Exhibit 1

CORRECTIONS EXPERT'S REPORT

ON

ADELANTO CORRECTIONAL FACILITY

Prepared by:

(b)(6)

Roseville, CA

November 16, 2017

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ADELANTO CORRECTIONAL FACILITY

I. SUMMARY OF REVIEW

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL), conducted a November 13-14, 2017 progress review and investigation at the Adelanto Correctional Facility (ACF) in Adelanto, California. The prior December 9-11, 2015 onsite investigation at this facility identified deficiencies in the areas of admission and release, special management units, population counts, grievance system, staff misconduct, retaliation, staff-detainee communication, staffing, training, legal access, visitation, language access, health and mental healthcare, and management team assistance. On February 2, 2016 CRCL received notification from ICE ERO of the death of an ACF detainee alleging delayed and inadequate medical care.[1] On December 19, 2016 CRCL received an email referral from the DHS Office of Inspector General (OIG) which alleged delayed and denied access to medical care, failure to provide medications and failure to respond to medical grievances.[2] On April 19, 2017 CRCL received a detainee complaint alleging delayed medical treatment, verbal abuse and retaliation by medical staff.[3] On May 13, 2017 CRCL received an email notification from ICE Joint Intelligence Operations Center (JIOC) Daily Detainee Assault Report of a use of force incident report involving a detainee diagnosed with mental illness and Hepatitis C.[4] On June 5, 2017 CRCL was notified by ICE of the May 30, 2017 death of a 46 year old detainee.[5] On June 21, 2017 CRCL received email notification from the ICE JIOC Daily Detainee Assault Report of a use of force incident involving a detainee- correctional officer assault. On June 26, 2017 CRCL received correspondence from The Border Rights Project on behalf of their clients alleging that two detainees participated in a hunger strike to protest the inhumane conditions at the ACF and in retaliation were beaten, placed in administrative segregation, denied access to medical care, denied access to their attorney, denied grievance forms and ICE did not respond to the detainees' requests for a credible fear interview.[6] Due to time limitations CRCL focused this investigation of operations in the following areas: admission and release, special management units, use of force, population counts, grievance system, staff misconduct, retaliation, staff-detainee communication, staffing, training, legal access, visitation, language access, health and mental healthcare, and management team assistance. This investigation also reviewed ACF's adherence to the 2011 Performance Based National Detention Standards (2011 PBNDS).

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[1] CRCL Complaint No. 16-06-ICE-0627

[2] CRCL Complaint No. 17-03-ICE-0103

[3] CRCL Complaint No. 17-07-ICE-0456

[4] CRCL Complaint No. 17-08-ICE-0299

[5] CRCL Complaint No. 17-09-ICE-0356

[6] CRCL Complaint No. 17-09-ICE-0366

Allegations related to the deaths, medical and mental health care are addressed by the medical and mental health experts who participated in the onsite investigations; however, I did review medical and mental health care from a correctional perspective relative to access to care complaints and grievances.

Through this review, I found operational deficiencies related to some of the allegations, as well as other operational deficiencies observed during the November 13-14, 2017 onsite investigation and document review.

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

II. PROFESSIONAL EXPERTISE

I am an expert corrections consultant. My educational background includes a Bachelor of Science Degree in Organizational Behavior from the University of San Francisco and a Master's Degree in Criminology, Law, and Society from the University of California at Irvine.

My correctional expertise results from 26 years of operating, managing, and performing direct supervision and oversight for up to ten male and female prisons with approximately 40,000 inmates and 15,000 staff for the California Department of Corrections and Rehabilitation (CDCR), where I served as Southern Regional Prison Administrator, Associate Director Female Offender Programs and Services, Deputy Director of Finance, Chief of Regulation and Policy Management, and Prison Rape Elimination Act (PREA) Executive Project Director. I was also the Director of Rehabilitation and Activation for the Federal Medical Prison Receiver appointed by the court in the *Plata v. Schwarzenegger* litigation, reporting to the Medical Receiver while also remaining a CDCR employee. My duties for the Receiver entailed creating evidenced-based rehabilitation program models in an integrated care environment and designing the physical configuration of the associated program space for a medical facility being built to correct constitutional deficiencies declared by the court. The medical facility and programs were built to accommodate vulnerable inmates with significant medical needs and mental health issues.

I have provided expert reports and testimony for prison and jail-related litigation in the States of Hawaii, Illinois, Massachusetts, Pennsylvania, and California, and testified in over 300 California Senate and Assembly legislative hearings related to prison and community corrections issues. My experience also includes teaching criminal justice-related subject matter at Stanford University and serving as an expert panelist for criminal justice research, sentencing, gender, transgender, correctional operations, probation, and California Public Safety Realignment issues. I am currently the Chief of the Alameda County Probation Department which includes responsibility for the Juvenile Justice Detention Center, and the retired Chief Adult Probation Officer for the City and County of San Francisco. I am also a retired member of the California Rehabilitation Oversight Board (CROB), appointed by the California State Legislature. CROB provides oversight of the CDCR's inmate prison rehabilitation programs and reports to the legislature. I also previously served as a Board member of the Association of Criminal Justice Researchers.

II. RELEVANT STANDARDS

A. ICE Detention Standards

ICE's 2011 PBNDS currently apply to ACF. This facility was covered by these standards during the entire period relevant to this investigation. Consequently, I relied on the 2011 PBNDS when looking at the specific allegations regarding conditions at the facility. Additionally, I considered ICE Directive 11062.1: Sexual Abuse and Assault Prevention and Intervention issued May 22, 2014, which was in force and effect during this period. The PBNDS 2011 which includes section 2.11 Sexual Abuse and Assault Prevention and Intervention (SAAPI) policies was also in effect during this period.

III. FACILITY BACKGROUND AND POPULATION DEMOGRAPHICS

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

The detainees are housed in a mix of dormitory and secure housing units. Housing units have Lower and Upper tiers. Male detainees held in segregation are housed in a Special Management Unit (SMU) at the West Facility. The SMU contains 32 cells with an upper and lower tier and has a total capacity of 64. The administrative SMU male count at this facility was 32, and the disciplinary SMU male count was 14 during the November 13-14, 2017 site visit. The administrative SMU female count was three and the disciplinary SMU female count was 1 during this population included a combination of detainees on disciplinary and administrative segregation status.

IV. REVIEW PURPOSE AND METHODOLOGY

The purpose of this review was to examine the specific allegations made in the complaints, as well as to identify other areas of concern regarding the operation of the facility. As part of this review, I examined a variety of documents; conducted a site visit of ACF on November 13-14, 2017, along with CRCL staff and experts who examined medical and mental health care; and interviewed ICE and ACF staff and detainees. Detainee names and alien numbers and staff names are omitted from this report, and instead listed in Appendix A.

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

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

- Reviewed detainee complaints

- Reviewed JIOC Daily Detainee Assault Reports
- Reviewed the Border Rights Project correspondence
- Reviewed the April 2016 ICE National Detainee Handbook
- Reviewed relevant ICE PBNDS 2011
    - Grievance System
    - Detainee Handbook
    - Admission and Release
    - Law Libraries and Legal Material
    - Recreation
    - Religious Practices
    - Staff-Detainee Communication
    - Special Management Units
    - Staff Detainee Communication
    - Classification System
    - Population Counts
    - Disciplinary System
    - Sexual Assault and Abuse Prevention and Intervention
    - Facility Security and Control
- Reviewed relevant ACA correctional standards

While at the ACF on November 13-14, 2017 and post visit, I did the following:

- Toured East and West Facility Housing Units
- Toured the SMUs
- Toured Visiting
- Interviewed housing officers
- Reviewed the Inter-Governmental Service Agreement between ICE and the City of Adelanto
- Reviewed institutional operational policies
- Reviewed law library access at ACF
- Interviewed the law librarian
- Reviewed the facility schedule for the law library
- Reviewed the recreation schedule for the SMUs
- Interviewed custody and program personnel regarding admission and release, SMUs, use of force, population counts, grievance system, staff misconduct, retaliation, staff-detainee communication, staffing, training, legal access, visitation, language access, health and mental healthcare, and management team assistance.
- Inspected the SMUs
- Inspected telephone pro bono number postings in the SMUs
- Reviewed detainee grievances logs for 1/1/2016-10/31/2017
- Reviewed specific detainee grievances and responses
- Interviewed Grievance Officer
- Reviewed detainee disciplinary reports
- Reviewed disciplinary segregation orders
- Reviewed disciplinary housing logs

- Interviewed male and female detainees in East and West Facilities
- Interviewed randomly selected detainees in the SMUs
- Spoke with various facility staff and management during the course of the review
- Met with various ICE staff during the course of the review
- Reviewed detainee housing rosters
- Reviewed detainee files
- Reviewed the ACF supplemental detainee handbook
- Reviewed Administrative Segregation and Disciplinary Segregation hearing notices, reports, detention files, and housing logs
- Reviewed detainee requests made to ICE
- Reviewed the Daily Activity Schedule
- Reviewed ACF policies on:
    - Classification
    - Detainee Programs-Recreation
    - Special Management Detainees/Special Management Unit Operations
    - Use of Force
    - Detainee Grievance Program
    - Detainee Rules and Disciplinary Procedures
    - Admission and Release
    - Detainee Handbook
    - Staff and Detainee Communication
    - Library Services
    - Language Line Services
    - Prevention of Sexual Assault and Abuse
    - Correspondence
    - Access to Telephones
    - Visitation
    - Training
    - General Incident Reports
    - Hunger Strikes

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

V. CORRECTIONS FINDINGS AND RECOMMENDATIONS

A. Admission and Release and Language Access

The 2011 PBNDS protects the Community, detainees, staff, volunteers and contractors by ensuring secure and orderly operations when detainees are admitted to or released from a facility. As part of this and the previous investigation I reviewed the admission and release

process. I interviewed staff in Receiving who are responsible for the intake screening, admission and release of detainees. I also reviewed intake screening and classification documents in detention files as part of my investigation. ACF continues to not conform to the Admission and Release Detention Standard.

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

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

Recommendation

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

B. Special Management Units

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

SMUs A and B at ACF housed 46 male detainees at the time of this investigation. ACF's SMU log identifies 15 cases with serious mental illness (SMI). The Women's SMU housed four detainees at the time of this investigation, and the SMU log identified 3 with SMI. The total number of detainees held in segregation at the time of this investigation was 50 detainees. The SMU detainee's SMI diagnosis and logs are incorrect. The CRCL mental health expert identified that 26 (32%) of the 50 detainees held in SMU at the time of this investigation had SMI. I additionally found when reviewing the SMU log that the log only tracks the number of days a detainee is held in segregation for the current stay. The longest amount of time a detainee was held in the SMU on the November 13, 2017 log was 426 days based on detainee #4's request for protective custody (PC). No detainee should be held in the SMU for this amount of time. Isolation alone can create physical safety concerns and can result in mental decompensation. Thirty-six percent (18) of the SMU population had been housed in the SMU for over thirty days. The majority of long term stays in the SMU are based on self PC requests due to the detainee's stated safety concerns. When I further analyzed the cases in the SMU, I found that four other detainees had spent over three hundred days in the SMU based on multiple stays. These four detainees had spent 370 to 904 days in the SMU. The Healthcare staff were making the required daily rounds, but detainees were being interviewed at the cell front which prohibits an accurate assessment

of the detainee's mental health condition. Detainees with SMI should be interviewed in a more therapeutic manner which should include removing the detainee from the cell. One of the rooms in the SMU should be converted into an interview room where private interviews between mental health personnel and detainees can be effectively conducted. The mental health expert will speak to the specific mental health cases housed in the SMU. No current strategy exists to address the detainees held long-term in SMU. If strategies are not developed, the mental health and other long-term detainee cases will continue to decompensate, and the population of the SMU will continue to grow.

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

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

Recommendations

2. ERO, IHSC and ACF must audit all SMU cases to identify those detainees housed in the SMU, partially or wholly due to mental health conditions and, develop a safe housing alternative with more intensive mental health services including mental health groups in a non-SMU setting for detainees with mental health conditions. (PBNDS 2011, SMU)
   STATUS: Not corrected previous recommendation - Long Term segregation of housing of detainees with serious mental health conditions should cease. A therapeutic unit should be established to house SMI detainees, where appropriate oversight and treatment results in those detainees eventual transition to a general population or step-down unit.
3. The Mental Health Director and IHSC must ensure that ACF mental Health staff conduct daily face to face rounds with all detainees in the SMU and provide appropriate mental health assessment and treatment. (PBNDS 2011, SMU)
   STATUS: Partially corrected previous recommendation - Daily rounds are being conducted; however, one of the rooms in the SMU should be converted into an interview room where private interviews between mental health personnel and detainees can be effectively conducted.
4. ICE must audit all detainees held in the SMU over 30 days for protective housing reasons and determine if transfer to another facility is more appropriate. (PBNDS 2011, SMU)
   STATUS: Partially corrected previous recommendation - SMU audits are being conducted every 30; however, 40% (20) of detainees continue to be housed over 30 days in the SMU. ICE must work with GEO to create a housing alternative for non-disciplinary placements in the SMU for over 30 days.
5. ERO must conduct an external audit of all detainees held in Administrative and Disciplinary Segregation over 30 days to determine if transfer to another facility could improve treatment or resolve use of the SMU for special housing. (PBNDS 2011, SMU)
   STATUS: Not corrected previous recommendation

C. Population Counts

The PBNDS 2011 requires three and encourages more custody counts of the detainee population daily; however, the Detention Standard also requires the count system to be

effective. The count system at ACF is not effective. There are six counts daily at the East and West Facility. Limited improvement has been made to the count process at ACF. The 1100 count has been moved to 10:30 AM which has reduced this count's interference with feeding, visitation, etc.; however, the PBNDS 2011 does not mandate six counts. Count can take up to 2 hours to clear. The number of counts was increased to six several years ago due to a detainee escape and was based upon a Corrective Action Plan agreement between ICE and ACF. The six counts at ACF creates extended delays in feeding, visiting (legal and regular), recreation, law library, and healthcare appointments. These extended delays impact all programming. In previous discussions with the Chief of Security, he did not have a concern with eliminating the 11:00 AM daily count which would reduce the number of counts to five; however, the 11:00 AM count time was moved to 10:30 AM and not eliminated.

