered the event. Apparently, in 2015 the City Water District changed the water source that feeds the facility from one water line to another. In doing so, as the water entered the alternate water line, there was sludge in the line that cleared through the system and caused a slight discoloration, odor and a change in taste. The LDF immediately had the water tested and it was safe for normal use and consumption.

The Warden indicated that bottled water was distributed due to the odor and taste issues and that the discoloration, odor and taste issues were resolved within 24 hours as the water line cleared. Many private citizens in the Jena community experienced the same conditions and there were no health-related issues reported. The facility medical department was unable to verify any detainee rashes as a result of this event.

The general conditions of the facility appeared to be very good. Janitorial cleaning crews worked throughout the facility and all areas visited appeared to be clean and well cared for. Again, while it is surely possible that the conditions at the facility were different in 2015 then at present, it is unlikely that there would be a significant difference.

Retaliation:

As indicated above, a detainee reported to the HRW that he feared he was being removed as a result of being on a hunger strike and that his commissary and phone accounts had been discontinued. The detainee was not specifically identified in the complaint. However, as a practical matter it is common practice

for detainees who are being removed to have commissary and phone accounts discontinued the evening before they leave the facility. I was unable to find any information to support the implication that the removal from the facility or the commissary and phone account discontinuance were the result of retaliatory treatment on the part of the facility. Rather, these actions are consistent with removal for deportation.

Findings:

- The allegation that detainees were denied meaningful access to legal representation and that the limited attorney visitation space unfairly limits detainees' ability to confer with counsel and prepare for his/her case is "**Unsubstantiated**." While there may have been complications in accessing all of the requested detainees on November 2-3, 2015, any problems could have been reduced or avoided by properly scheduling the attorney visitation with the specified detainees prior to the visit.
- The allegation that LDF staff made threats of bodily harm and used racial slurs and derogatory language is "**Unsubstantiated**." While there clearly could have been inappropriate language or threats used by some staff member(s) in 2015 as alleged, we observed no evidence of such interaction in the present. The allegation appears to be more unlikely than likely to have happened as alleged.
- The allegation that the general conditions at LDF were unsanitary and the water tasted and smelled bad, causing rashes on detainees after showering is "**Unsubstantiated**." While there was a 24-hour period during the changing of the city water line that the water had an odor and tasted bad, the water was tested and found to be safe for human use. There was no documentation available to support the allegation of rashes caused by detainees showering.
- The allegation that detainees were retaliated against for being on a hunger strike or as a result of their speaking with the HRW is "**Unsubstantiated**." There was insufficient information provided and insufficient evidence to determine any specific act of retaliation related to this complaint.

Recommendations:

- None related to this complaint

VII. Additional review and Findings:

In addition to the specific issues we reviewed related to the above complaint, I reviewed the following general issues and operational areas of the facility:

- Use of Force
- Special Management Unit (Segregated Housing)
- Sexual Abuse and Assault Prevention and Intervention
- Detainee Grievance System
- Visitation
- Recreation Program
- Mail Services
- Religious Services
- Telephones Access
- Legal Library Services

These areas of the LDF operations and my observations of each will be discussed below:

1. Use of Force

The PBNDS 2011 requires that, "an employee submit a written report no later than the end of his or her shift when force was used on any detainee for any reason[17]; all facilities shall have ICE/ERO-approved written procedures for After-Action Review of use-of-force incidents[18]; and, the primary purposed of the After-Action Review is to assess the reasonableness of the actions taken and determine whether the force used was proportional to the detainee's actions."[19]

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[17] PBNDS 2011, 2.15 (Use of Force and Restraints), II. (Expected Outcomes), 11.
[18] PBNDS 2011, 2.15 (Use of Force and Restraints), V. (Expected Practices), P. (After-Action Review…), 1.
[19] PBNDS 2011, 2.15 (Use of Force and Restraints), V. (Expected Practices), P. (After-Action Review…), 1.

Analysis:

There was a total of 44 uses of force in 2016 with three occurring in the first 2 ½ months of 2017. Many of these incident reports documented very minor uses of force and, in some instances, even documented incidents where extraction teams were prepared and introduced, but because of detainee compliance, force was not actually used.[20]

During the site inspection, I reviewed incident reports that involved use of force by facility personnel.[21] My observation is that force is used sparingly and it is apparent that personnel view use of force as a last resort after other attempts have failed to gain compliance. This is reflected in the relatively few incidents involving significant force over the past year. Reports are written timely and Force After-Action Reviews are completed on all force incidents per the PBNDS 2011 standards.[22] The composition of the Force After-Action Review Team as outlined in the PBNDS 2011 is followed and reviews are conducted in a timely manner.

With regard to the incident reports involving use of force, my observation is that the reports reviewed were generally inadequate. Many of the reports did not adequately describe the specific actions taken by personnel in overcoming resistance during a force incident. For example, many reports contained what I refer to as catch-phrases such as, "I enter the cell to restrain detainees left arm,"[23] or, "I entered the cell and made contact with the detainee,"[24] without any description of what actions were specifically taken to "restrain" or without any description of the "contact" made with the detainee. This is not consistent with the industry best practice of specifically describing the actions taken in a force incident. As indicated, PBNDS 2011 requires a report be written in a timely

[20] Because of the effort to capture and report all instances of force, some incidents are categorized as force in which no force was used, unnecessarily inflating the number of force incidents. While we support the documentation of incidents that require the assembly of an extraction team, if force is not used it should be documented and explained that after a show of force, compliance was gained without the application of force. An example of an incident where no force was used but was not documented as such is MI 04-22-2016-027.
[21] I reviewed about a dozen randomly selected incidents involving use of force over the past 12 months.
[22] Additional comments below address the reporting and After-Action Reviews.
[23] See incident report MA 04-08-2016-025.
[24] See incident report MA 07-04-2016-34.

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manner, but does not speak to the content or quality of the reports. However, it is implicit in the standard that reports contain enough information as to allow management staff, the After-Action Review Committee, to determine the appropriateness of the use of force actions and to determine if follow up actions, such as training, are appropriate.

In the examples above, it is necessary to describe specific actions taken by the officer to "restrain or make contact" with the detainee. Obviously, a detainee could be "restrained or contacted" in many different ways, including pushing, pulling, punching, or tackling.[25] It is necessary to specifically report what actions were taken to affect the desired outcome and overcome resistance.

Even when force tactics are appropriately applied, if specific actions by the officer(s) are not documented in detail in written reports it leaves room for questions and allegations to be made after the fact. When officers' actions are specifically documented, the report stands as evidence to exactly what happened and leaves little room for subsequent interpretations or allegations. Specific documentation is also absolutely necessary for meaningful oversight and accountability in the Force After-Action Review Committee process.

Consideration must be given to the impact that poorly written reports have on the Force After-Action Review Committees conducted by the management. It is not possible to accurately evaluate the appropriateness of a use of force if the <u>specific</u> actions of involved staff are not descriptive. The threat perceived, efforts made to temper the force response, the need to use force, the amount of force necessary to overcome resistance, and the extent of any injury are impossible to determine and judge without reports that accurately depict the detailed actions of each participant.[26]

An observation to strengthen the After-Action Review process is for the committee to utilize the comments section on their After-Action Review Form to document and memorialize the date the committee met and reviewed an incident, the strengths and weaknesses found in the review and any training

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[25] It is also possible to "restrain" or "make contact" with a detainee without using any force at all.
[26] These standards are outlined in the US Supreme Court Case, Hudson V. McMillan (503 U. S. 1, 112 S. Ct. 995).

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needs or follow-up actions that may be necessary, etc. Using a check-the-box form only with signatures at the bottom doesn't even confirm that the participating signatories met as a committee to review the incident and collectively determined the necessity and the appropriateness of the force. The process will be greatly strengthened by better documentation of the After-Action Review Committee findings.