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

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

Recommendation

6. ERO and ACF must develop and implement an efficient population count process that comports with the 2011 PBNDS to eliminate the problematic delays that six daily counts cause in the delivery of meals, visitation (legal and regular), recreation, law library access, and detainee medical appointments. (PBNDS 2011, Population Counts) STATUS: Partially corrected previous recommendation - ACF continues to conduct six daily population counts when the Chief of Security previously did not have a concern with reducing the number of daily counts to five which would improve detainee access to programs and services.

D. Grievance System, Staff Misconduct, Retaliation,

The 2011 PBNDS protects detainees' rights and ensure they are treated fairly by providing a procedure for them to file both informal and formal grievances and receive timely responses relating to any aspect of his/her detention, including medical care. One important aspect of the Grievance System Standard is detainees are protected from harassment, discipline, punishment or retaliation for filing a complaint or grievance. Detainee #3 called the OIG hotline to make a complaint about inadequate medical care.[7] Included in his complaint was ACF's failure to adequately respond to detainee #3's medical grievances. I completed a comprehensive review of the detainee grievances for 2016 and 2017. Detainees filed 380 grievances in 2016 and 512 grievances for the period of January 2017 through October 2017. Over one-third of the grievance complaints relate to inadequate and access to medical and mental health care issues. This large number of healthcare related grievances is not typical in a correctional setting, and is a key indicator that the healthcare needs of the detainee population is not being met. During the previous investigation in 2015 the large number of medical and mental health grievances

[7] CRCL Complaint No. 17-03-ICE-0103

was also raised. The medical expert will provide the expert opinion on medical care and the mental health expert will opine on the mental health care; however, grievance systems are designed to act as am important indicator or early warning system to assist leadership of both ICE/ACF to identify significant issues within the facility. Medical and mental-health care concerns were also one of the major issues raised by detainees during detainee interviews that CRCL staff and I conducted at this facility. Discourteous staff treatment and retaliation were also raised by detainees during the detainee interviews. Detainees filed 57 staff complaint grievances in 2016 and 37 staff complaint grievances from January through October 2017.

Alleged misconduct includes verbal disrespect and harassment of detainees by healthcare, program, and custody staff, discrimination based on race, retaliation when detainees voice grievances, and excessive use of force. During detainee interviews CRCL staff and I conducted, detainees voiced numerous concerns regarding the grievance system. Detainees report having no faith in the grievance system due to a lack of responsiveness by staff and the grievance system being ineffective. A lack of follow through and failure to correct reported complaints and failure to address issues of staff disrespect toward detainees are contributing factors to the detainees' lack of faith in the grievance system. GEO does not effectively track detainee's grievances regarding staff misconduct and does not provide ICE with a copy of each staff complaint as mandated by the PBNDS. Critical healthcare issues are raised in the grievances and failure to timely respond to the raised concerns can create life threatening situations for the detainees. Additionally, once GEO and ICE are advised of medical and mental health issues and fail to respond, the system and personnel can be at legal risk of being found to be deliberately indifferent.

During onsite detainee interviews, the detainees reported they continue to be verbally harassed and disrespected by ACF staff in healthcare, program, and custody, discriminated against based on race and subjected to retaliation when they voice grievances. These reports mirror the staff misconduct formally documented in grievances. Adult Local Detention Facility Performance Based Standard 4-ALDF-6A-07 mandate that detainees [Inmates] are not subjected to personal abuse or harassment.

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

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

Recommendations

7. ICE/ACF Management (including the Warden), must develop a reporting system to ensure that facility personnel effectively respond to and resolve the detainee grievance issues assigned to them by the Grievance Coordinator. (PBNDS 2011, Grievance System) STATUS: Not corrected previous recommendation - Responses to grievances continue to be ineffective in addressing detainee concerns.
8. ICE/ACF Management must develop a review and trend tracking system for all grievances reporting staff mistreatment. (PBNDS 2011, Grievance System)

STATUS: Not corrected previous recommendation - Detainee grievances about facility staff mistreatment are currently not submitted to ICE as mandated by PBNDS 2011. ICE should receive a copy of all staff-related grievances upon their receipt by the GEO Grievance Coordinator.

a. All staff grievances should be tracked by date, time, location, issue and identify of the involved staff.
b. GEO's onsite leadership should analyze the report of grievances against staff on a weekly basis to look for trends and detainee reports of mistreatment involving the same staff member.

9. ACF Warden must hold facility staff accountable for substantiated abusive and disrespectful treatment of the detainees, as determined by the Grievance Coordinator and or other facility personnel. (PBNDS 2011, Grievance System)
STATUS: Not corrected previous recommendation
10. ACF's healthcare grievance process (medical, mental health and dental) is currently unreliable. The ACF Medical Unit should establish a staff position that is responsible for timely review and response to medical grievances, and ensure the appropriate follow-up actions are taken to prevent further detainee injury or death. (PBNDS, Grievance System) - New Recommendation
11. A separate healthcare medical grievance log should be instituted to track healthcare-related grievance submittals and timely responses. (PBNDS, Grievance System) - New Recommendation
12. A monthly audit should be conducted of the submitted healthcare grievances to improve timeliness of care and ensure appropriate access to medical, mental health and dental care. (PBNDS, Grievance System) - New Recommendation

E. Staff-Detainee Communication, Training and Turnover

In the previous 2015 investigation ICE and ACF management cite staff communication, turnover and medical as the three largest problems at this facility. The medical and mental health expert will speak to the healthcare related staffing issues in this investigation. Both ICE and ACF management previously attributed the high custody staff turnover to the pay level of the officers. There are several other contract correctional facilities in close proximity to ACF which previously were hiring ACF correctional officers once ACF had trained them because the other facilities offered higher salary and benefits. ACF has increased the compensation for correctional officers which has reduced the number of vacancies and improved retention rates. The pay increase has stabilized the workforce.

Staffing levels at the East and West facilities was impacted by GEO eliminating over 20 officer positions as reported during the previous 2015 investigation. The positions were eliminated based on the reduced population levels at the facility; however, the positions that were eliminated directly impacted the movement of the detainees to medical, feeding, visiting (legal and regular), etc. Some of these positions have been re-instated and filled which has reduced movement delays; however, there continues to be a lack of adequate custody positions to provide correctional healthcare escorts to medical and mental health appointments within the facility and to outside appointments. I have reviewed the current custody post assignment schedule which identifies that ACF currently has 5 dedicated medical transportation officer

positions, 7.20 medical holding cell observation officers, 1.60 medical officers, and 24 utility officer positions. The total healthcare correctional officer staffing needs should be analyzed, and the available positions reviewed to determine the number of custody positions needed on each shift for each healthcare related functions and to ensure the number of correctional officer positions needed on each shift, seven days per week are available to eliminate the custody staffing barrier to access to care.

FINDING: ACF HAS AN INADEQUATE NUMBER OF CORRECTIONAL OFFICER HEALTHCARE ESCORT POSITIONS WHICH CREATES A BARRIER FOR DETAINEES TO ACCESS MEDICAL AND MENTAL HEALTH CARE

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

Recommendation

13. ICE AND ACF leadership must develop a post-assignment schedule that creates a staffing plan which resolves the current staffing deficiencies that are impacting operational inefficiencies, such as excessive count times, meal delays, and limited visitation, legal access and recreation time allotments. (PBNDS 2011, Facility Security and Control)
    STATUS: Partially corrected previous recommendation – The post assignment schedule has been revised and additional correctional officer positions have been added however, the correctional officer medical escort and transportation staffing should be increased to adequately support the medical and mental health escort needs within the facility and to outside appointments and care.

F. Legal Access

Law Library

During the previous onsite investigation in 2015 language access was identified as a barrier to legal access for LEP detainees. It was previously recommended that a bi-lingual librarian be hired to support the Spanish speaking detainees. The law librarian retired which created the opportunity for GEO to hire a bi-lingual, Spanish speaking librarian; however, GEO did not hire a Spanish speaking librarian. This was a significant missed opportunity for GEO to provide improved access to legal services for Spanish speaking detainees. During onsite interviews with male detainees on November 13, 2017, detainees voiced significant complaints regarding the lack of language assistance related to using Lexis-Nexis, obtaining legal copies and preparing legal forms that are only available in English. Detainees reported when other detainees try to assist them with translation the detainees are threatened with a disciplinary. The new law librarian is not bi-lingual which also contributes to the communication difficulties with LEP detainees.

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

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

Recommendations

14. ACF should grant the female Law Librarian's transfer and hire a Spanish speaking Librarian. (PBNDS 2011, Law Library and Legal Material)
    STATUS: Not corrected previous recommendation – The female law librarian retired and created a law librarian vacancy. GEO did not hire a Spanish speaking law librarian which continues to create legal access difficulties.
15. ACF must institute a computer training class, demonstrating use of the Lexis-Nexis software and computers, and create a detainee worker position in each housing unit to assist detainees with utilizing the computer system. (PBNDS 2011, Law Library and Legal Material)
    STATUS: Not corrected previous recommendation - LEP detainees continue to have difficulties using the Lexis-Nexis computers and preparing legal related forms that are only available in English.

G. Limited English Proficiency-Language Access

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

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

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

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

Previous Recommendations

16. ACF must develop a Language Line logging system and require all facility staff to record its use; by date and A#. (DHS Access Plan 2012) (PBNDS 2011, Multiple)
    STATUS: Partially corrected previous recommendation - The Language Line logs exist at various locations within the facilities, but non-medical staff do not consistently use the language line.
17. ICE/ADF must ensure all forms issued to detainees for informational purposes and/or for detainee signatures must be written and/or translated in a language the detainee comprehends. All written material provided to detainees shall generally be translated into Spanish to comply with the Detention Standards. (DHS Language Access Plan 2012) (PBNDS, Multiple)
    STATUS: Not corrected previous recommendation

H. Detainee #1 and 2 Death Review (Names listed on Appendix A)

As Part of this investigation I was asked by CRCL to review from a correctional practice perspective any significant factors regarding Detainee #1 and 2's[8] deaths that could have negatively impacted access to care while held at ACF. Additionally, Detainee #3 also made a complaint via the OIG hotline[9] that ACF provided inadequate medical care including failure to provide timely or follow-up care, failure to schedule approved offsite diagnostics and other medical related issues. My investigation identified that lack of adequate correctional staffing to perform escorts to care internally within the facility and to conduct transports to outside care creates a significant barrier for all detainees to access care at ACF. In my previous investigation I identified that a significant number of correctional staff vacancies existed which negatively impacted all operational areas within the facility. Many correctional staff vacancies have been filled; however, there continues to be a need to increase the number of medical escorts. The lack of adequate correctional officer medical escort positions results in delayed medical transports to outside care and cancelled onsite medical appointments and medical clinics which prevents timely access to medical and in some cases, can create life threatening conditions for detainees held at this facility.

FINDING: LACK OF ADEQUATE CORRECTIONAL OFFICER MEDICAL ESCORT STAFFING CREATES BARRIERS TO CARE AND CAN CREATE LIFE THREATENING CIRCUMSTANCES FOR DETAINEES

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

Previous Recommendation

None. Recommendation number 13 addresses the need for GEO to conduct a staffing analysis to determine the number of correctional medical escort officers needed to conduct

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[8] CRCL Complaint Nos. 16-06-ICE-0627 and 17-09-ICE-0356

[9] CRCL Complaint No. 17-03-ICE-0103

medical transports to outside care and to inside medical clinics and appointments to remove access to care barriers. No additional recommendation is needed.

I. Detainee #4, 5, 6 and 7- Excessive Use of Force Allegations

As Part of this investigation I was asked by CRCL to review three use of force complaints.[10] I reviewed the incidents involving Detainee #4 and Detainee #5 allegations and could not substantiate any irregularities with the use of force with these incidents based on the available information. Videos were not available related to these two incidents. I do note that both incidents involve detainees with mental illness. The mental health expert will identify the consequences of not providing adequate mental health treatment for detainees. Use of force incidents is one of the many negative consequences of not providing adequate treatment and medications for detainees with mental illness. Providing effective mental health treatment, medications and housing for detainees with mental illness will reduce the number of use of force incidents at this facility.

On June 26, 2017, CRCL received correspondence from The Border Rights project on behalf of Detainees #5 and #6 alleging both detainees were beaten, placed in segregation, denied access to medical care, denied appropriate access to their attorney, denied grievance forms and ICE did not respond to the detainees' requests for a credible fear interview. These actions allegedly were taken in retaliation for these detainees participating in a hunger strike protesting their treatment and inhumane conditions at ACF. I reviewed the incident reports and viewed the video recording of this incident. GEO staff complied with the Use of Force Policy and PBNDS 2011 in relationship to responding to this incident. This incident involved a large number of detainees who participated in a sit in protest locking arms and sitting at tables in the dayroom. Custody staff provided the involved detainees with numerous opportunities to respond to directives to return to their beds. The detainees failed to comply, and their actions began to incite detainees in other areas of the housing unit. Custody staff gave further directives to the involved detainees, and in order to not lose control of the unit, ultimately dispersed OC Pepper Spray to control the situation. The use of OC Pepper spray to gain detainee compliance was appropriate given the circumstances, and the detainee's failure to comply with multiple directives from custody for the detainees to return to their beds. Detainees were medically evaluated upon the conclusion of the incident. I found no evidence to support that detainees were not provided with medical care; however, I did identify a significant issue with the decontamination process. When exposure to OC pepper spray occurs, the appropriate method to decontaminate effected detainees is to use cold water generally in a shower. The facility does not have any access to cold water. The facility only provides a mix of cold and hot water through a shower head to comply with the temperatures required for environmental health and safety. The warm water will exacerbate the burning effect of the OC pepper spray. GEO must obtain a cold-water source in a shower in both the East and West facilities to be used when decontamination from an OC pepper spray incident is needed. Access to the detainees' attorney was suspended during the initial incident and response, but was provided as soon as it was feasible. I did not substantiate that the detainees were denied access to grievance forms.

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[10] CRCL Complaint Nos. 17-08-ICE-0299, 17-09-ICE-407 and 17-09-ICE-0366

During my investigation I also reviewed ICE records in relationship to the allegation that ICE did not respond to Detainee #5 and #6's request for a credible fear interview. There is no record of Detainee #5 requesting a credible fear interview. Detainee #6 claimed a credible fear on May 25, 2017. On May 30, 2017 he requested a credible fear interview. On June 9, 2017 Detainee #6 received a credible fear interview. The allegation of failure to provide a credible fear interview is not substantiated.

FINDING: ALLEGATIONS OF EXCESSIVE USE OF FORCE, FAILURE TO PROVIDE MEDICAL CARE, FAILURE TO PROVIDE ATTORNEY ACCESS AND DENIAL OF GRIEVANCE FORMS ARE NOT SUBSTANTIATED

Previous Recommendation

18. ACF must provide access to a cold-water shower in the East and West Facilities for use to decontaminate detainees who have been exposed to OC Pepper Spray. (PBNDS 2011, Use of Force) - New Recommendation

VI. SUMMARY OF OUTSTANDING PREVIOUS RECOMMENDATIONS

Below are status updates of previous ACF findings and recommendations:

1. ACF continues to fail to meet the Admission and Release, Intake Screening Standard as interpreters or language lines are not consistently used for LEP detainees during the intake screening process and completion of the numerous intake forms. The facility must correct their intake and admission process by consistently utilizing interpreters during the intake screening and admission process and ensuring detainees are signing documents in a language he/she understands or is provided oral assistance in order to comply with the detention standard. (PBNDS 2011, Admission and Release)
   STATUS: **Not corrected-previous recommendation**
2. ERO, IHSC and ACF must audit all Special Management Unit (SMU) cases to identify those detainees housed in the SMU, partially or wholly due to mental health conditions and, develop a safe housing alternative with more intensive mental health services including mental health groups in a non-SMU setting for detainees with mental health conditions. (PBNDS 2011, SMU)
   STATUS: **Not corrected previous recommendation** - Long Term segregation of housing of detainees with serious mental health conditions should cease. A therapeutic unit should be established to house SMI detainees, where appropriate oversight and treatment results in those detainees' eventual transition to general population or a step-down unit.
3. The Mental Health Director and IHSC must ensure that ACF mental Health staff conduct daily face to face round with all detainees in the SMU and provide appropriate mental health assessment and treatment. (PBNDS 2011, SMU)
   STATUS: **Partially corrected previous recommendation** - Daily rounds are being conducted; however, one of the rooms in the SMU should be converted into an

interview room where private interviews between mental health personnel and detainees can be effectively conducted.

4. ICE must audit all detainees held in the SMU over 30 days for protective housing reasons and determine if transfer to another facility is more appropriate. (PBNDS 2011, SMU)
   STATUS: **Partially corrected previous recommendation** - SMU audits are being conducted every 30 days; however, 40% (20) of detainees continue to be housed over 30 days in the SMU. ICE must work with GEO to create a housing alternative for non-disciplinary placements in the SMU for over 30 days.
5. ERO must conduct an external audit of all detainees held in Administrative and Disciplinary Segregation over 30 days to determine if transfer to another facility could improve treatment or resolve use of the SMU for special housing. (PBNDS 2011, SMU)
   STATUS: **Not corrected previous recommendation**
6. ERO and ACF must develop and implement an efficient population count process that comports with the 2011 PBNDS to eliminate the problematic delays that six daily counts cause in the delivery of meals, visitation (legal and regular), recreation, law library access, and detainee medical appointments. (PBNDS 2011, Population Counts)
   STATUS: **Partially corrected previous recommendation** - ACF continues to conduct six daily population counts when the Chief of Security previously did not have a concern with reducing the number of daily counts to five which would improve detainee access to programs and services.
7. ICE/ACF Management (including the Warden), must develop a reporting system to ensure that facility personnel effectively respond to and resolve the detainee grievance issues assigned to them by the Grievance Coordinator. (PBNDS 2011, Grievance System)
   STATUS: **Not corrected previous recommendation** - Responses to grievances continue to be ineffective in addressing detainee concerns.
8. ICE/ACF Management must develop a review and trend tracking system for all grievances reporting staff mistreatment. (PBNDS 2011, Grievance System)
   STATUS: **Not corrected previous recommendation** - Detainee grievances about facility staff mistreatment are currently not submitted to ICE as mandated by PBNDS 2011. ICE should receive a copy of all staff-related grievances upon their receipt by the GEO Grievance Coordinator.
   c. All staff grievances should be tracked by date, time, location, issue and identify of the involved staff.
   d. GEO's onsite leadership should analyze the report of grievances against staff on a weekly basis to look for trends and detainee reports of mistreatment involving the same staff member.
9. ACF Warden must hold facility staff accountable for substantiated abusive and disrespectful treatment of the detainees, as determined by the Grievance Coordinator and or other facility personnel. (PBNDS 2011, Grievance System)
   STATUS: **Not corrected previous recommendation**
10. ICE AND ACF leadership must develop a post-assignment schedule that creates a staffing plan which resolves the current staffing deficiencies that are impacting operational inefficiencies, such as excessive count times, meal delays, and limited visitation, legal access and recreation time allotments. (PBNDS 2011, Facility Security and Control)

STATUS: **Partially corrected previous recommendation** - The post assignment schedule has been revised and additional correctional officer positions have been added however, the correctional officer medical escort and transportation staffing should be increased to adequately support the medical and mental health escort needs within the facility and to outside appointments and care.

11. ACF should grant the female Law Librarian's transfer and hire a Spanish speaking Librarian. (PBNDS 2011, Law Library and Legal Material)
    STATUS: **Not corrected previous recommendation** - The female law librarian retired and created a law librarian vacancy. GEO did not hire a Spanish speaking law librarian which continues to create legal access difficulties.
12. ACF must institute a computer training class, demonstrating use of the Lexis-Nexis software and computers, and create a detainee worker position in each housing unit in order to assist detainees with utilizing the computer system. (PBNDS 2011, Law Library and Legal Material)
    STATUS: **Not corrected previous recommendation** - LEP detainees continue to have difficulties using the Lexis-Nexis computers and preparing legal related forms that are only available in English.
13. ACF must develop a Language Line logging system and require all facility staff to record its use; by date and A#. (DHS Access Plan 2012) (PBNDS 2011, Multiple)
    STATUS: **Partially corrected previous recommendation** - The Language Line logs exist at various locations within the facilities, but non-medical staff do not consistently use the language line.
14. ICE/ADF must ensure all forms issued to detainees for informational purposes and/or for detainee signatures must be written and/or translated in a language the detainee comprehends. All written material provided to detainees shall generally be translated into Spanish to comply with the Detention Standards. (DHS Language Access Plan 2012) (PBNDS, Multiple)
    STATUS: **Not corrected previous recommendation**

New Recommendations

Below are recommendations for new deficiencies I found during the December 2017 onsite Investigation. These recommendations are based on the 2011 PBNDS.

1. ACF's healthcare grievance process (medical, mental health and dental) is currently unreliable. The ACF Medical Unit should establish a staff position that is responsible for timely review and response to medical grievances, and ensure the appropriate follow-up actions are taken to prevent further detainee injury or death. (PBNDS, Grievance System) - **New Recommendation**
2. A separate healthcare medical grievance log should be instituted to track healthcare-related grievance submittals and timely responses. (PBNDS, Grievance System) - **New Recommendation**
3. A monthly audit should be conducted of the submitted healthcare grievances to improve timeliness of care and ensure appropriate access to medical, mental health and dental care. (PBNDS, Grievance System) - **New Recommendation**

4. ACF must provide access to a cold-water shower in the East and West Facilities for use to decontaminate detainees who have been exposed to OC Pepper Spray. (PBNDS 2011, Use of Force) - **New Recommendation**

CRCL ADELANTO DETENTION FACILITY INVESTIGATION

APPENDIX A

Detainee Name and A Numbers

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

On-site Investigation Report – Adelanto, December 2017

(b)(6)

December 12, 2017

Introduction

This report responds to a request by the Office for Civil Rights and Civil Liberties (CRCL) to review and comment on the medical care provided to detainees at the Adelanto Correctional Facility (Adelanto or ACF) by the contractor GEO, under the authority of U.S. Immigration and Customs Enforcement (ICE). My opinions are based on the materials provided and reviewed and an on-site investigation of the facility on November 13th and 14th, 2017. I had previously visited the facility on December 9th-11th, 2015. My opinions are expressed to a reasonable degree of medical certainty. ICE, ICE Health Service Corps (IHSC), Correct Care Solutions (CCS) and GEO personnel were most pleasant and cooperative during my investigation.

Overview of Findings

Overall, the medical care at the Adelanto facility is inadequate and does not meet the 2011 Performance Based National Detention Standards (PBNDS) standards[1]. Since my last investigation, important improvements have been made. For example, the facility now uses an electronic health record (EHR), as was recommended subsequent to the 2015 onsite investigation. Problems previously cited with the medical management of hunger strikes has been successfully remediated. And, the facility has now developed a quality assurance program and is making an effort to identify and remediate problem areas. However, major problems remain. While problems were previously and currently identified in a number of areas, almost all of those problems continue to be linked to one fundamental problem: incompetent clinical medical leadership; a problem cited in my previous on-site investigation report. The consequence of incompetent medical leadership is a medical program where care is uneven, uncoordinated, lacking in continuity, and lacking in provision. Even with the successful deployment of an electronic health record, medical documentation remains incomplete. Medical care moves forward slowly and inefficiently and things fall through the cracks. There are significant delays and denials of care for medical conditions, including serious medical conditions.

Specific Findings

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

1. ***Complaints*** – The Office for Civil Rights and Civil Liberties received a high number of complaints about medical care prior to our on-site investigation, including six cases cited in the Retention Memo (see cases 1-6 in Appendix II) that was sent to ICE Headquarters, and a number of complaints identified during the on-site investigation.

   Cases cited in the Retention Memo:

   a. Complaint No. 16-06-ICE-0627 (Case 1 in Appendix II) involves a detainee death. The complaint of inadequate care is **substantiated**. This case will be discussed in greater detail in item 2.
   b. Complaint No. 17-09-ICE-0356 (case 2) also involved a detainee death. As that death is currently under investigation by another office in DHS, my access to records on that case was denied. **Unable to review.**
   c. Complaint No. 17-03-ICE-0103 (case 3) alleged inadequate care for a knee injury. This complaint is **substantiated.**
   d. Complaint No. 17-07-ICE-0456 (case 4) alleged inadequate care for ear pain. This complaint is **not substantiated.**
   e. Complaint No. 17-09-ICE-0366 (case 5) alleged inadequate medical care after a use of force incident. This complaint is **substantiated.**
   f. Complaint No. 17-09-ICE-0366 (case 6) alleged inadequate medical care after a use of force incident and during a hunger strike. This complaint is **partially substantiated.**

   Cases identified osite in facility grievance logs (sample cases)

   g. Case 7 (see Appendix II) alleged inadequate and delayed access to care for a wrist fracture resulting in mal-union (improper healing resulting in deformity) of a wrist fracture. This grievance matter is **substantiated.**
   h. Case 8 alleged inadequate and delayed access to care for a complicated ankle injury with possible joint and bone infection. This grievance matter is **substantiated.**

2. ***Detainee Death*** - I have previously conducted a records review of this death and I have reviewed the ICE Office of Detention Oversight (ODO) Detainee Death Review (DDR). The ODO DDR found numerous inadequacies in the medical care provided in this case. Among my findings were three inadequacies that were likely related, in my opinion, to the fatal outcome. These include a) the failure of the nurse to respond appropriately or evaluate the detainee when he was in acute distress, b) multiple additional delays in getting access to needed care for the detainee after the illness had been recognized by staff, and, c) a failure of medical staff to manually obtain vital signs during the emergency medical evaluation.