Before completing the site inspection, I met jointly with the Warden, the Assistant Warden and the Major to discuss my concerns about the lack of specific detail in some of the written reports, as well as the lack of documented detail in the After-Action Review process. All four gentlemen were receptive to my comments and expressed appreciation for the observations and recommendations, pledging to complete the necessary training to remedy the deficiencies in report writing.

Recommendations:

- LDF should require that force incident reports clearly describe the specific actions taken by each staff member involved in a use of force incident and that the use of catch-all language should be avoided. While the PBNDS 2011 requires only that a written report be completed by the end of shift when force is used on a detainee, it is implicit and imperative that the detail describing each officer's actions be sufficient to determine the appropriateness of the actions taken. (**PBNDS 2011, 2.15, II., 11. (Expected Outcomes) and V., B., 4. (Expected Practices), Priority 1**)
- LDF should review and revise the use of force and report writing training curriculum provided to supervisors and line personnel to ensure the training includes industry standard practices for detailing actions taken in force incidents. (**Best Practices**)
- LDF should ensure that After-Action Reports include comments to demonstrate any follow-up actions that may be necessary in terms of training, etc. (**Best Practices**)

2. Special Management Unit (SMU)

The PBNDS 2011 states that, "Any detainee who represents an immediate, significant threat to safety, security or good order shall be immediately controlled by staff and, if cause exists and supervisory approval granted, placed in administrative segregation. ICE and the detainee shall be immediately provided a copy of the administrative segregation order describing the reasons for the detainee's placement in the SMU."[27] It also requires that, "Prior to a detainee's actual placement in administrative segregation, the facility administrator or designee shall complete the administrative segregation order (Form I-885 or equivalent), detailing the reasons for placing a detainee in administrative segregation."[28]

Analysis:

Special Management Unit at LDF is utilized very sparingly and as a last resort for the safety of detainees and the facility staff. At the time of our visit there were only nine detainees in the SMU.[29] Segregation Orders are completed when a decision is made to place a detainee in administrative segregation. Reviews of administrative segregation placements are being conducted within appropriate timeframes and logs are kept depicting access to recreation, showers, phones, etc., per the PBNDS 2011. Documentation for security checks, retention hearings and disciplinary hearings is completed and thorough.

During our unit inspection, we observed the law library booth, the telephone cart and the recreation yards, all services provide to detainees in SMU. All activities are documented as they occur for each detainee and safety checks are conducted every 15-30 minutes. The operation of the SMU at LDF is in compliance with the PBNDS 2011.

[27] PBNDS 2011, 2.12 (Special Management Units), II. (Expected Outcomes), 3.

[28] PBNDS 2011, 2.12 (Special Management Units), V. (Expected Practices), A. (Placement in Administrative Segregation), 2. (Administrative Segregation Order), a.

[29] There are nine detainees in segregated housing out of a population of over 1100 detainees at the facility.

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Recommendations:

None related to this process.

3. Sexual Abuse and Assault Prevention and Intervention (SAAPI)

The PBNDS 2011, "…requires that facilities that house ICE/ERO detainees act affirmatively to prevent sexual abuse and assaults on detainees; provide prompt and effective intervention and treatment for victims of sexual abuse and assault; and control, discipline and prosecute the perpetrators of sexual abuse and assault.[30] The PBNDS 2011 SAAPI standards contain a multitude of specific requirements that must be implemented to ensure compliance. The SAAPI program and process were thoroughly evaluated by the CRCL team while on-site at LDF.

Analysis:

The SAAPI Coordinator was interviewed regarding the Sexual Abuse and Assault Prevention and Intervention process. From all the documents reviewed and the on-site inspection, it is apparent that the LDF management has posted appropriate notifications throughout the facility and appropriately trained the personnel. The zero tolerance for sexual abuse and assault is clearly communicated and allegations of sexual abuse or assault are appropriately documented, reported, and investigated.[31]

The SAAPI pre-screening requirement of the PBNDS 2011 for all detainees during the intake and classification process is functioning well. The standard intake process includes the risk assessment tool necessary to determine vulnerability and is included in every detainee intake file. The officers managing the intake process are knowledgeable and skilled in administering the prescreening assessment.

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[30] PBNDS 2011, 2.11, I.

[31] There were five SAAPI complaints at LDF in the past year.

When allegations of sexual abuse or assault are made, the involved detainees are separated and medically examined, the crime scene is secured and processed if identified, the detainees are interviewed by a mental health clinician, moved to appropriate and safe housing, all required notifications are made, local law enforcement is contacted and responds to assist with any crime scene evidence and investigate any criminal allegations. Allegations that, if true would not constitute a crime, are also taken seriously and investigated administratively by the SAAPI Coordinator. The quality of the investigations is very good; the proper witnesses are interviewed and the reports are well written.

In reviewing the tracking system utilized to track and coordinate all the activities related to the SAAPI, it was evident that the system currently in place for tracking and ensuring compliance with all requirements and timelines is very well established. The SAAPI Coordinator had an effective tracking mechanism for ensuring compliance with all notifications and timelines and for evaluating and assessing the effectiveness of the SAAPI program with data collection and reporting as required by the PBNDS 2011. The LDF SAAPI process is in full compliance with the PBNDS 2011.

Recommendations:

None related to this process.

4. Detainee Grievance System

The PBNDS 2011 standard, Grievance System, 6.2, I, “protects a detainee’s rights and ensures that all detainees are treated fairly by providing a procedure for them to file both informal and formal grievances, which shall receive timely responses relating to any aspect of their detention, including medical care.” The standard includes specific requirements that must be met for compliance.

Analysis:

Grievance forms are available upon request in each housing unit in both the Spanish and English language. During our on-site inspection, officers in the housing units provided grievance forms upon request. Locked boxes are in each

housing unit for detainees to place initiated grievance forms. The Grievance Coordinator picks up requests and grievances from the locked boxes and processes them daily.[32]

The Grievance Coordinator logs, makes copies, scans and emails the grievances to the Captain who assigns staff to interview the detainee and complete the grievance response. The completed grievances are returned to the Grievance Coordinator who copies, logs, sends a copy to the detainee's file and returns the completed grievance to the detainee. If a grievance is a personnel complaint, the grievance is assigned to the supervisor of the subject of the complaint. If the grievance issue is regarding medical care or personnel, the grievance is processed in the same manner except it is assigned to the IHSC supervisor for handling.

Our review determined that the grievance process at LDF is functioning well, timeframes for processing the grievances are being met and issues are being resolved appropriately. Grievance findings are determined and expressed in terms of, "resolved." While this is not contrary to the PBNDS, the process may be better served by developing a finding process that includes more specific language such as, "grievance granted," "grievance granted in part," or, "grievance denied." This type of documentation would provide information to the management team regarding grievance outcomes that could serve to influence operational and program practices.

Recommendations:

- LDF should consider modifying the grievance process to allow for a clearer description of what is being granted, granted-in-part or denied in a grievance request. (**Best Practices**)

5. Visiting Services

PBNDS 2011, Visitation, 5.7, I, "ensures that detainees shall be able to maintain morale and ties through visitation with their families, the community, legal

[32] At LDF the Grievance Coordinator possesses the only issued key for the locked boxes.

representatives and consular officials, within the constraints of the safety, security and good order of the facility."

Analysis:

LDF has visiting for family and friends scheduled and in operation seven (7) days a week. Visitation is operated Monday through Friday from 9:00 am - 1:00 pm; and, from 6:00 pm – 10:00 pm. Visitation on Saturday and Sunday is from 8:00 am - 10:00 am; 12:00 pm – 4:00 pm; and, 8:00 pm – 10:00 pm. Legal visitation also operates seven (7) days per week from 7:00 am – 11:00 pm. All Visits are conducted in a non-contact visitation area requiring the use of phones to communicate.[33]

There is not a high volume of visitation at LDF due to its remote location. There are not many complaints about the general visitation program and detainees who receive visits seem to be satisfied. Some expressed the preference for contact visits rather than non-contact. However, contact visitation is not a PBNDS requirement and LDF is in compliance with the PBNDS requirements.