3. ***Lack of Medical Leadership*** – In order to be compliant with the 2011 PBNDS, a medical program must have a leadership structure, including a Clinical Medical

Authority (CMA, usually a physician), and a Health Services Administrator (HSA). This "designation of authority" is critical for the organized and appropriate provision of medical services, and the final measure of the adequacy of the leadership is found in the care that is ultimately delivered. In my previous report, I cited this as a problem area and reported inadequate supervision and care as significant consequences. Although ACF made one effort by changing the medical contractor, that new contractor left the same incompetent leadership in place. Again, I found that poor clinical leadership has continued to result in inadequate medical care for the ACF detainees.

4. ***Grievances*** – Adelanto does have a grievance process and that process includes complaints or grievances on medical care. In the previous 2015 investigation, there were more than 200 grievances about medical care. In 2017, the number has actually increased. Most of those complaints continue to involve delays or denials of care. The *majority* of the complaints about delays or denials of care *were substantiated*. In spite of both a grievance and quality assurance program, there is no evidence that either the high number of grievances or the high number of substantiated grievance complaints led to any effective remediation of the root causes that lead to delayed or denied care.

5. ***Medical Records*** –Adelanto has successfully deployed an electronic health record (EHR). This represents a significant improvement over the paper record used in the past. However, problems relating to medical documentation persist. For example, many documents are scanned into the medical record, often without being reviewed and signed off by the physician (which is required) and very frequently with no notation of the scanned documents content being reflected in the progress notes written by the providers. This results in key medical information being ignored and important medical consultant recommendations being ignored and contributes to the inadequate care and delayed care observed at the facility. Also, even though the EHR has a module for inputting an electronic medical administration record (MAR), which ensures detainees receive their prescribed medications or alerts the clinicians when medications are missed, the lack of a wireless network in the facility prevents nurses from actually using this module. As a result, paper MARs are used and then scanned later into the EHR. This insufficient process deprives clinicians of up to date information regarding when medications have been given, how medications have been given, and if/when they have been refused or missed.

6. ***Access to Care*** – My review of medical records and interviews with detainees supported the allegations that access to medical care was slow and, in some cases, never happened. For example, I found that treatment for fractures is not undertaken with appropriate urgency at ACF. In a number of cases, injured detainees with documented fractures had to wait for initial evaluation, emergency medical consultation (if it happened at all), and definitive orthopedic care. Providers often failed to note or act on significant findings or recommendations made by outside medical specialists. The facility also continues to experience

long delays for access to care for both acute and chronic medical conditions. Discussions with the HSA identified contributing factors as inadequate provider staffing, and inadequate custodial (security) support of the medical operation.

a. *Medical Provider Staffing:* The wait time to see a provider for both acute illness/injury and chronic care needs are often excessively long, and this appears to be due in part to the inadequate staffing of providers (both physician and nurse practitioner). In addition to long waits for appointments to see providers, the providers are not adequately reviewing and following up on the recommendations made by outside medical specialist (including ER and hospital specialists) upon the detainee/patient's return to ACF. For example, a detainee who underwent surgery to remove her gallbladder received no post-operative visit. Another patient who saw a urologist for an infection did not receive the antibiotics that were recommended. Yet, another patient saw a cardiologist who made recommended medication changes that were ignored by the ACF physician, yet no comments or reasons were recorded in the detainee's medical record.

b. *Custodial Staffing in Support of Medical Operations*: A quality improvement investigation by the medical unit identified that 60-80 clinic appointments in the facility were *cancelled* due to the unavailability of a runner, and outside appointments were often cancelled due to lack of transportation staff and/or transport vehicles.

Summary of Key Findings

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

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

2. There is inadequate *medical provider staffing* (physicians and mid-levels). Facility performance **DOES NOT meet the 2011 PBNDS** (II.21).

3. There is inadequate *custody staffing to support the medical operation*. Facility performance **DOES NOT meet the 2011 PBNDS** (V.B)

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

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

Discussion

At the time of our on-site investigation, the medical care at Adelanto was seriously deficient and did not meet the 2011 PBNDS. Significant deficiencies cited in a previous CRCL investigation remained unaddressed.

I have made the following recommendations for implementation of a Corrective Action Plan. If the facility cannot correct these deficiencies within the timeline proposed, I would recommend that ICE pull detainees from this facility until the medical care can be brought into alignment with the PBNDS and acceptable standards of medical care.

Initial recommendations for corrective action were provided to ICE on November 17, 2017, immediately following the on-site.

1**. Medical Leadership**: In 2015, CRCL clearly warned Adelanto that clinical leadership was not competent and that negligent medical care was occurring as a result. In 2017 – two years later – no correction was made to address this critical failure. It is more likely than not that the failure to hire an effective, qualified clinical leader led to the inadequate detainee medical care that contributed to medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees at ACF. Competent, qualified and effective clinical leadership is urgently required.

New leadership cannot be recruited immediately – it will take some time to put new leadership in place. For that reason, until competent, qualified and effective clinical leadership can be put in place at the facility, the following measures must occur to ensure the safety of detainees in custody at ACF:

At-risk detainees must be immediately removed from the facility (transferred to another facility with a well-functioning medical program). Detainees at-risk include those with chronic diseases (such as cardiac, diabetes, HIV and other chronic infectious conditions), detainees with disabilities, anyone requiring outside medical specialist care, all detainees over the age of 55 and anyone else deemed to be medically vulnerable due to any other condition.

CCS, the medical contractor, in consultation with IHSC, must increase day-to-day medical care for those detainees who remain at the facility. Attention should be focused on the following serious areas:

2. **Provider Staffing**: The durrent inadequate provider staffing levels and appointment scheduling must be corrected in order to reduce the high rate of appointment cancellations and the chronic problem of delayed access to care. To assist with this corrective action, providers must not be allowed to fully control and change their own appointment schedules. Also, all detainee appointment cancellations must be monitored

and tracked, and rescheduling the detainee for the next and first available provider must be a priority.

The current inadequate "hand-off" procedures for those detainees returning from an outside hospital, emergency room or medical specialty consultation must be greatly improved. Going forward, all recommendations by outside medical consultants and providers should be reviewed immediately by both a nurse and a provider (physician or mid-level practitioner) upon the detainees return to the facility. All returning detainees should be seen and examined by a facility practitioner as soon as possible within 24 hours of return in order to review the ongoing plan of care with the detainee, supported by a full medical note and orders being placed in the medical record as required, and prescriptions that are immediately filled and dispensed as directed and required. If practitioners are off-site (after hours) when the detainee is returned to the facility, the on-call provider should be contacted, the recommendations and directions from the outside medical provider must be relayed to the on-call provider for orders and disposition, and the involved detainee must be the first detainee seen by the facility provider the next day. In all cases where the ACF provider choses to deviate from the care recommended by the outside specialist, a full and complete note must be immediately entered in the medical record documenting the clinical rational for deviating from the recommended care.

Those providers whose medical care has been sub-standard and must be closely monitored and supervised. Probation or temporary limitations of privileges must be considered for those problematic providers, in order to ensure improvements.

3. **Custody Staffing and Support for Medical:** Custody staffing and transportation capacity must be increased to adequately support the medical operation. No medical appointment – either within the facility or outside (such as a consultation with an off-site specialist) – should ever be canceled due to unavailability of medical duty officers or "runners," or for lack of transportation vehicles (including transport by wheel chairs or gurneys). Staffing and transportation must be increased to ensure uninterrupted access to appropriate and needed medical care.

4. **Timely Access to Care:** The above issues must be addressed in order to provide timely access to adequate medical care at ACF. During the corrective plan's deployment, routine assessment of care in terms of timeliness and adequacy will be essential.

Sincerely,

(b)(6)

Appendix I

Expert Qualifications and Methods

Expert Qualifications

1. I am a physician licensed in the state of California. I am board certified in Internal Medicine and am a Fellow of the American College of Physicians.

2. I am a Professor of Medicine and Associate Dean of Academic Affairs at the University of California Riverside School of Medicine.

3. I have been a physician since 1991. I have worked in the field of correctional health care for the past 18 years. From 1997 to 2004, I was a full time correctional physician for the Rhode Island Department of Corrections; for the final three years I served as the State Medical Program Director for the department where I oversaw all medical care for the State of Rhode Island prisons and jails for both men and women, including medical, psychiatric and dental services. From 2005 to 2011, I worked full time in the Eleanor Slater Hospital, the state psychiatric hospital, on secured units caring for patients that included both sentenced and forensic populations. I am a member of the American Academy of Correctional Physicians.

4. I have written and published over twenty peer-reviewed papers in academic journals related to prison health care and am an Associate Editor of the International Journal of Prisoner Health Care. I currently serve as the Court Appointed Monitor for the Consent Decree in litigation involving medical care at Riverside County Jails. I have served as an independent expert to the Federal Court on standards of hepatitis C management in prisons, and have served as a plaintiff's expert in a number correctional health cases. I have consulted on detention health issues both domestically and internationally for the Open Society Institute and the International Committee of the Red Cross among others. I have worked with the Institute of Medicine on several workshops related to detainee healthcare. I co-founded and am co-director of the Center for Prisoner Health and Human Rights at Brown University and am a Co-Investigator of the University of California Criminal Justice and Health Consortium.

5. A more detailed listing of my experience in correctional health care, my participation in the development of national correctional policy and standards, my experiences as a consultant and expert witness, and a list of my publications are included in my curriculum vitae, which is attached.

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

Methods of Review

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

Appendix II

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

Identity of Cases Cited in this Report

My Case No.	A #	Name	ICE Complaint #
1.		(b)(6)	16-06-ICE-0627
2.			17-09-ICE-0356
3.			17-03-ICE-0103
4.			17-07-ICE-0456
5.			17-09-ICE-0366
6.			17-09-ICE-0366
7.			
8.			
9.			

On-Site Investigation Report – Adelanto Correctional Facility, November 2017

(b)(6)

December 18, 2017

Introduction

This report responds to a request by the Office for Civil Rights and Civil Liberties (CRCL) to review and comment on the mental health care provided to detainees at the Adelanto Correctional Facility (ACF) by the contractors GEO and Correct Care Solutions (CCS) under the authority of U.S. Immigration and Customs Enforcement (ICE). My opinions are based on the materials provided and reviewed and an on-site investigation of the facility on November 13-14, 2017. My opinions are expressed to a reasonable degree of medical certainty. ICE, GEO and Correct Care Solutions personnel were helpful and welcoming throughout the investigation.

Overview of Findings

Overall, the mental health care at the Adelanto facility for those with serious mental illnesses needs significant improvement in the area of Mental Health Care and currently does not fully meet the 2011 Performance Base National Detention Standards (PBNDS). In December of 2015, CRCL with a team of subject matter experts, visited ACF. At that time, the over-arching and most significant issue was the absence of appropriate medical and mental health leadership. The same is true two years later. At Adelanto, psychiatric leadership continues to be absent and sub-standard mental health care is occurring as a result. With the exception of an electronic medical record (which needs significant improvements described herein), and more out-of-cell time for detainees in administrative segregation (many of whom remain inappropriately housed), no other major or recommended changes have been effectuated since 2015. As was true in 2015, detainees with serious mental disorders are suffering the most as they are sometimes inappropriately diagnosed, often inappropriately housed and often inappropriately medicated, or not medicated at all. Without psychiatric leadership to provide ongoing supervision of cases of detainees with serious mental disorders and implement changes within the facility to create appropriate care and housing, little has changed. There continues to be an overall lack of knowledge of the histories of those detainees with serious mental disorders. Even though the collection of collateral information is fundamental to the mental health treatment of persons with serious mental disorders, there was no evidence that staff attempted to obtain collateral historical information. Persons with serious mental disorders are still present at ACF, and in alarming high numbers in the segregation unit, obviating the need for specific mental health housing, which was also recommended during the 2015 onsite. Due to the lack of diagnostic understanding and detainee history, some patients were receiving substandard and inappropriate care. There is also poor continuity of care when detainees have to be transported outside of the facility for acute care. On the men's side (West) of ACF, mental health evaluation appointments continue to be hindered because the corrections officers are required to escort the

detainee to their clinic appointment, though in 2015 an office was recommended for the mental health staff on the men's side, mental health staff continue to be hindered by lack of private space in which to evaluate detainees close to their dorms. Improving technology, including installing facility-wide wireless, allowing mental health staff to use laptops connected to an intranet, is necessary for patient safety. The clearest example of this need is demonstrated by the lack of an electronic medication administration record (MAR). An electronic MAR is not being used at ACF because nurses administering medication directly to patients in their dorms are unable to use laptops to enter the data because the facility lacks wireless. As a result, not only are medication errors occurring, but there is a lack of medication adherence data being tracked. These are urgent patient safety issues that the facility must address immediately. Finally, staff report consistent confusion about the location of their patients because the electronic medical record system does not provide patient location and most staff do not have another reliable manner of determining the location of their patients. This results in delayed care and is also a patient safety issue that must be addressed immediately. Finally, with a thoughtful and qualified leader who is involved on-site, the above recommendations, most of which were made two years ago, could be addressed. Though a psychologist was put in place to supervise the mental health team, much of the needed leadership and decision-making is psychiatric. Furthermore, even if a psychiatrist is found, no mental health professional can effectively lead if not given the ability and authority to change fundamental aspects of how and where persons with serious mental disorders are pharmacologically treated and housed. Therefore, an effective leader must be a psychiatrist with authority to make needed changes.