Recommendations:

- LDF should identify additional space at its facility that would allow for an increased number of contact visitation for detainees and their families. The reason visitation is limited to non-contact only is because of the limitations in the physical plant. Designating some additional space for visitation may also alleviate any congestion for legal visitation during normal business hours by allowing the three-general visitation visiting booths to be utilized for attorney visits. **(Best Practices)**

6. Recreation

PBNDS 2011, Recreation, 5.4, I, "ensures that each detainee has access to recreational and exercise programs and activities, within the constraints of safety, security and good order."

[33] Visitation is conducted "behind glass" with the use of phones to allow participants to communicate.

Analysis:

The recreation program at LDF is operated 7 days a week. There are four large outdoor recreation yards utilized by the general population housing units and a separate outdoor recreation/exercise area for detainees housed in the Special Housing Unit. The outdoor recreation schedule is posted weekly and rotates the designated housing units by day and time in the four different recreation yards. Detainees in common housing units recreate together according to the schedule. The outdoor recreation yards have fields for soccer games, basketball courts and exercise equipment.

Our observation is that the recreation program at LDF is fully compliant with all PBNDS 2011 standards and is a "**best practice**" program.

Recommendation:

- None related to this process

7. Mail Services

PBNDS 2011, Correspondence and Other Mail, 5.1, I, "ensures that detainees shall be able to correspond with their families, the community, legal representatives, government offices and consular officials consistent with the safe and orderly operation of the facility."

Analysis:

We inspected the mailroom and interviewed the mailroom supervisor assigned to coordinate the delivery of mail. She had a good system for processing and delivering mail to detainees. All mail is opened in the housing units in the presence of the detainees. When money orders are received in mail, the mail supervisor makes copies to verify what was received and forwards to the detainee's trust account.

The legal mail is processed in a manner that requires detainees to sign for receipt of legal mail. The Mailroom Officer personally logs legal mail in a log book. She

then takes the legal mail to the detainee in his/her housing unit and opens the mail in front to the detainee checking only for contraband. The mailroom supervisor keeps good records that verify that legal mail has been received. The mail delivery at LDF is organized and efficient.

Recommendations:

None related to this process.

8. Religious Services

PBNDS 2011, 5.5 Religious Practices I, Purpose and Scope, provides that, "detainees of different religious beliefs are provided reasonable and equitable opportunities to participate in the practices of their respective faiths, constrained only by concerns about safety, security and the orderly operation of the facility."

Analysis:

We interviewed the LDF Religious Services Coordinator. Services are offered on a regular schedule for all religious affiliations.[34] Detainees are approved to participate in the religion of their choice. All accepted religious activities and observances, services, special diets and headwear are accommodated.[35] Religious services are provided by volunteers who come to the facility on a regularly scheduled basis or by fellow detainees who lead services as lay clergymen. In our interviews with detainees no complaints were expressed when queried about religious services and accommodations.

Recommendations:

- LDF should provide a Halal meal along with the Kosher and vegetarian religious meal selections. (**Best Practices**)

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[34] Catholic, Protestant, Muslim and Jewish services times are offered on the weekly schedule. The Catholic, Jewish and Muslim services are conducted by detainees because clergy are not available in the community to provide services to the detainee population.

[35] Halal meals are not offered but, the menu is pork-free and Muslim detainees can also choose a vegetarian diet.

9. Telephone Access

PBNDS 2011, 5.6, Telephone Access, I, Purpose and Scope, “ensures that detainees may maintain ties with their families and others in the community, legal representatives, consulates, courts and government agencies by providing them reasonable and equitable access to telephone services.”

Analysis:

Telephones are located in the housing units at LDF. Detainees have unfettered access to make phone calls. The detainees have a PIN number to use when making calls. The phones are available all day up until bedtime each evening. We observed detainees using the telephones in the housing units throughout our inspection. All detainees interviewed indicated that access to phones was fully adequate. Some detainees have complained that the telephone calls are too expensive.

Recommendations:

None related to this process

10. Law Library Services

PBNDS 2011, 6.3, Law Libraries and Legal Material, I., Purpose and Scope, “protects detainees’ rights by ensuring their access to courts, counsel and comprehensive legal materials.”

Analysis:

We visited the law library and reviewed the logs kept to document law library usage. The logs confirmed that detainees who wish to use the law library have adequate opportunity and access to do so. There is a main law library and a satellite law library available to the detainees in the Special Management unit.

Detainees submit requests to use the law library directly to the law library officer who schedules detainees and escorts them to the law library.

The library materials are kept current by ICE officials and detainees are available to assist other detainees if they need assistance with using the law library.[36] Copies are provided to detainees upon request. All detainees interviewed indicated that law library access, availability and legal materials are fully adequate.

Recommendations:

- None related to this process

General Observations:

The personnel at LDF are knowledgeable and professional. The facility appeared generally to be in good repair, painted and clean. The tenor and tone of the facility was generally good and the interaction between detainees and officers did not appear to be strained. Supplies, such as, hygiene items, board games and grievance/request forms were in abundance in the housing units.

While Food Services operations are normally addressed in the CRCL inspections by an Environmental Health Specialist, our specialist(s) was not available on this inspection. So, we toured and inspected the main kitchen where the food is stored and prepared. The freezer and storage areas were clean, food was properly stored, boxes were labeled and dated and temperature logs were kept.

The food preparation was properly organized and workers wore the proper hair nets. Trays were assembled in thermal tray containers and properly stacked, delivered and served to detainees in the housing units. Three hot meals are prepared, delivered and served each day. Our interviews with detainees produced no complaints regarding the food and food services is rarely the subject of detainee grievances. We have no recommendations for improvement in Food Services.

[36] Law library material on Nexus Lexus is available in several languages including Spanish and English. All updated materials are provided by ICE quarterly.

DHS-00039-1523

Summary of Recommendations:

The following is a summary of the recommendations made throughout the body of this report:

- LDF should require that force incident reports clearly describe the specific actions taken by each staff member involved in a use of force incident and that the use of catch-all language should be avoided. While the PBNDS 2011 requires only that a written report be completed by the end of shift when force is used on a detainee, it is implicit and imperative that the detail describing each officer's actions be sufficient to determine the appropriateness of the actions taken. (**PBNDS 2011, 2.15, II., 11. Expected Outcomes and V., B., 4. Expected Practices, Priority 1**)
- LDF should review and revise the use of force and report writing training curriculum provided to supervisors and line personnel to ensure the training includes industry standard practices for detailing actions taken in force incidents. (**Best Practices**)
- LDF should ensure that After-Action Reports include comments to demonstrate any follow-up actions that may be necessary in terms of training, etc. (**Best Practices**)
- LDF should consider modifying the grievance process to allow for a clearer description of what is being granted, granted-in-part or denied in a grievance request. (**Best Practices**)
- LDF should identify additional space at its facility that would allow for an increased number of contact visitation for detainees and their families. The reason visitation is limited to non-contact only is because of the limitations in the physical plant. Designating some additional space for visitation may also alleviate any congestion for legal visitation during normal business hours by allowing the three-general visitation visiting booths to be utilized for attorney visits. **(Best Practices)**
- LDF should provide a Halal meal along with the Kosher and vegetarian religious meal selections. **(Best Practices)**

Onsite Investigation Report

Jena/LaSalle Detention Facility, March 2017

(b) (6), MD, FACP
(b) (6)
Riverside, CA 92506

March 29, 2017

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Introduction

This report responds to a request by the Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL), to review and comment on the medical care provided to detainees at the Jena/LaSalle Detention Facility (JDF) by the U.S. Immigration and Customs Enforcement (ICE), ICE Health Service Corps (IHSC). My opinions are based on the materials provided and reviewed in advance and an onsite investigation of the facility on March 13-14, 2017. My opinions are expressed to a reasonable degree of medical certainty. JDF and IHSC personnel were most pleasant and cooperative during my investigation.

Expert Qualifications

(b) (6)

1.

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3.

4.

5.

6. (b) (6)

Methods of Review

In advance of the onsite investigation, I reviewed documents provided by CRCL that it received from ICE and JDF. During the onsite 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 and are similar to those adopted by the IHSC. I reviewed roughly 80 individual detainee medical records in total. I conducted individual interviews with six detainees selected at random from chronic care rosters or selected because of complaints received. Where relevant to findings, reference is made to the 2011 Performance Based National Detention Standards (PBNDS 2011).

Overview

JDF is located in Jena, LaSalle Parish, Louisiana. It houses roughly 1100 adult detainees. Medical care is provided by IHSC with support of contract staff from the staffing contractor InGenesis under the supervision of IHSC.

Overall, I found the medical care at JDF to be good. There were two areas where the current program did not meet the PBNDS 2011 as required by contract. This report will focus on deficiencies and areas requiring further attention in order to meet those standards.

Findings of Deficiencies

1. **Insufficient Medical Professional Staffing:** The facility staff has insufficient licensed staff to service the population of over roughly 1100 detainees. This is not just my opinion as a detention medical expert, but it is the opinion of IHSC as documented by vacancies in multiple areas per the facility's own staffing plan. For example, nursing staffing levels are also below the facility staffing plan with a vacancy rate of 32% for registered nurses (RN) and 17% for licensed practical nurses. Insufficient staffing impacts access to care by delays in both acute care (sick call) and follow-up for non-urgent care (such as chronic disease clinics) and reviews of the medical records documented delays in such follow-up.

   JDF has had difficulty in securing stable physician staffing. There have been periods

where the facility has gone without on-site physicians in the past. At the time of my visit, the clinical medical authority (CMA) was absent on leave and unavailable. There was a TDY CMA present, but he was only expected to remain onsite for a short period. The onsite CMA is a critical position for the medical program. In addition, deficiencies cited in this report regarding consistency in the provision of chronic care provided by mid-level providers suggest inadequate oversite of mid-levels by a physician. I have been assured by IHSC leadership that IHSC is aware of and working to address the medical staffing issues through the contracting process. However, until these issues are resolved, staffing does not meet the standards.

PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § II.21, V.B.

2. **Sub-specialty support for Infectious Disease/HIV**: The facility is located in a remote area, creating challenges in accessing sub-specialty care. In spite of these challenges, JDF has managed to secure timely sub-specialty consults in the most common specialties. However, the facility was unable to secure consultation for detainees with HIV. Even when they reached out to an academic medical center, their referrals were declined. This appears to be a function of the location of the facility and not a failure of effort on behalf of the medical provider.

   PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § II. 5, V.A.5

Detainee deaths

I made an attempt to review the deaths of three detainees who were cited in the retention memo. In two of the three cases (Cases #2 and #3 in Appendix I), my access to the medical records was remotely blocked, possibly because the files are under investigation by another office. I was able to review the medical record in one case (Case # 1 in Appendix I).

In case #1, physician oversite of the mid-level practitioners was scant, and physician involvement in the case was insufficient. This is likely a result of the physician staffing challenges cited earlier in this report. In addition, nurses failed to report abnormal vital signs to a provider, a likely result of incomplete nursing guidelines for reporting parameters. This finding represents an opportunity for improvement. Nursing guidelines should have complete parameters for abnormal vital signs requiring notification of a provider.

Complaints

The retention memo cites complaints from three transgender detainees (cases #5, 6 and 7 in Appendix I) who alleged inadequate medical care while temporarily detained at JDF. My investigation of the medical records *did not substantiate* these complaints.

Overall Medical Care

While this report focuses on deficiencies in the medical care at HCDF, it is important to comment briefly on the medical program as a whole. Performance of the medical program met the PBNDS 2011 in all other areas, including medical leadership (HSA), medical record keeping and acute care and off-site sub-specialty care other than Infectious Disease/HIV. Strengths include the quality of the medical leadership in the facility and the electronic health record. While the permanent HSA is away on TDI, the acting HSA was experienced and well qualified. Overall I found the medical care to be good.

Review of medical records using a jointly developed CRCL/IHSC tool kit revealed some opportunities for improvement (roughly 50% of chronic care or acute visits for asthma did not record peak flow measures as required by IHSC guidelines, several diabetic cases did not have recommended lab tests as required by IHSC guidelines, two out of seven cases with seizure disorder and an anti-epileptic drug requiring therapeutic drug monitoring did not have appropriate bloodwork done). In spite of these opportunities for improvement, I found overall chronic care met PBNDS standards.

Summary of Recommendations

Overall medical care of ICE detainees at the JDF meets the requirements in PBNDS 2011 with the exception of the following areas where care **does not** currently meet those standards:

1. **Insufficient Medical Professional Staffing:**

   Recommendation: The facility must ensure medical staffing is adequate to meet the staffing plan and to ensure appropriate and timely medical care is provided to detainees. The facility medical program is overseen by IHSC but depends on contractors to deploy adequate staff. The facility is located in a remote rural location. This makes it more difficult to recruit qualified professionals to work in the facility. The only practical ways to address the challenge of the remote location are to increase compensation to provide incentive to attract qualified contract professionals or to recruit more IHSC licensed professionals to be deployed at the facility. IHSC should conduct a medical staffing analysis to determine the appropriate number of medical staff needed to provide constitutionally adequate medical care to the detention population at LDF.

   PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § II.21, V.B.

2. **Sub-specialty support for Infectious Disease/HIV**:

   Recommendation: The facility is located in a remote area, creating challenges in accessing sub-specialty care. If the facility is unable to secure qualified sub-specialty support in the area of HIV, it may be prudent for ICE to avoid placing detainees with this

medical need at this particular facility until appropriate sub-specialty support can be secured. Accordingly, ICE should assess the sub-specialty support available in Jena, Louisiana and, where sub-specialty support is determined to be limited or unavailable, transfer detainees in need of the specific sub-specialty services to another facility until appropriate sub-specialty support can be secured.

PERFORMANCE does NOT meet the PBNDS 2011, Medical Care, § II. 5, V.A.5

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

Appendix I

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

Identity of Cases Cited in this Report

My Case No.	Alien No.	Name	CRCL Complaint No.
	(b) (6)		
1.			16-09-ICE-0612
2.			16-06-ICE-0605
3.			16-04-ICE-0628
4.			
5.	(b) (6)		
6.			
7.			

REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE LASALLE DETENTION FACILITY
Jena, Louisiana

by

(b) (6)
(b) (6)
Mansfield, MA 02048
(b) (6)

for the

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

April 29, 2017

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REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE LASALLE DETENTION FACILITY

A. INTRODUCTION

At the request of the U.S. Department of Homeland Security's Office for Civil Rights and Civil Liberties, the following is a summary of the observations, conclusions and suggested remedies of (b) (6) in regard to suicide prevention practices within the LaSalle Detention Facility in Jena, Louisiana.