Specific Findings

1. ***Mental Health Leadership*** – After our 2015 on-site, a psychologist was put into place as the mental health leader at ACF (Dr. [redacted]). Though he has successfully increased the frequency with which psychologists see detainees with serious mental disorders in segregation, he has not been given the authority or ability to fundamentally change how detainees with serious mental disorders are housed within the facility, how histories are taken and how collateral information is collected, how safe patient handoffs are made, or how medication is being prescribed and how those orders are executed, operationalized and tracked. Though Dr. [redacted] is working hard and at the top of his license, the critical areas needing improvement require a psychiatrist leader, and a psychologist leader is helpful for supervision and coordination of staff, but ultimately insufficient given the particular inadequacies of the mental health care at ACF (many of which are medical in nature and require a medical doctor, i.e. a psychiatrist to solve). Some systems resolve this by having a medical director (psychiatrist) and an assistant clinical director (a psychologist), for example. Though there is a psychiatrist within the corporate structure of CCS, ACF mental health staff reported that they have little to no contact with him. Even the staff psychiatrist with whom I spoke (Dr. [redacted]) reported that he essentially has no psychiatric clinical leader present on the ground in the facility or even any presence over the phone or email. It is more likely than not that the failure to hire an effective, qualified psychiatric leader led to at least one detainee death, and continues to pose a risk to the safety of other detainees. Competent, qualified and effective on-site psychiatric mental health leadership is urgently required and the lack of it is a violation of the 2011 PBNDS.

2. ***Inappropriate Segregation of Detainees with Serious Mental Disorders*** – There continues to be large number of detainees with serious mental disorders being housed in Administrative Segregation, obviating Adelanto's need for a dedicated and appropriate mental health housing unit. Additionally, detainees with serious mental disorders are being housed in disciplinary segregation For instance, in one case (Case 1), the detainee remained in segregation continuously for 212 days with the reason for his placement documented by ACF staff as "self PC," meaning that, somehow, staff had allowed this detainee to choose to continue his own's segregation, which is a very confusing and inappropriate practice. Cumulative segregation days, when multiple segregation stays occur, were also shockingly high. In one case (Case 2), detainee had been in segregation for a total of 904 days. Clinical staff did not consider themselves as responsible for the segregation and/or ongoing segregation of their patients. For example, Dr. [redacted] stated, "We don't segregate people, it's done by custody." There appeared to be neither authority nor interest on the part of the clinical staff to ensure their patients were not inappropriately segregated. In some cases, detainees reported that they wanted to be segregated for their LGBT status (Case 4) and in at least one instance this was recorded on a facility tracking sheet as the reason (Case 5). The physical set-up in disciplinary segregation is different and much less safe than administrative segregation. Disciplinary segregation cells havedouble bunks with places for tie-off's where detainees can successfully hang themselves. At the time of our on-site, 26 of the 50 detainees in segregation had serious mental disorders (such as Schizophrenia or other primary psychotic disorders). Staff reported that 60% to 70% of detainees in administrative segregation had serious mental disorders. Staff also reported that they preferred certain detainees with serious mental disorders to be housed in administrative segregation, stating it is "the best option" available for some of them because of the absence of other options for appropriate mental health housing; even for those who are stable.. Staff also explained that segregation is used at ACF because there is no other housing location within the facility that allows for close observation of detainees with serious mental disorders, which is both inhumane and in violation of ICE Directive 11065.1, Review of the Use of Segregation for ICE Detainees (Segregation Directive) and PBNDS 2011 revisions to Standard 2.12 "Special Management Units," which has been revised to incorporate requirements from the Segregation Directive.

3. ***Inadequate "Hand-off's" of Detainees Returning from Outside Hospitals*** – Hand-off's occur when a patient's care transitions from one provider to another. This discontinuity creates opportunities for error when clinical information is not accurately transferred between providers. Ineffective hand-off communication presents a critical threat to patient safety. An estimated 80% of serious medical errors involve miscommunication during hand-offs and transfers.[1] For persons requiring acute stabilization in hospital psychiatric units, communication was profoundly lacking between ACF and the outside hospitals (API, Anaheim Global, White Memorial and Arrowhead). In fact, the staff I interviewed stated that most frequently acute psychiatric patients are taken to API, yet not one staff member had ever spoken to or communicated directly with the attending psychiatrist at API (Dr. [redacted]). I found no evidence that recommendations by

[1] Joint Commission Center for Transforming Healthcare. Handoffs communication. http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1.

outside hospitals were reviewed immediately upon a patient's return or that those recommendations were considered and/or put into action at ACF. For example, an ACF clinician receiving patients who had just been hospitalized for suicidal behavior, had no documentation of the patient's diagnosis from the outside facility, nor were the outside facility's medication recommendations effectuated at ACF, nor was any reasoning recorded in the medical chart as to why those recommendations were ignored. In fact, most often I found no references at all in the psychologist's or psychiatrist's progress notes that their patient had even been recently hospitalized. At ACF, there is daily documentation entitled "Hospital Admission and Follow-up" for outside facilities which nurses do daily. This document, however, appeared to be primarily an exercise in finding out when the detainee would return to the facility, rather than a communication tool for care coordination. In other words, it is important to know when the detainee will return to the facility, but it is critical to know what kind of treatment took place at the acute care facility and what the treatment recommendations are of the acute care facility. Just knowing when a detainee will return to ACF is not enough. ACF providers should learn from the progress, or lack of progress of a patient and consider or enact recommendations of hospital staff to ensure the ongoing safety and stabilization of the patient once returned to the facility.

4. ***Obtaining Adequate Patient History and Collateral Information*** - There was zero improvement in this area from what was found and recommended in 2015. In fact, it appears that the 2015 mental health recommendations in this area were totally ignored. I was unable to find a single instance of collateral information being collected for any detainee in ACF. Furthermore, initial mental health evaluations, which are a fundamental tool in the initiation of mental health care, continue to be poor, without mention or documentation of any patient history from the detainee's previous facility, let alone any collected from the detainees'previous care providers or family members. As I wrote in my 2015 report, an essential cornerstone of psychiatric care for detainees with serious mental disorders includes obtaining what is frequently referred to as "collateral information."[2] This term refers to a patient's historic mental health and/or medical information, typically that the patient himself or herself would or could not provide secondary to having a serious mental disorder and a lack of insight and/or judgment. Obtaining collateral information is considered a standard of care in the U.S. for all mental health professionals treating persons with serious mental disorders. Collateral information can be obtained in the form of medical records, phone calls with former treatment providers, or family members. Collateral information is critical to building an accurate diagnosis and treatment plan. Similar to my observations in 2015, in 2017 when I met with and reviewed the charts of detainees with mental disorders, I observed several cases where diagnoses and treatment plans were inaccurate, which could have been avoided by obtaining a collateral history. Overall, the pervasive lack of collateral information continues to result in in persons with serious mental disorders receiving incorrect diagnoses, suboptimal care and, inappropriate or no psychotropic (and specifically, antipsychotic) medication.

[2] American Psychiatric Association Practice Guideline for the Psychiatric Evaluation of Adults, Second Edition, 2006. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/psychevaladults.pdf

5. ***Inadequate Psychiatric Care (Including Problematic Patient Visits and Lack of Mental Health Treatment with Long-Acting Injections)*** – ACF currently has two psychiatrists, one which practices solely via tele-psychiatry, and the other which practices in-person at the facility. I found that little thought (or leadership direction) was given to determining which detainee-patients were appropriate for tele-psychiatry and which detainee-patients required in-person care. For example, detainees in the "outpatient" areas who are more stable and can be transported easily to clinic are those who should be receiving tele-psychiatry, though at ACF, the tele-psychiatrist would "see" detainees in segregation, which would require that detainee to be stable enough to be transported to clinic in order to present themselves in front of the tele-psychiatry camera. One such example was a detainee-patient in segregation with ongoing instability who at the time of our visit was not prescribed ***any*** standing antipsychotic medication despite his decompensation and diagnosis of schizophrenia (Case 3). While the in-person psychiatrist did see many of the detainees in segregation, I was informed by all of the detainees who I saw in segregation that the psychiatrist never opened their door, never went inside their cell, and/or never pulled them out to speak with them individually, regardless of their level of stability. This is an inappropriate standard of care for the practice of psychiatry in ***any*** setting, let alone in a correctional setting. As I wrote in 2015, in large part due to the lack of collateral information as described above, I observed that detainees were receiving treatment with psychotropic medications that were often suboptimal. When treatment with psychotropic medication is suboptimal, the detainees remained needlessly unstable, were more likely to be housed in segregation, and were more likely in need of acute hospitalization. During this recent onsite, I also continued to observe documentation of medication "refusals," yet there was little evidence that psychiatric staff had worked to build rapport with detainees, and use all the tools available to them in order to gain the detainees' medication adherence. Though the ICE Health Service Corps National Formulary includes several atypical and typical antipsychotic medications, these medications were often not prescribed in appropriate or robust dosing. Furthermore, long-acting antipsychotics (LAI's) are still not being used at Adelanto, though they are also on the formulary (28:16.0 8.08 haloperidol decanoate and 28:16.0 8.24 fluphenazine decanoate and others may be obtained through TAR's), even though they represent a cornerstone of mental health care at most correctional facilities nationally. Use of long-acting antipsychotics increases the likelihood of detainee-patient stability, decreases safety concerns for the detainee and staff, and lessens the need for acute care. In the case of Adelanto, their use would decrease Adelanto's reliance on segregation housing of the seriously mentally disordered detainee population. Training for psychiatrists in the use of decanoate medications and training for nursing staff in administering these injections would bring Adelanto's mental health care program into the current standard of care for treating persons with serious mental disorders.

6. ***Need for an Electronic Medication Administration Record (MAR)*** - Currently, there is a lack of ability to see what medications any patient is currently taking, electronically. Though ECW (ACF's electronic medical record) has the capacity for an electronic MAR to be used at ACF, security issues were cited as a reason not to provide wireless throughout the facility, which prevents the nurses from documenting on laptops, in-the-moment, when patients actually take their medications (which is the standard in most correctional settings). Not only is this critical for psychiatric patients who decompensate

quickly when not taking their medications, but no doing so often leads to poor outcomes. The lack of one master electronic MAR has resulted in there being three different sources for recording current medications and current medication adherence: 1) ECW current meds, 2) Paper MARs located in the pharmacy and 3) Clinical progress notes. I found that these three sources often contradicted one another, which is both dangerous and can easily lead to poor patient outcomes. Most clinical staff agreed that the paper MAR was the best source of current information, but when clinical staff must go to great lengths (i.e. physically visit the pharmacy to pull paper MAR's) and spend time comparing data to see if there are errors in medications or poor adherence, patient safety is continually at risk. Facilities that are much larger than ACF with areas of high security, all have wireless systems within their facilities in place. It is therefore unclear why ACF is unable to keep up with this technological standard that other facilities maintain.

7. ***Need for Detainee/Patient Location Information Within the EMR*** - Currently, the ACF clinical staff are unable to see where their detainee-patients are located using the ECW, and not all clinical staff have access to GEO's location tracking system. When clinical staff do not know where their patients are located, they sometimes will not be seen, and they may also be mistakenly noted as being hospitalized offsite when they have actually just returned from the hgospital to ACF, which is a vulnerable time for patients. It is also a time when the detainee should be seen immediately and more frequently. ACF's clinical team must know where their detainee-patients are located to ensure patient safety. This is technically possible for GEO to connect location information to the ECW to populate these data, but it has not been made a priority.

8. ***Access to Care*** - There are two major barriers to appropriate access to care for detainees with serious mental disorders at ACF. One barrier is physical space. Though it was recommended in 2015, there continues to be no physical space for clinicians to see detainees on the men's side (West). Therefore, clinical staff must rely on officers to bring those detainee-patients to clinic, and when there is a shortage of officers or when mentally ill patients are reluctant to leave their housing area, patient care is greatly and negatively affected. Again because of thelack of wireless in the facility, the clinicians are unable to bring a laptop with them while they see patients. It is difficult to make appropriate clinical decisions when the clinician is unable to see, in-the-moment, what medications a patient is taking, the content of the clinician's previous notes on the detainee-patient, or any historical information. Standards of care in most correctional facilities involve clinicians with individual laptops moving throughout the facility,and accessing the electronic chart via secured wireless. Yet we were informed by ACF staff that 60 to 80 visits per week were canceled due to the lack of of transporting officer' availability. If clinicians were allowed to access the electronic chart via laptops they carry with them during rounds and provide informed care where their patients are located, access to care for detainees at ACF would greatly improve.

9. **Detainee Interviews** - I conducted 11 individual interviews with detainees (nine men and two women). As in 2015, the overall theme that resulted from the detainee interviews was that adequate mental health histories were not obtained and, therefore, diagnoses were not made or were incorrect, and psychiatric treatment plans were either lacking or incorrect. This resulted in the detainee receiving inappropriate psychotropic medication, or no

medication, which caused further mental decompensation, or destabilization and, in some cases, resulted in the need for housing in segregation.

In one exemplary case (Case 7), a detainee, despite a cumulative 269 days in segregation, continued to have the provisional diagnosis of "Unspecified Psychosis" and was prescribed no medication. Nowhere in his chart was there any evidence that collateral history was asked of him or collected from other sources. However, during my interview with him, he immediately told me that he was classified as "EOP" in the CDCR system; a clear signal that he has a serious mental disorder requiring robust psychiatric care. CDCR refers to those detainees classified as "lower functioning…due to an acute onset or significant deterioration of a serious mental disorder characterized by a definitive impairment of reality testing and/or judgement which creates dysfunctional or disruptive social interaction or severe impairment of activities of daily living."[3] It appears that clinical staff at ACF are not trained to ask these simple historical questions that are critical to patient care. Further, it was not possible to ascertain what type of history was obtained on this patient, if at all, as there was no initial mental health evaluation present anywhere in hischart. Moreover, I was unable to find any recent visit with the psychiatrist for this detainee, though historical facility notes demonstrated a history of him being described as "acting strange in dormitory" and placement in the infirmary under psychological observation.

In another case (Case 8), though the detainee had 87 cumulative days in segregation and had been back and forth to API (psychiatric inpatient unit at an outside hospital), he was being seen only off-and-on by the Tele psychiatrist. Furthermore, during his last visit to API, he was placed on a long-acting antipsychotic injection there (Haldol decanoate), yet because of what appears to be both poor follow-up and a lack of continuity of care, this medication was discontinued at ACF. A 8/8/2017 note from Dr. [redacted] shows the injection is ordered and to be given, but the detainee subsequently saw the Tele psychiatrist and the injection was not continued and not given. No orders for the injection were ever carried out and there was no documentation or notes written by either psychiatrist as to the reasoning behind it's discontinuation. In my interview with him, it was immediately clear that he had a serious mental disorder and needed robust psychiatric care. He also immediately told me about his history at the Los Angeles Twin Towers Correctional Facility, however nothing regarding his history was documented in his chart.

In another case of a male detainee who had spent 68 cumulative days in segregation (Case 9), my examination of him showed acute psychosis and thought disorganization. He easily reported a profound mental health history to me, including multiple stays at Patton State Hospital (in Patton, California) and Central Regional Hospital (in Butner, North Carolina). Furthermore, he reported that he had received long-acting psychotic injections in the past during his treatment at these State Hospitals. Despite this history, he was on no standing antipsychotic medication at ACF, and he was suffering as a result. His tactile hallucinations led to delusions that persons were touching him inappropriately, which led to y rape allegations and investigations within the facility that were

[3] Report on Department of Corrections, California State Auditor, Bureau of State Audits: https://www.bsa.ca.gov/pdfs/reports/2001-104.pdf

unnecessary. The paper MAR revealed that antipsychotic medication was prescribed as "PRN" meaning that it would only be given if the patient asked for it. Of note, the dose of this medication (Seroquel 400 mg) is dangerous when given all at once to a person who does not have tolerance for this particular medication. For example, a person not taking Seroquel for several days, then quickly resuming Seroquel at a 400 mg dose would likely experience hypotension and be at risk for falls and head injuries. This is typically a medication which must be carefully tapered up in increments over days to safely reach a 400mg dose and giving a 400mg dose to a person all at once who has not consistently been on this dose is totally inappropriate and dangerous as a PRN medication. This particular detainee, like all the others that I interviewed in segregation, stated that when he does see the in-person psychiatrist, the psychiatrist simply stands at his door andspeaks to him through the door, and never sits down with him or enters his cell for any meaningful interaction.

In another case of a detainee who had been in segregation for 288 cumulative days (Case 10), the reason cited in the facility segregation tracking sheet was again "self PC." Though this detainee was very stable upon examination, he continued to remain in segregation because it was what the detainee himself wanted, not due to a compelling clinical reason. He was also a detainee in segregation that was being seen via Tele psychiatry. Upon entering his cell, I also observed that he had a large blister pack of ibuprofen with his belongings; an unusual occurrence for a detainee at this level of observation. Typically, in segregation persons are not permitted to have anything that they could use to harm themselves (including large amounts of pills). Those pills could have also been shared by the detainee with peers during out-of-cell time. Allowing high observation detainees this amount of pills in their possession is markedly unsafe for the detainee and his peers.

In another case (Case 11), an officer highlighted this particular detainee as being the most unstable detainee in segregation, reporting that he floods his cell, bangs his head, and tells custody he is blind (a delusion as the detainee demonstrates clear eyesight). His documented diagnosis was schizophrenia. During my examination of him, he was experiencing active auditory hallucinations. He had recently come from the inpatient psychiatric unit at API, yet no API records were in his chart and no clinician or psychiatrist note referenced what occurred at the hospital or how it led to changes in his care at ACF. I reviewed his electronic chart with Nurse [redacted] to make sure that, in fact, no API records were present and, indeed, none were. In this case, the detainee did not wish to be in segregation, and reported that his symptoms (namely auditory hallucinations) were worsening with so much time in isolation. It is common for psychotic symptoms, such as auditory hallucinations, to get worse when persons with schizophrenia are alone in isolation (i.e. voices often quiet when a person is engaged with others). The detainee said to me, "I hate to be alone."

In another case (Case 12), a female detainee in segregation for 426 cumulative days was examined and found to be stable: not requiring segregation, clinically, for any discernible reason. The documented reason for her segregation on the facility tracking sheet was again, "self PC." However, there was no documentation or clinical evidence (during my exam with her) that this patient had a serious mental disorder or an ongoing need for segregation.

In the last case I discuss in this section, (Case 13), a detainee in segregation for149 days with the provisional diagnosis of "Unspecified Psychosis," despite her easily providing her history as a person with Schizophrenia, which she relayed wasdiagnosed at age 20 (the detainee is now 48 years old), continued to experience auditory hallucinations. Her continual hallucinations were likely due to the antipsychotic medication (Geodon) that was inappropriately prescribed by the ACF psychiatrist, who was apparently not taking into account when the patient was provided meals and when the patient received her medication. Geodon is absorbed effectively with the intake of food (calories).[4] However, because ACF was not coordinating the detainees meals with her medication administration, the detainee was grossly undertreated when I saw her. According to the medical literature, it can be estimated that she was receiving (absorbing) only 50% or less of her Geodon dose because it was not given to the detainee with food.[5]

10. ***Complaints*** - The Office for Civil Rights and Civil Liberties received many medical complaints, and fewer mental health complaints during both onsites. The mental health deficiencies discussed previously were discovered during my routine check of detainee records for mental health concerns, or were reported to me by other members of the investigation team who observed detainees in the segregation unit. The two mental health complaints discussed below were received by CRCL prior to the 2017 onsite. Both complaints involve detainees who are psychiatrically unstable and inappropriately segregated. Both were substantiated as discussed.

    a. Complaint relates to Case 14 and involves a use of force incident involving the detainee who is reported to have become aggressive and combative, threatening officers and throwing tissue paper throughout his cell area. Five officers entered the cell and, after a physical confrontation, eventually restrained the detainee who was found to have a serious mental disorder and wasregularly housed in segregation. Upon review of the case, the detainee was diagnosed with Schizophrenia. In the days before this incident the detainee was described as "disheveled… Responding to internal stimuli" and was noted as mentally decompensating. He had entered ICE custody from the Los Angeles County Twin Towers Correctional Facility where he was in mental health housing and receiving the antipsychotic Risperdal. During his transition from Twin Towers to ACF, he was likely without medication for at least one day. By the time he arrived at the at the facility,he saw a psychiatrist, and was prescribed antipsychotic medication, three days had passed. This amount of time off of his antipsychotic medication was likely sufficient for him to mentally decompensate. In this case, ACF failed to provide continuity of care. Furthermore, this detainee remained in segregation housing when we were at the facility, which

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[4] Reference: *The effect of food on the absorption of oral ziprasidone*. Psychopharmacol Bull. 2007;40(3):58-68. "administration of ziprasidone with food is crucial to ensure optimal, reliable dose-dependent bioavailability and thus predictable symptom control and tolerability."

[5] Reference: *The impact of calories and fat content of meals on oral ziprasidone absorption: a randomized, open-label, crossover trial*. J Clin Psychiatry. 2009 Jan;70(1):58-62. Epub 2008 Oct 21. "Oral ziprasidone absorption is influenced by the presence of food, and the U.S. prescribing information instructs patients to take the medication with food. Studies in healthy volunteers have shown that the bioavailability of ziprasidone is enhanced when it is administered in the presence of a standard U.S. Food and Drug Administration (FDA) meal. Absorption is also dependent on the timing of drug administration relative to food, with reduced absorption when taken 2 hours after, rather than immediately following, food."

was six months after the complaint was filed with CRCL. This complaint is, therefore, **substantiated**.

b. Complaint relates to Case 15 and involves another use of force incident. The use of force report states that the detainee became hostile in his cell, struck a corrections officer, and was eventually subdued and placed in mechanical restraints. It was revealed that ACF had diagnosed the detainee with psychosis and he was being regularly housed in segregation. Upon review of his chart, I observed that the detainee had, in fact, been diagnosed with Schizophrenia, and had a history of taking antipsychotic medications. Two months prior to the incident, the detainee was documented as taking antipsychotic medication off-and-on. There is no evidence that a long-acting injection was ever offered to this detainee, though he was prescribed oral medication (perphenazine) that is available in the long-acting form. It is unclear why he was not psychiatrically hospitalized just prior to this incident. The incident itself, unfortunately, was the extreme event that finally triggered the hospitalization. It is documented in the chart that the motivation for the incident was delusional in nature. Dr. [redacted] wrote, "patient is clearly unstable, not clear and his thinking and impulsive. He attacked a staff member, believing that the staff member swore at him and spit at him (no evidence to support this). He clearly needs a higher level of care." In this case, inadequate psychiatric treatment was provided (i.e. not attempting to initiate a long-acting injection for a psychotic detainee who was poorly adherent to his antipsychotic medication) and there was a delay in appropriate care provided to this detainee (i.e. the hospital transfer should have taken place before the use of force event, when the detainee was clearly demonstrating mental decompensation). This complaint is **substantiated**.

Summary of Key Findings

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

1. Psychiatric leadership and oversight continues to be absent at Adelanto. The lack of leadership and oversight is a violation and **DOES NOT meet the 2011 PBNDS (4.3 V. B)**
2. Adelanto's electronic medical record lacks a Medication Administration Record (MAR) and patient location information, leading to unsafe mental health care for detainees. Mental Health record keeping at Adelanto **DOES NOT meet the 2011 PBNDS (4.3 II 23, 4.3 V.Y.1.a)**
3. Adelanto's practice of not obtaining adequate patient histories is a violation of the PBNDS and leads to inadequate and inappropriate mental health care for detainees with all levels of mental health disorders. **DOES NOT meet the 2011 PBNDS (4.3 V. N.3.b)**
4. Adelanto continues to have inadequate and delayed access to care for persons in mental health crisis who are in need of acute inpatient psychiatric hospitalization which **DOES NOT meet the 2011 PBNDS (4.3 V. N.3.j.4).**

5. Adelanto inappropriately houses detainees with serious mental disorders ly in segregation, rather than housing them in an appropriate mental health housing arrangement. Continuous and prolonged segregation housing of the mentally ill, has lead to inadequate mental health care, and increased the likelihood of poor mental health outcomes which **DOES NOT meet the 2011 PBNDS (4.3 V. N.3.j.3) as well as ICE Directive 11065.1, Review of the Use of Segregation for ICE Detainees (Segregation Directive) from the PBNDS 2011 revisions to Standard 2.12 "Special Management Units."**

Discussion

Though Adelanto's mental health team appears to be working to the best of their ability within their roles and within facility constraints, the lack of psychiatric leadership, particularly absent a leader who has the qualifications, experience and authority to make significant changes to how patient care is delivered, continues to result in ongoing inadequate mental health care. The most important issue at ACF continues to be the inappropriate segregation of detainees with serious mental disorders, obviating the need for different levels of mental health care and housing within the facility, other than segregation. Within the last two years, the use of dormitory housing (5B) for men has offered some degree of lower level mental health housing, though this remains problematic as supervision is minimal, the population is mixed, and there continues to be no opportunity for mental health evaluations in or near that housing space. Attempting to do their best, given the situation, mental health staff have reported that they believe segregation is the best housing option available for many of their detainee-patients; even those who are stable and do not technically require segregation. Due to the lack of appropriate leadership, there is also an unusual belief among the ACF mental health providers that it is somehow up to the patient to determine their level of care. In that way, if the patient wishes to be in segregation, rather than placing the patient in the least restrictive environment according to their clinical symptoms, the patient be allowed to remain in restrictive housing if that is their wish. This is evidenced in the pervasive use of "self PC" recorded as the reason, in many cases, for detainees in segregation. A qualified psychiatric leader should audit the charts and examine all patients with mental disorders in segregation in order to change treatment (including pharmacologic), if needed, as well as review the appropriateness of the detainee's housing. A qualified psychiatric leader could also work with GEO and ICE to develop a specialized mental health step-down unit, as well as moderate observation mental health housing (or "MOH" as it is known in many facilities), which is typically a dorm setting for persons with mental health diagnoses who are relatively stable, who need no more than outpatient level mental health care. These levels of care are common in correctional settings and there are many national examples that can be learned from. Finally, a psychiatric leader would advocate for the standard of care that would include adequate use of antipsychotic medication, including long-acting injections, safe patient handoffs to/from acute hospitalization, taking of detainee-patient histories, collection of collateral information to inform care, and instituting needed technological changes to ensure patient safety, such as an electronic MAR and access to detainee-patient locations within the electronic medical record.