This assessment was based upon a review of numerous U.S. Immigration and Customs Enforcement (ICE), ICE Health Services Corps, and The Geo Group[1] directives and other documents relating to suicide prevention; various suicide prevention training curricula; on-site review of physical plant and suicide prevention practices within the LaSalle Detention Facility on March 13 and 14, 2017; health care chart reviews of several ICE detainees held at the facility and placed on suicide precautions; interviews with several custody, medical, and mental health personnel, as well as detainees; and memorandum dated March 3, 2017 from the U.S. Department of Homeland Security's Office for Civil Rights and Civil Liberties to the U.S. Immigration and Customs Enforcement regarding the LaSalle Detention Facility: *Complaint Nos. 16-06-ICE-0612, 16-06-ICE-0605, 16-04-ICE-0628, 16-03-ICE-0207.*

B. <u>FINDINGS AND RECOMMENDATIONS</u>

Detailed below is this writer's assessment of suicide prevention practices within the LaSalle Detention Facility. It is formatted according to this writer's eight (8) critical components

[1]The Geo Group is the contracted correctional provider for the LaSalle Detention Facility.

of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/morbidity-mortality review. This protocol is consistent with the "Significant Self-Harm and Suicide Prevention and Intervention" section of the *Operations Manual ICE Performance-Based National Detention Standards* (2011) (hereafter referred to as 2011 PBNDS).[2] Where indicated, recommendations are also provided.

Custody operations of the LaSalle Detention Facility (LDF) are managed by The Geo Group, whereas the provision of health care services to detainees are managed by the ICE Health Services Corps (IHSC). The LDF, located in Jena, Louisiana, housed approximately 943 male and 178 female detainees on March 13, 2017, the first day of the writer's assessment. The average length of stay was stated to be approximately 32 days.

The Geo Group developed a local operating procedure (LOP) for suicide prevention at the LaSalle Detention Facility entitled "Suicide Recognition and Prevention" (No. 4.1.7, effective July 1, 2014). *Of note, IHSC officials assigned to the LaSalle Detention Facility could not provide an LOP regarding suicide prevention (entitled "Suicide Prevention and Intervention," No. 1501 at other ICE-contracted facilities), and instead simply provided this writer with the ICE Health*

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[2]U.S. Department of Homeland Security (2011), Immigration and Customs Enforcement, *Operations Manual ICE Performance-Based National Detention Standards* (2011 PBNDS),Washington, DC: Author. It should be noted that many of the components and descriptors contained within the PBNDS's "Significant Self-Harm and Suicide Prevention and Intervention" section were based upon, and consistent with, previous publications authored by this writer [see, e.g., Hayes, L.M. (2006), "Suicide Prevention in Correctional Facilities: An Overview," in M. Puisis (Ed.), *Clinical Practice in Correctional Medicine*, 2nd Edition, Philadelphia, PA: Mosby, Inc., 317-328; Hayes, L.M. (2005), "Suicide Prevention in Correctional Facilities," in C. Scott and J. Gerbasi (Eds.), *Handbook of Correctional Mental Health*, Washington, DC, American Psychiatric Publishing, Inc., 2005, 69-88; "Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons," contained within the National Commission on Correctional Health Care (2008), *Standards for Health Services in Jails*, 8th Edition, Chicago, IL, as well as their website: http://www.ncchc.org/filebin/Resources/Suicide-Prevention-2013.pdf

Service Corps Operations Memorandum No. 16-002 ("Significant Self-Harm and Suicide Prevention and Intervention," effective March 28, 2016) issued from IHSC headquarters.

1) Staff Training

The key to any suicide prevention program is properly trained correctional staff, who form the backbone of any correctional system. Very few suicides are actually prevented by mental health, medical or other professional staff. Because detainees attempt suicide in their housing units, often during late afternoon or evening, as well as on weekends, they are generally outside the purview of program staff. Therefore, these incidents must be thwarted by correctional staff who have been trained in suicide prevention and are able to demonstrate an intuitive sense regarding the detainees under their care. Simply stated, correctional officers are often the only staff available 24 hours a day, thus they form the front line of defense in suicide prevention.

The 2011 PBNDS requires that all staff "shall receive a minimum of eight (8) hours of training initially during orientation and repeated at least annually," (at page 264) and requires instruction in the following areas: environmental concerns; first aid training; liability; recognizing verbal and behavioral cues that indicate potential suicide; demographic, cultural and precipitating factors of suicidal behavior; responding to suicidal and depressed detainees; effective communication between correctional and health care personnel; necessary referral procedures; constant observation and suicide watch procedures; follow-up monitoring of detainees who have already attempted suicide; and reporting and documentation procedures.

FINDINGS: This writer conversed with several individuals with knowledge of suicide prevention training at the LDF, as well as reviewed the Geo Group's "Suicide Recognition and Prevention" curriculum. The review found that there was both inconsistent and disjointed suicide prevention training practices at the facility. For example, Geo's "Suicide Recognition and Prevention" curriculum, which comprised 81 PowerPoint slides with a suggested course length of 2.5 hours was problematic for several reasons. First, the curriculum was developed in 2009 and contained outdated research data on inmate suicides. In addition, the curriculum appeared to be focused on inmate suicide in other Geo-contracted "correctional" facilities and did not contain any sensitivity to suicide prevention within ICE facilities and the unique composition of ICE detainees and unique stressors of such an environment. For example, one PowerPoint slide stated "Many of the inmate/detainees are in the facility for terrible crimes. Some could be there because of murder, rape or child molestation." Such a statement is obviously untrue. Further, the Geo curriculum contents were not consistent with 2011 PBNDS requirements, e.g., the Geo curriculum did not address "liability" nor "cultural and precipitating factors of suicidal behavior." The Geo curriculum contained only 2.5 hours of instruction, whereas the 2011 PBNDS requires 8 hours of both orientation and annual suicide prevention training. The Geo Group was responsible for all training of its personnel, and IHSC mental health clinicians were not involved in the delivery of suicide prevention training. Finally, the Geo curriculum contained instruction on the corporate Geo suicide prevention policy which was in some ways inconsistent with the required ICE Health Service Corps "Significant Self-Harm and Suicide Prevention and Intervention" policy (OM 16-002). For example, the Geo curriculum stated that, when more than one detainee is placed on Level 1 suicide precautions, supervision can occur the via closed circuit television (CCTV) monitoring, as well as a staff member can supervise between 1 and 3 detainees on suicide precautions. This is

a violation of the 2011 PBNDS which does not permit either CCTV monitoring or observation of more than 1 inmate by 1 staff member.

With regard to suicide prevention training of IHSC personnel at the LDF, this writer was previously provided with a copy of 45 PowerPoint slides produced by IHSC entitled "Suicide Prevention." The slides included information on suicide risk factors, inmate suicide research, a partial listing of this writer's previously developed "guiding principles to suicide prevention," and review of the "Significant Self-Harm and Suicide Prevention and Intervention" section of the 2011 PBNDS. The duration of this 45-PowerPoint slide presentation was unclear. This writer was informed by IHSC mental health clinicians that the annual training was provided to all (medical and mental health) IHSC personnel via on-line instruction. It would be this writer's opinion that because attitude and collaboration are critical ingredients to suicide prevention, these principles are lost when a staff member is sitting alone in a chair at a computer terminal. As such, suicide prevention training is most effective when presented in a classroom format in collaboration with custody, medical, and mental health personnel. This writer was also informed that IHSC personnel previously received telephonic training on completion of suicide risk assessments.[3]

Finally, although this reviewer made repeated requests for data regarding compliance rates for both initial and annual suicide prevention training for all Geo, ICE, and IHSC personnel conversing with detainees on a regular basis, such data was never provided and this reviewer was simply informed that all personnel were trained as required.

[3]Telephonic training is obviously also not desirable.

CONCLUSION/REMEDY: The provision of suicide prevention training at the LaSalle Detention Facility was found to be problematic at several levels. Data on compliance rates for such training was not available (and is a basic component to any quality assurance program); Geo and IHSC utilized different training curricula and instructors; the Geo curriculum was outdated, not sensitive to the ICE detainee population, and limited to 2.5 hours of instruction; and it appeared doubtful that any new Geo and IHSC personnel received the required 8 hours of initial orientation training in suicide prevention (as required by the 2011 PBNDS). It is strongly recommended that IHSC and Geo collaborate on the development of joint curricula for orientation and annual suicide prevention training. Preferably, instruction should be provided by a IHSC mental health clinician. Finally, both IHSC and Geo should keep easily accessible data on the percentages of staff who complete both initial (orientation) and annual suicide prevention training. Maintenance of compliance data for staff training is a basic ingredient to any quality assurance program.

2) Intake Screening/Assessment

Intake screening/assessment is also critical to a correctional system's suicide prevention efforts. A detainee can attempt suicide at any point during incarceration -- beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social

support system, psychiatric history, and various "stressors of confinement."[4] Most importantly, prior research has consistently reported that at least two thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.[5] In addition, according to the most recent research on inmate suicide, at least one-third of all inmate suicide victims had prior histories of both mental illness and suicidal behavior.[6] The key to identifying potentially suicidal behavior in inmates is through inquiry during both the intake screening/assessment phase, as well as other high-risk periods of incarceration. Finally, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission to such placement.

The 2011 PBNDS require that "all detainees shall receive an initial mental health screening, by a qualified health care professional or health-trained correctional officer, who has been specially trained, within 24 hours of admission. The results of the screening shall be documented on the approved intake screening form, which contains observation and interview items related to potential significant self-harm/suicide risk."

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[4]Bonner, R. (1992), "Isolation, Seclusion, and Psychological Vulnerability as Risk Factors for Suicide Behind Bars," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 398-419.
[5]Clark, D. and S.L. Horton-Deutsch (1992), "Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 144-182.
[6]Hayes, L.M. (2010), *National Study of Jail Suicide: 20 Years Later*, Washington, DC: U.S. Department of Justice, National Institute of Corrections.

FINDINGS: Although not having the opportunity to observe both the pre-screening and intake screening processes at the LaSalle Detention Facility, this writer was able to verify that ICE, Geo, and IHSC appeared to adequately collaborate on the intake screening process at the LDF, and nursing staff were able to provide both pre-screening and intake screening in an environment that allowed for privacy and confidentiality. However, as this writer found during previous assessments of ICE-contracted facilities, the IHSC intake screening form currently utilized was grossly inadequate for the identification of suicide risk. The intake screening form, which was contained within the electronic health medical record (called "eClinicalWorks") is limited to the following five (5) mental health and suicide risk questions:

- Have you ever tried to kill yourself?
- Are you currently thinking about killing or harming yourself?
- Do you now or have you ever heard voices that other people don't hear; seen things or people that others don't see; or felt others were trying to harm you for no logical or apparent reason?
- Have you ever been diagnosed with a mental illness or have you ever been hospitalized for psychiatric reasons?
- Is there a history of mental illness in your family?

These limited areas of inquiry has probably resulted in the under-reporting and under-identification of detainees who are at risk for suicide. In fact, this writer was surprised to review informal data maintained by a IHSC clinician on a "Suicide Watch Log" that indicated only approximately 24 detainees were placed on suicide precautions at the LDF from January 2016 through February 2017 - a period of over 13 months. Given the average daily population of approximately 1,100 detainees, the number of detainees identified as suicidal appeared extremely low.

Further, pursuant to current policies and practices, nursing rounds in segregation were conducted daily and mental health rounds conducted twice weekly (which exceeded 2011 PBNDS requirements of weekly rounds). However, as this writer found during previous assessments of ICE-contracted facilities, the IHSC clinicians were required to complete a "Mental Health Segregation Rounds" form when interacting with either mental health caseload or non-mental health caseload detainees housed in segregation. The form included the following 10 questions:

1) Does the detainee have a mental health DSM-5 diagnosis?
2) Does the detainee present any active symptoms?
3) Is the detainee receiving MH treatment?
4) Is the detainee compliant with his/her treatment?
5) Is the detainee currently engaging in any dangerous or disruptive activity that would render his/her return to the general population a threat to the detainee or the safety/security of the facility?
6) Would the detainee benefit from a higher level of care?
7) Is the detainee frequently followed up by medical personnel (other than MH)?
8) Is the detainee frequently followed up by MH personnel?
9) Has there been deterioration on the detainee's condition while in segregation?
10) Is the detainee involved in activities while he/she is in segregation?

Ironically, despite the initial appearance of a comprehensive inquiry regarding serious mental illness, the form did *not* contain any suicide risk inquiry nor a brief mental status examination. Given the common knowledge throughout the correctional field regarding the disproportionate number of suicides that occur in segregation environments, the absence of any suicide risk inquiry was troubling.

CONCLUSION/REMEDIES: Several recommendations are offered to improve the intake screening and other assessment processes within the LaSalle Detention Facility. These recommendations are consistent with those provided during the previous assessments of ICE-

contracted facilities *First*, the Intake Screening form (IHSC 795-A) currently embedded in eClinical Works should be revised to include the following specific areas of inquiry:

- Was detainee a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates detainee is a medical, mental health or suicide risk now?
- Have you ever attempted suicide?
- Have you ever considered suicide?
- Are you now or have you ever been treated for mental health or emotional problems?
- Have you recently experienced a significant loss (relationship, death of family member/close friend, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Are you thinking of hurting and/or killing yourself?

Second, in order to answer the first question above ("Was detainee a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?), IHSC should develop an "alert screen" within its eClinicalWorks electronic health record to tag such information. As such, the following protocol is recommended:

- Any detainee placed on suicide precautions should be tagged on the "alert screen" of the eClinicalWorks by mental health staff;
- Medical staff conducting intake screening should always review the detainee's alert screen to verify whether they were previously confined in an ICE facility and had any history of suicidal behavior/placement on suicide precautions during any prior confinement; and

- Regardless of the detainee's behavior or answers given during intake screening, further assessment by mental health staff should always be initiated based on documentation reflecting possible mental illness and/or suicidal behavior during an inmate's prior confinement within an ICE facility.

Third, the current "Mental Health Segregation Rounds" form should be revised to include a brief suicide risk inquiry (such as "Are you thinking of hurting and/or killing yourself?"), as well as brief mental status examination.

Fourth, although mental health clinicians should converse with all detainees housed in segregation on a twice-weekly basis, the "Mental Health Segregation Rounds" need only be completed for detainees that are currently on the mental health caseload.

3) <u>Communication</u>

Certain signs exhibited by the detainee can often foretell a possible suicide and, if detected and communicated to others, can prevent such an incident. There are essentially three levels of communication in preventing detainee suicides: 1) between the sending institution/arresting-transporting officer and correctional staff; 2) between and among staff (including mental health and medical personnel); and 3) between staff and the suicidal detainee. Further, because detainees can become suicidal at any point in their incarceration, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff.

<u>FINDINGS</u>: Effective communication between correctional, medical, and mental health staff is not an issue that can be easily written as a policy directive, and is often dealt with more

effectively through examples of multidisciplinary problem-solving. Although on-site for only two days, this writer sensed that Geo, IHSC, and ICE staff had good working relationships. In addition, IHSC's integrated eClinicalWorks contained both medical and mental health records that better ensured communication between medical and mental health personnel. In addition, this writer was informed that IHSC mental health clinicians have a "noon" meeting each day to discuss detainees with serious mental illness and/or detainees placed on suicide precautions. In addition, a multidisciplinary meeting is held for any detainee housed in segregation for more than 30 days.

CONCLUSION/REMEDY: Other than other suggested remedy related to better collaboration in the provision of suicide prevention training offered earlier in this report, no other recommendations are offered regarding this component.