Summary of Recommendations (CRCL already provided these Recommendations to ICE and IHSC as "initial recommendations," immediately following the November 2017 onsite investigation)

In 2015, ERO and GEO management was notified that psychiatric leadership was absent and that sub-standard mental health care was occurring at ACF as a result. During the 2017 onsite, I found that no corrections had been implemented to address this failure. It is likely that the failure to hire an effective, qualified psychiatric leader contributed to at least one detainee death, and continues to pose a risk to the safety of other detainees at ACF. Competent, qualified and effective psychiatric leadership is urgently required. Recognizing that it will take some time to put new leadership in place, the following measures should occur to ensure the health and safety of detainees in ICE custody at ACF:

1. **At-risk detainees should be immediately removed from the facility and transferred to another facility with competent psychiatric leadership and a well-functioning mental health program.** That facility should be able to provide appropriate housing and treatment for at-risk detainees with serious mental disorders. Detainees at-risk are those taking (or refusing) antipsychotic and mood stabilizing medications, especially those detainees currently in ACF segregation and those with recent inpatient hospital stays. **DOES NOT meet the 2011 PBNDS (4.3 V. O.1)**

2. **The ACF Medical Contractor, in consultation with ICE IHSC and a skilled psychiatrist leader, should review all cases of ACF detainees with serious mental disorders to ensure accuracy or make appropriate changes**. Attention should be focused on the following serious areas:

    a. Collateral data should be obtained for each ACF detainee with a serious mental disorder. Moving forward, this data should be in each detainee's initial mental health evaluation and obtained by the admitting clinician. In cases where collateral data was never obtained, clinicians must go back and obtain it and document it in the chart. During the investigation collateral data was absent in ***all*** cases. Typically, this data comes from the facility where the detainee was housed prior to their transfer to ACF, or from family members. If records cannot be obtained, ACF clinical staff should develop communicative relationships with staff at the facilities where ACF detainees most commonly come from and obtain this information by phone, which is permitted and expected under HIPPA, for purposes of patient safety and coordination of care. **DOES NOT meet the 2011 PBNDS (4.3 V. O.3.b)**

    b. Diagnoses and medication should be reviewed to ensure they are correct and appropriate. Attention should be given to taking detainees off ineffective medications – such as those only absorbed well with a meal, but are not administered at ACF meal times, or antipsychotics prescribed as PRN's (as-needed medications) for detainees with clear histories of taking long-acting antipsychotic injections. If patients refuse medications or injections, the ACF mental health providers should work with them so the detainee will accept them and document those attempts at compliance. **DOES NOT meet the 2011 PBNDS (4.3 V. O.4)**

    c. There should be a housing review and assessment for each detainee with a serious mental disorder to determine whether their housing is appropriate given the detainee's

clinical status. Although clinical staff reported that some stabilized detainees are segregated because they "want" to be in segregation, each detainee should be at the least restrictive level of care, given their mental health status and progress. **DOES NOT meet the 2011 PBNDS (4.3 V. O.5)**

d. Detainees with serious mental disorders should be removed from administrative segregation, as that environment is physically unsafe and not conducive to improving the detainee's mental health status. **DOES NOT meet the 2011 PBNDS (4.3 V. O.5)**

e. The current "hand-off" procedures for those detainees returning from an outside hospital, emergency room or mental health specialty consultation are thoroughly inadequate and should be greatly improved. (See recommendation 2.c under Medical Care, for further clarity.) **DOES NOT meet the 2011 PBNDS (4.3 V. O.3.k)**

f. In all cases where the ACF provider chooses to deviate from the care recommended by an outside specialist (including a recommendation to continue a long-acting antipsychotic injection), a full and complete note should be entered in the detainee's medical record documenting the clinical rational for the deviation from the outside provider's recommended care. **DOES NOT meet the 2011 PBNDS (4.3 V. O.1.b)**

3. **Custody staffing and transportation capacity should be increased to adequately support the mental health operation**. No clinical appointment – either within the facility or outside – should be canceled due to officer unavailability. Staffing and transportation should be increased to ensure uninterrupted access to appropriate medical/mental healthcare. In 2015, it was recommended that the facility create an office on the West (men's) side for mental health staff to be able to see male detainees without reliance on officers to escort them to clinic, but this important recommendation was not implemented and resulted related problems that were found during the 2017 onsite. It remains a necessary recommendation. **DOES NOT meet the 2011 PBNDS (4.3 V. O.3).**

4. **ACF's medical contractor, in consultation with ICE IHSC, should immediately institute an electronic Medication Administration Record (MAR).** Currently, there is no electronic capability allowing ACF mental health staff to see what medications any detainee-patient is currently taking. Though the current ECW has the capacity for this, security concerns were cited as a reason not to provide wireless throughout the facility, preventing nurses from documenting on laptops when detainees actually take their medications (which is the standard in most correctional settings) or refuse them. The ability to do this is critical for psychiatric patients, who decompensate quickly when not taking their medications; often resulting inpoor outcomes. ACF's lack of one master electronic MAR has resulted in there being 3 different records of current medications (ECW current meds, the paper MAR and the progress notes) which were often found to be contradictory. When clinical staff are forced to go to great time-consuming lengths to pull up a paper MAR and compare the data for medication errors or poor patient adherence, the detainee's safety is at risk. **DOES NOT meet the 2011 PBNDS (4.3 II 23, 4.3 V.Y.1.a)**

5. **ACF's medical contractor, in consultation with ICE IHSC, should immediately populate the electronic medical record (ECW) with the detainee-patient location.** When ACF's clinical staff do not know where their detainee-patients are located, those detainees may not be seen as needed and required. Also staff may mistakenly assume the detainee is in

the hospital when they, in fact, have just returned to ACF: which is a vulnerable time for those detainees. The detainee's clinical team should know where their detainee-patient is located. It is technically possible, and should be made a priority for GEO to connect with ECW to populate this data, which will better ensure patient safety. **DOES NOT meet the 2011 PBNDS (4.3 II 23, 4.3 V.Y.1.a)**

Thank you for the opportunity to provide information and recommendations.

Sincerely,

(b)(6)

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

Appendix I

Expert Qualifications and Methods of Review

Expert Qualifications

1. I am a physician licensed in the state of California. I am board certified in general psychiatry with a subspecialty board certification in forensic psychiatry.
2. I am an Assistant Clinical Professor of Medicine at the University of California, Los Angeles, David Geffen School of Medicine.
3. I am the Medical Director of the Los Angeles County Office of Diversion and Reentry for the Los Angeles County Department of Health Services. In this role I plan, develop and implement jail diversion projects and programs designed to offer health, mental health, and law enforcement personnel countywide a means to redirect County residents with mental illness and/or substance use disorders away from the criminal justice systems and into community treatment and services and establish partnerships between the Office of Diversion and other partners within the Department of Health Services, Department of Public Health, Department of Mental Health, the District Attorney, Public Defender, Alternate Public Defender, the Sheriff's Department and other law enforcement agencies throughout the County, and various community partners and providers with the goal of implementing initiatives to increase diversion opportunities for justice-involved residents of the County as well as develop information technology-related systems used to manage and document diversion-related efforts and resources.
4. I am a member of the Criminal Panel for the Los Angeles Superior Court and work one day per week at Department 95, the Los Angeles Mental Health Court, providing competency to stand trial evaluations for the presiding judge. In my role on the criminal panel, I enter several facilities in order to conduct evaluations, including the Los Angeles County Jail facilities, State Hospitals and other community facilities.
5. I served as an expert over the course of approximately five years on behalf of the plaintiffs in the Jose Antonio Franco-Gonzalez, et al. v. Eric H. Holder, Jr., Attorney General, et al., United States District Court, Central District of California. I also serve as a pro bono consultant for the Vera Institute of Justice on program development for immigration court liaison services and mental competency measures/screening. I continue to serve as an instructor to UCLA law students representing immigrants and a clinical supervisor to UCLA and UCR residence conducting forensic evaluations for immigration purposes.
6. I have been a physician since 2005. I've worked with persons who are underserved who have serious mental disorders for the past 10 years. I've worked in each of the Los Angeles County hospitals (LAC+USC Medical Center, Harbor-UCLA Medical Center and Olive View-UCLA Medical Center) and at Twin Towers Correctional Facility providing emergency, inpatient and outpatient care to persons with mental disorders.
7. I've published in peer-reviewed journals on the topics of persons with serious mental disorders and the immigration detention system. I am a member of the University of California Criminal Justice and Health Consortium, the Human Rights Committee and

Law Enforcement Liaison Committee of the American Academy of Psychiatry and the Law.

8. A more detailed listing of my experience and publications are included in my curriculum vitae, which is attached.
9. I am familiar with the degree of care and skill ordinarily exercised by members of the medical and mental health professions involving the care and treatment of inmates and pre-trial detainees in correctional facilities.

Methods of Review

In advance of the on-site investigation, I reviewed the documents provided by the Office for Civil Rights and Civil Liberties (CRCL) of the Department of Homeland Security. During the on-site investigation, I toured the facility including dormitories, pill lines and segregation, reviewed documents and electronic medical records and interviewed staff and detainees. I performed focus reviews of medical records for those detainees who had mental health conditions, and particular those who were in segregation. I reviewed 15 individual detainee medical charts, and conducted 11 individual interviews with detainees; I also interviewed two staff members of the mental health treatment team.

Appendix II

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

Identity of Cases Cited in this Report:

My Case #	A#	Detainee Name	CRCL Complaint #
1	(b)(6)		
2			
3			
4			
5			
6			
7			
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11			
12			
13			
14			17-08-ICE-0299
15			17-09-ICE-0356

Office for Civil Rights and Civil Liberties
U.S. Department of Homeland Security
Washington, DC 20528

Homeland Security

April 25, 2018

MEMORANDUM TO: Matthew Albence
Executive Associate Director
Enforcement and Removal Operation
U.S. Immigration and Customs Enforcement

FROM: Veronica Venture
Deputy Officer
Office for Civil Rights and Civil Liberties

Dana Salvano-Dunn
Director, Compliance Branch
Office for Civil Rights and Civil Liberties

SUBJECT: Adelanto Correctional Facility Complaint Nos. 17-03-ICE-0103, 16-06-ICE-0627, 17-07-ICE-0456, 17-08-ICE-0299, 17-09-ICE-0356, 17-09-ICE-0407, 17-09-ICE- 0366, and 17-10-ICE-0401[1]

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) is conducting an investigation into conditions of detention for U.S. Immigration and Customs Enforcement (ICE) detainees at the Adelanto Correctional Facility (ACF) in Adelanto, California. CRCL's onsite investigation, which occurred on November 13-14, 2017, was a follow-up review to our December 2015, onsite investigation. In addition, the onsite investigation was in response to three detainee deaths and CRCL's receipt of more recent allegations at ACF in the following areas: medical care, mental health care, use of force, hunger strikes, segregation, grievances, staff-detainee communication, legal access, language access, and suicide prevention and intervention.

We greatly appreciate the cooperation and assistance provided by ICE and ACF management and personnel before and during the onsite. As part of the review, CRCL used the same independent subject-matter experts that we used for the 2015 onsite: a medical consultant, a mental health consultant and a penologist. As a result of detainee and staff interviews, document reviews, and direct onsite observations, our experts identified concerns related to medical and mental health care, use of force, segregation and housing, grievances, staff-detainee communication, legal access, language access, and suicide prevention and intervention. At the

[1] Complaint No. 17-10-ICE-0401, alleging inadequate conditions of detention and lack of appropriate visitation, was added to the Adelanto complaints after CRCL disseminated the Retention Memo to ICE.

conclusion of our onsite investigation, CRCL and the subject-matter experts held an exit-briefing where we relayed our findings to local ICE and ACF management and relevant field personnel. During those discussions, the subject-matter experts also provided recommendations to address many of the identified concerns.

Due to the serious nature of certain health and safety-related findings, CRCL also submitted initial informal recommendations to ICE leadership on November 20, 2017 for immediate action. We understand ICE has been working on addressing those matters over that last few months, including a site visit during the week of March 12, 2018.

Enclosed with this memorandum are the reports prepared by our subject-matter experts. The experts' priority recommendations are listed below in the body of this memorandum. CRCL requests that ICE formally concur or non-concur with these recommendations and provide an implementation plan for all accepted recommendations within 60 days.