4) Housing

In determining the most appropriate location to house a suicidal detainee, there is often the tendency for correctional officials in general to physically isolate the individual. This response may be more convenient for staff, but it is detrimental to the detainee. The use of isolation not only escalates the detainee's sense of alienation, but also further serves to remove the individual from proper staff supervision. National correctional standards stress that, to every extent possible, suicidal detainees should be housed in the general population, mental health unit, or medical infirmary, located in close proximity to staff.

Of course, housing a suicidal detainee in a general population unit when their security level prohibits such assignment raises a difficult issue. The result, of course, will be the assignment of

the suicidal detainee to a housing unit commensurate with their security level. Within a correctional system, this assignment might be a "special housing" unit, e.g., restrictive housing, disciplinary confinement, administrative segregation, etc., However, to every extent possible, such detainees should be housed in suicide-resistant, protrusion-free cells, and provided a mattress. Further, cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), removal of clothing (excluding belts and shoelaces) and issuance of safety "smocks," as well as the use of physical restraints (e.g., restraint chairs/boards, straitjackets, leather straps, etc.) should be avoided whenever possible, and only utilized as a last resort for periods in which the detainee is physically engaging in self-destructive behavior. Housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, but on the ability to maximize staff interaction with detainees. As shown below, several of these concerns were found at the LDF.

The 2011 PBNDS clearly state that cells housing suicidal detainees "will be free of objects or structural elements that could facilitate a suicide attempt," and "Deprivations and restrictions placed on suicidal detainees need to be kept at a minimum. Suicidal detainees may be discouraged from expressing their intentions if the consequences of reporting those intentions are unpleasant or understood to result in punitive treatment or punishment. Placing suicidal detainees in conditions of confinement that are worse than those experienced by the general population detainees can result in the detainee not discussing his or her suicidal intentions and falsely showing an appearance of getting well fast."

<u>FINDINGS</u>: The Geo "Suicide Recognition and Prevention" policy (No. 4.1.7) vaguely addressed the basic requirements for the "suicide-resistant" housing of suicidal detainees by stating that "The isolation room will be free of objects or structural elements that could facilitate a suicide attempt…," whereas the IHSC Operations Memorandum No. 16-002 ("Significant Self-Harm and Suicide Prevention and Intervention," effective March 28, 2016) does *not* address suicide-resistant housing for suicidal detainees except to say that "actively suicidal" detainees should be placed in a "room that is free of objects or structured elements that could facilitate a suicide attempt," but does *not* require suicide resistant housing for "potentially" suicidal detainees observed that 15-minute intervals. The following is a summary of designated LDF locations that house suicidal detainees, including a critique as to whether or not they are suicide-resistant:

1) <u>Medical Housing Unit</u>: Two cells (No. 5 and 6) were designated to house detainees on suicide precautions. With one exception, each of these cells was suicide-resistant and did not contain any obvious protrusions conducive to a suicide attempt by hanging. The exception was the metal bunks containing ventilation holes that could be utilized as an anchoring point in a suicide attempt by hanging. Retrofitting the bunks by covering the holes would thwart a suicide attempt by hanging.

2) <u>Special Management (Segregation) Unit</u>: This unit contained 12 cells that would only be utilized to house suicidal detainees if both of the Medical Housing Unit cells were occupied. Each of these cells were *not* suicide-resistant, and contained several hazards, including double metal bunks, grab bars, and window bars that could easily be utilized as anchoring points in a suicide attempt by hanging. Any cell designated in the segregation unit for overflow housing of suicidal detainees should be retrofitted by replacement of the double metal bunks with bunks with no hazards, replacement and installation of grab bars designed with a closed bottom (i.e., no open space), removing (by caulking) the gap between the window bar and window.

In addition, this writer was informed that there were occasions in which detainees placed on suicide precautions were *not* provided with mattresses by Geo personnel. Although this writer

conversed with Geo officials who insisted that suicidal detainees were always provided with mattresses, this assertion was contradicted by Geo officers who informed this writer that suicidal detainees were provided with safety smocks and blankets, but not provided with mattresses. In fact, Geo's previously referenced "Suicide Recognition and Prevention" training curriculum stated that: "Inmate/detainee will not have access to blankets, sheets, *mattresses*, or pillow cases (except at bedtime).

CONCLUSION/REMEDIES: There were a few concerns regarding the housing of suicidal detainees in the LaSalle Detention Facility. *First*, The Geo Group should ensure that all detainees placed on suicide precautions are housed in cells that are suicide-resistant. *Second*, Geo and IHSC suicide prevention policies do not adequately address procedures for deciding which possessions and privileges are provided to detainees on suicide precautions. As such, it is strongly recommended that both policies be revised to include the following requirements:

- All decisions regarding the removal of a detainee's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk as determined on a case-by-case basis by mental health staff;

- If mental health staff determine that a detainee's clothing needs to be removed for reasons of safety, the detainee shall always be issued a safety smock and safety blanket;

- A mattress shall be issued to each detainee on suicide precautions unless a detainee utilizes the mattress in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilizes to obstruct visibility into the cell, etc.);

- All detainees on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.), unless the detainee has lost those privileges as a result of a disciplinary sanction; and

- Detainees on suicide precautions shall not automatically be locked down. They should be allowed dayroom access commensurate with their security level and clinical judgment of mental health staff.

5) <u>Levels of Supervision/Management</u>

Experience has shown that prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody is by hanging.[7] Medical experts warn that brain damage from asphyxiation can occur within four minutes, with death often resulting within five to six minutes. In inmate suicide attempts, the promptness of the response is often driven by the level of supervision afforded the inmate. The 2011 PBNDS allows for two levels of observation, i.e., “Detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring,” whereas “Detainees on suicide precautions who have not been placed in an isolated confinement setting by the qualified mental health professional will receive documented close observation at staggered intervals not to exceed 15 minutes (e.g., 5, 10, 7 minutes).”

In addition to requirements for the observation of detainees on suicide precautions, the 2011 PBNDS contain requirements for daily and comprehensive suicide risk assessments, downgrading the level of observation following a period of stability, and providing periodic follow-up assessments (pursuant to individualized treatment plans) following discharge from suicide precautions. The “treatment plan” requirements of the 2011 PBNDS include: “1) strategies and interventions to be followed by the staff and detainee if suicidal ideation reoccurs, 2) strategies

[7]Hayes, L.M. (2010), *National Study of Jail Suicide: 20 Years Later*, Washington, DC: U.S. Department of Justice, National Institute of Corrections.

for improved functioning, and 3) regular follow-up appointments based on level of acuity." Finally, the 2011 PBNDS prohibits use of "contracting for safety" by stating that "Contracting for safety provides no guarantee that the patient shall not attempt suicide, and may give staff a false sense of security. This practice is not to be relied on by staff."

FINDINGS: Both the Geo's "Suicide Recognition and Prevention" policy (No. 4.1.7) and ICE Health Service Corps Operations Memorandum No. 16-002 ("Significant Self-Harm and Suicide Prevention and Intervention") address the levels of observation and management of suicidal detainees. The IHSC policy offers three levels of observation: *Suicide Watch* (requiring continuous, one-on-one observation with the detainee issued a safety blanket and safety smock), *Constant Watch* (requiring continuous, one-on-one observation with the detainee issued regular bedding and clothing), and *Mental Health Observation* (requiring observation at staggered 15 minute intervals). Although not clearly articulated within the policy (as well as not stated within the 2011 PBNDS), both *Suicide Watch* and *Constant Watch* are reserved for detainees who are deemed to be "actively suicidal, whereas *Mental Health Observation* is reserved for detainees who are deemed to be "potentially suicidal." The Geo policy simply references "constant observation" and "close observation" (at staggered intervals not to exceed 15 minutes).

In addition, the IHSC policy requires daily assessments of detainees on all three levels of observation, including completion of both an "Initial Suicide Risk Assessment" form (to justify placement on suicide precautions) and a "Follow-Up Suicide Assessment" form (to justify discharge from suicide precautions). The IHSC policy only briefly addresses treatment planning by simply stating: "The treatment plan must address the relevant factors that contribute to the

detainee's suicidal ideation (e.g., environmental, historical, biological, psychological and social) and must be updated, as necessary. Although the IHSC Operations Memorandum requires that a mental health clinician assessed the detainee "within 72 hours after the detainee is discharged from *Suicide Watch*," there are *not* any similar instructions for follow-up of detainee's release from either *Constant Watch* or *Mental Health Observation*. The Geo policy does not adequately address follow-up assessments or treatment planning by mental health staff.

This writer had an opportunity to review the medical charts of 12 detainees who were on suicide precautions at some point during 2016 and 2017 at the LaSalle Detention Facility. Without opining about the clinical judgment used in any of the reviewed cases, the review found that all detainees were assessed daily by a clinician as required, with most assessments apparently occurring within the privacy of the clinician offices. The review found that 10 of 12 cases included adequate completion of suicide risk assessments (SRA), with one case involving an SRA not being completed and another involving inadequate justification on the SRA for both an inmate's continuation on, and discharge from, suicide precautions. Although there was a general lack of treatment planning in most cases, most detainees remained on suicide precautions at the LDF for a short period of time (often only a few days) before being transferred to another ICE facility or deported. Overall, given the fact that few detainees are placed on suicide precautions and remain on that status for only a few days before being transferred, there were adequate practices found regarding the management of suicidal detainees by mental health clinicians.

CONCLUSION/REMEDY: Only one recommendation is offered. The Geo and IHSC suicide prevention policies do not contain operational definitions of behavior that distinguishes

Suicide Watch, *Constant Watch*, and *Mental Health Observation*. As such, it is strongly recommended that the following definitions be considered:

> *Suicide Watch* and *Constant Watch* are reserved for the detainee who is actively suicidal, either by threatening or engaging in self-injury, or has a plan to commit suicide, and would be considered a high risk for suicide. This detainee should be observed by an assigned staff member on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals.
>
> *Mental Health Observation* is reserved for the detainee who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, a detainee who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under *Mental Health Observation*. This detainee should be observed by staff at staggered intervals not to exceed every 15 minutes, and should be documented as it occurs.

Consideration should also be given to integrating the "high acute risk," "moderate acute risk," and "low risk" terms utilized in the Suicide Risk Assessment forms into the three levels of observation.

6) <u>Intervention</u>

Following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive. A facility's policy regarding intervention should be threefold: 1) all staff should be trained in standard first aid and CPR; 2) any staff who discovers a detainee attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin life-saving measures; and 3) staff should never presume that the detainee is dead; but rather initiate and continue appropriate life-saving measures until relieved by medical personnel. All housing units should contain a first aid kit, CPR mask or Ambu bag, and rescue tool (to quickly cut through fibrous material). As stated in the 2011 PBNDS, "Following a suicide attempt, security staff shall initiate and continue appropriate life-saving measures until relieved by arriving medical personnel.

The arriving medical personnel shall perform the appropriate medical evaluation and intervention. The clinical medical authority or designee will be notified in situations when referral to the emergency room of a local hospital is required." Unfortunately, the standards do not address the issue of appropriate emergency medical response equipment.

FINDINGS: Perhaps due to the vagueness of the 2011 PBNDS, both Geo's "Suicide Recognition and Prevention" policy (No. 4.1.7) and ICE Health Service Corps Operations Memorandum No. 16-002 ("Significant Self-Harm and Suicide Prevention and Intervention") failed to adequately address the appropriate policies and procedures for the emergency response to a suicide attempt.

In addition, during a tour of the LDF, this writer observed that locked first aid kits were located on the wall outside of most housing units. Following an inquiry, it was determined that housing unit officers did *not* have access to the first aid kits, and that only responding supervisory staff had keys. Following considerable delay, a supervisor was found and opened one of the first aid kits. Unfortunately, the kit only contained gloves and bandages, and not the necessary equipment to respond to a suicide attempt by hanging. Of note, the aforementioned Geo suicide prevention training curriculum contained a PowerPoint slide that stated: "A Rescue Knife must be maintained in each inmate/detainee housing unit. This can be used to cut a ligature or other rope-like material in the event of a suicide attempt by hanging. This tool should be accounted for at the beginning of each shift and secured to prevent unauthorized access. Be sure to find the location of this tool in your area in case you need it." Contrary to this training directive, Geo did *not* have any emergency rescue tools available its LDF personnel.

Finally, similar to the difficulty in verifying suicide prevention training received at the LaSalle Detention Facility, this writer requested data regarding compliance rates with first-aid and CPR/AED training for all LDF personnel, including ICE, IHSC and Geo employees working in the facility and conversing with detainees on a regular basis. Such data was never provided and this writer was simply informed that all personnel were trained as required.

CONCLUSION/REMEDY: Both Geo's "Suicide Recognition and Prevention" policy (No. 4.1.7) and ICE Health Service Corps Operations Memorandum No. 16-002 ("Significant Self-Harm and Suicide Prevention and Intervention") should be revised to include specific procedures for the appropriate emergency medical response to a suicide attempt. All staff should be trained in the use of the emergency equipment and know its location. At a minimum, the revised policies should include the following procedures:

1) All staff who come into regular contact with detainees should be trained in standard first aid procedures and CPR;

2) Any staff member who discovers a detainee engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, Ambu-bag or CPR mask, and rescue tool);

3) Correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical

> personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

In addition, emergency rescue tools or "cut-down" tools (utilized to quickly cut through fibrous material) should be placed in an emergency response bag (that includes the Ambu bag and first aid kit) and located in close proximity to each housing unit. All Geo housing unit staff should have access to the equipment.

Finally, both IHSC and Geo should keep easily accessible data on the percentages of staff who are currently compliant with both first aid and CPR/AED training. Maintenance of compliance data for staff training is a basic ingredient to any quality assurance program.

7) Reporting

Pursuant to the 2011 PBNDS, as well as both Geo and IHSC policies, in the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of the command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the inmate and incident.

FINDING: Fortunately, the LaSalle Detention Facility has not had a recent incident that necessitated this Reporting mechanism.

CONCLUSION/REMEDY: None

8) Follow-up/Mortality Review

Pursuant to the 2011 PBNDS, every detainee suicide should be examined by a mortality review: "The mortality review process shall include review of: circumstances surrounding the incident, review of procedures relevant to the incident, training of staff, medical/mental reports involving the victim, identification of possible precipitating factors, recommendations for changes in response to the incident (e.g., policy, training or retraining, counseling, reprimand or discipline the staff identified as failing to follow suicide prevention procedures, physical plant, medical or mental health services and operational procedures)."

FINDING: Both Geo's "Suicide Recognition and Prevention" policy (No. 4.1.7) and the ICE Health Service Corps Operations Memorandum No. 16-002 ("Significant Self-Harm and Suicide Prevention and Intervention") were consistent with the mortality review requirements of the 2011 PBNDS following a detainee suicide. Although the morbidity review of serious suicide attempts was not technically required under the 2011 PBNDS, the LDF experienced a serious suicide attempt in March 2016 that resulted in the detainee's transfer to a local hospital for emergency medical treatment. The incident resulted in a morbidity review by IHSC officials and personnel at LDF, as well as an external review by ICE Health Service Corps headquarters.

CONCLUSION/REMEDY: None

C. CONCLUSION

It is hoped that the findings, conclusions and remedies contained within this report will be of assistance to The Geo Group, ICE Health Services Corp, and U.S. Immigration and Customs

Enforcement officials and staff in their joint efforts to improve current suicide prevention practices for ICE detainees within the LaSalle Detention Facility.

Respectfully Submitted By:

/s/ (b) (6)
(b) (6)
April 29, 2017