Recommendations

Medical Care

CRCL's medical expert made the following priority recommendations regarding medical care at ACF. All of these recommendations relate to the 2011 PBNDS Medical Care Standard, which requires timely and efficient access to medical services

Medical Leadership

1. In 2015, CRCL clearly informed Adelanto that clinical leadership was not competent and that problematic medical care was occurring as a result. In 2017 – two years since the 2015 onsite – the experts found no evidence that corrections were made to address this issue. The failure to hire an effective and qualified clinical leader contributed to the inadequate detainee medical care that resulted in medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees at ACF. The current medical leadership does not meet the requirements set forth in the 2011 PBNDS. Accordingly, **ACF should hire a competent, qualified, and effective onsite clinical leader immediately.** (2011 PBNDS Medical Care: II.1 through 9, II.12 through 16, II.20 and 21, II.23 and 25, II.27, II.29 and 30, V.A and B, V.F.1 and 3, V.G.1 through 4, V.G.6 and 7, V.G.9 through 12, V.I and J, V. L, V.Q through S, and V.U, V.W and X, V.Y.1.b, V.Z, V.BB.2)
2. In the event that new leadership cannot be recruited immediately – as it is likely that it will take some time to put new leadership in place – **at-risk detainees should immediately be removed from the facility and transferred to other facilities with well-functioning medical programs.** "At-risk" detainees include those with chronic diseases (such as cardiac, diabetes, HIV and other chronic infectious conditions), detainees with disabilities, anyone requiring outside medical specialist care, all detainees over the age of 55, and anyone else deemed to be medically vulnerable due to other conditions. (2011 PBNDS Medical Care: II.6, V.B)

Provider Staffing
The ACF medical contractor, Core Civic Solutions (CCS), in consultation with IHSC, should increase day-to-day medical care for detainees at ACF. Attention should be focused on the following areas of concern:

3. Current staffing levels and appointment scheduling are inadequate and lead to a high rate of appointment cancellations and chronically delayed access to care. **The current inadequate provider staffing levels and appointment scheduling problems should be corrected in the following ways**. (PBNDS 2011 Medical Care: II.1, II.5 through 9, II.21 and 22, II.27, V.A and B, V.F.3.a, V.U and W, V.BB)
    a. Providers should not be allowed to fully control and change their own appointment schedules.
    b. Detainee appointment cancellations at ACF should be monitored and tracked.
    c. When detainee-patient cancellations *are* appropriate, the detainee should be rescheduled for the first available provider.
4. Those providers whose medical care has been sub-standard should be more closely monitored and supervised. Probation or temporary limitations of privileges should be considered for those problematic providers, in order to ensure improvements. (2011 PBNDS Medical Care: II.21, V.B, V.T and U)

Detainee Returns from Offsite Care
The current inadequate "hand-off" procedures being utilized, when detainees return from medical or mental health care at an outside hospital, emergency room or medical specialty consultation should be improved to ensure an appropriate continuum of care. (2011 PBNDS Medical Care: II.1, II.7 and 8, II.12, II.16 and 20, V. A and B, V.F.a, V.G.2 and 12, V.I, V.S.4 and 5, V.W) Attention should be focused in the following areas:

5. **All recommendations made by outside medical/mental health consultants and providers should be reviewed immediately by both a nurse and a provider** (physician or mid-level practitioner) upon the detainees' return to ACF.
6. **All returning detainees should be seen and examined by an ACF medical or mental health practitioner within 24 hours of return to the facility** in order to review the ongoing plan of care with the detainee. **The examination should be supported by a full medical note and placement of orders in the medical record** as required. Prescriptions should be immediately filled and dispensed.
7. If ACF practitioners are off-site (after hours) **when the detainee is returned to the facility, the on-call provider should be contacted, the recommendations and directions from the outside medical provider should be relayed to the on-call provider for orders and disposition, and the involved detainee should be seen by the facility provider as early as possible the next day.**
8. **In all cases where the ACF provider choses to deviate from the care recommended by the outside specialist, a full and complete note should immediately be entered in the medical record** documenting the clinical rational for deviating from the recommended care.

Custody Staffing Support for Medical
ACF custody staffing and transportation is currently inadequate to support medical operations and ensure uninterrupted access to appropriate and needed medical care. (2011 PBNDS Medical Care: II.7, V.A and B, V.R and S, V.W)

9. **Custody staffing and transportation capacity should be increased** to adequately support the medical operation and ensure uninterrupted access to appropriate and needed medical care.

10. **Medical appointments – either within the facility or outside (such as a consultation with an off-site specialist) – should not, absent extraordinary circumstances, be canceled due to unavailability of medical duty officers or "runners," or for lack of transportation vehicles** (including transport by wheel chairs or gurneys).

Mental Health Care

CRCL's mental health expert made the following priority recommendations regarding medical care at ACF. All of these recommendations relate to the 2011 PBNDS Medical Care Standard, which requires appropriate, timely, and efficient access to mental health services.

11. Following CRCL's 2015 investigation, it was reported to ERO and GEO management that psychiatric leadership was absent at ACF and that sub-standard mental health care was occurring as a result. During the 2017 onsite, there was no evidence that corrections had been implemented to address this concern. This failure to hire an effective, qualified psychiatric leader continues to pose a risk to the safety of other detainees at ACF. Accordingly, **ACF should hire competent, qualified and effective on-site psychiatric leadership, immediately.** (2011 PBNDS Medical Care: II.5, II. 8 and 9, II.12, II.14 through 16, II.20 and 21, II.25 and 27, II.30; V.A.1-7, V.B, V.F.1 through 3.a, V.G.1 through 4, V.G.6, V.G.11 and 12, V.I-J.2 and 4, V.J.12 and 13, V.J.16 through 19, V.M.1 and 2, V.N.1 through 6, V.Q, V.R.1.a and f, V.R.2, V.S.4 and 5, V.U, V.W, V.X.6 through 12, V.Y.1.b and .4.c.a), V.BB.2.e, V.DD)

12. Recognizing that it will take some time to put new leadership in place, **at-risk detainees should be removed from the facility and transferred to other facilities with competent psychiatric leadership and a well-functioning mental health program.** Those facilities should be able to provide appropriate housing and treatment for at-risk detainees with serious mental disorders. Detainees at-risk are those taking (or refusing) antipsychotic and mood stabilizing medications, especially those detainees currently in ACF segregation, and those with recent inpatient hospital stays. (2011 PBNDS Medical Care: II.6, V.B, V.N, V.Q)

13. The ACF medical contractor, in consultation with ICE IHSC and a skilled psychiatrist leader, should review all cases of ACF detainees with serious mental disorders to ensure accuracy or make appropriate changes. Attention should be focused on the following serious areas:

a. **Collateral data should be obtained for each ACF detainee with a serious mental disorder. Moving forward, this data should be acquired and entered in each detainee's initial mental health evaluation and reviewed by the admitting clinician.** In cases where collateral data was never obtained, clinicians should obtain it and document it in the chart. During the investigation, collateral data was absent in ***all*** cases reviewed. Typically, this data comes from the facility where the detainee was housed prior to their transfer to ACF, or from family members. If records cannot be obtained, ACF clinical staff should develop communicative relationships with staff at the facilities where ACF detainees most commonly come from and obtain this information by phone, which is permitted and expected under HIPPA, for purposes of patient safety and coordination of care. (2011 PBNDS Medical Care: II.1 and 5, II.15 and 23, II.30, V.J and K, V.M and N, V.S.5, V.U and W, V.Y, V.BB)

b. **IHSC and CCS and should review diagnoses and medication to ensure they are correct and appropriate. Attention should be given to taking detainees off ineffective medications** – such as those only absorbed well with a meal, but are not administered at ACF meal times, or antipsychotics prescribed as PRN's (as-needed medications) for detainees with clear histories of taking long-acting antipsychotic injections. If detainee-patients refuse medications or injections, the ACF mental health providers should work with the detainee so the detainee will accept them, and then document those compliance attempts. (2011 PBNDS Medical Care: II.1 and 16, II.20 and 27, II.30, V.G and H, V.J.2 and 4, V.J.11 through 13, V.J. 16 and 17 narrative, V.M, V.N.1 through 3, V.N.4 through 6, V.Q, V.R and S, V.W and Y, V.BB)

c. **There should be a housing review and assessment for each detainee with a serious mental disorder to determine whether their housing is appropriate, given the detainee's clinical status.** Although clinical staff reported that some stabilized detainees are segregated because they have *requested* to be in segregation, each detainee should be at the least restrictive level of care when at all possible and deemed appropriate by mental health leadership, taking into account the detainee's mental health status and progress. (2011 PBNDS Medical Care: II.5 and 6, II.13, II.27 and 30, V.F.3, V.N, V.Q and S, V.Y, V.BB)

d. Detainees with serious mental disorders are routinely – and inappropriately – housed in administrative segregation at ACF. **Detainees with serious mental disorders should only be housed in administrative segregation as a last resort,** as that environment is not conducive to improving mental health status. (2011 PBNDS Medical Care: II.5 and 6, II.13, II.27 and 30, V.F.3, V.N, V.Q and S, V.Y, V.BB; ICE Directive 11065.1, Review of the Use of Segregation for ICE Detainees [Segregation Directive] from the PBNDS 2011 revisions to 2.12 Special Management Units)

14. **In all cases where the ACF provider chooses to deviate from the mental health care recommended by an outside specialist (including a recommendation to continue a long-acting antipsychotic injection), a full and complete note should be entered in the detainee's medical record documenting the clinical rational for the deviation** from the outside provider's recommended care. (See recommendation 8 under Medical Care for further clarity.) (2011 PBNDS Medical Care: II.1, II.7 and 8, II.12, II.16 and 20, V. A and B, V.F.a, V.G.2 and 12, V.I, V.S.4 and 5, V.W)

15. **Custody staffing and transportation capacity should be increased to adequately support the mental health operation. No clinical mental health appointment – either within the facility or outside – should be canceled due to officer unavailability. Staffing and transportation should be increased to ensure uninterrupted access to appropriate medical/mental healthcare.** In 2015, it was recommended that the facility create an office on the West (men's) side for mental health staff to be able to see male detainees without reliance on officers to escort them to clinic, but this important recommendation was not implemented and resulted in related problems that were found during the 2017 onsite. It remains a necessary recommendation. (2011 PBNDS Medical Care: II.7, V.A and B, V.R and S, V.W)

16. **ACF's medical contractor, in consultation with ICE IHSC, should immediately institute an electronic Medication Administration Record (MAR).** Currently, there is no electronic capability allowing ACF mental health staff to see what medications any detainee-patient is currently taking. Although the current ECW has the capacity for this, security concerns were cited as a reason not to provide wireless accessibility throughout the facility. This prevents nurses from documenting on laptops when detainees take their medications or refuse them (which is the standard process in most correctional settings). The ability to do this is especially critical for psychiatric patients, who decompensate quickly when not taking their prescribed medications; often resulting in poor outcomes. ACF's lack of one master electronic MAR has resulted in there being three different records of current medications (ECW current meds, the paper MAR, and the progress notes) which were found to be often contradictory. When clinical staff are forced to go to great time-consuming lengths to pull up a paper MAR and compare the data for medication errors or poor patient adherence, the detainee's safety is at risk. (2011 PBNDS Medical Care: II.23 and 27, V.S, V.Y.1.a)

17. **ACF's medical contractor, in consultation with ICE IHSC, should immediately populate the electronic medical record (ECW) with the detainee-patients' location.** When ACF's clinical staff do not know where their detainee-patients are located, those detainees may not be seen as needed and required. In addition, staff may mistakenly assume the detainee is in an offsite hospital when they, in fact, have just returned to ACF, which is a vulnerable time for those detainees. The detainee's clinical team should know where their detainee-patient is located. It is technically possible, and should be made a priority for GEO to connect with ECW to populate this data, which will better

ensure patient safety. (2011 PBNDS Medical Care: II.8 and 12, II.20 and 23, V.F.3.a.3 and 4, V.G.12, Y.1.a and b)

Conditions

CRCL's corrections expert made the following priority recommendations. All of these recommendations relate to the 2011 PBNDS.

18. In 2015, CRCL recommended that ACF use interpreters and/or language lines consistently for LEP detainees during the intake screening process and completion of the important and required intake forms. ACF continues to fail to meet the Admission and Release Standard. Interpreters or language lines are not being consistently used for LEP detainees during the intake screening process and completion of the intake forms. **ACF should consistently use interpreters or language lines for LEP detainees during the intake process.** (PBNDS 2011 Admission and Release: II.8, V.F, V.G)
19. In 2015, CRCL recommended that ACF should correct its intake and admission process by ensuring detainees are signing documents in a language the detainee understands, or by providing oral assistance in order to comply with the detention standard. ACF continues to fail to meet this standard. **ACF should ensure that detainees are signing documents in a language they understand or provide oral assistance.** (PBNDS 2011 Admission and Release: II.8, V.F, V.G)
20. In 2015 CRCL recommended that long-term segregation housing of detainees with serious mental health conditions at ACF should cease. This was not corrected. **A therapeutic unit should be established to house Special Management Unit (SMU) detainees, where appropriate oversight and treatment results in those detainees' eventual transition to general population or a step-down unit.** ERO, IHSC and ACF must audit all SMU cases to identify those detainees housed in the SMU, partially or wholly due to mental health conditions and develop a safe housing alternative with more intensive mental health services (including mental health group therapy) in a non-SMU setting. (PBNDS 2011 Special Management Units: II.4, II.6, II.7)
21. In 2015, CRCL recommended that the Mental Health Director and IHSC ensure that ACF Mental Health staff conduct daily face-to-face rounds with all detainees in the SMU, and provide appropriate mental health assessments and treatment. Daily rounds are being conducted; however, **one of the rooms in the SMU should be converted into an interview room where private face-to-face interviews between mental health personnel and detainees can be effectively conducted.** (PBNDS 2011 Special Management Units: II.6 and 7, II.8, V.A, V.F; Medical Care: V.F.1, V.N)
22. In 2015, CRCL recommended that ERO should audit all detainees held in the SMU over 30 days for protective housing reasons and determine if transfer to another facility is more appropriate to improve treatment or resolve the inappropriate use of the SMU for housing detainees with serious mental illnesses. While SMU audits are being conducted every 30 days, 40% (20) of the detainees

continue to be housed over 30 days. **ERO should work with GEO to create a housing alternative for non-disciplinary placements in the SMU for over 30 days.** (PBNDS 2011 Special Management Units: II.8 and 9, II.19,V.A, V.F)

23. In 2015, CRCL recommended that ERO and ACF develop and implement an efficient population count process to eliminate the problematic delays that six daily counts cause in the detainees' access to meals, medical care, visitation, recreation, and law library. ACF continues to conduct the problematic six counts, even though the Chief of Security was not concerned with reducing the number to five. **ICE and ACF should reduce the number of daily counts to five as a way to improve detainee access to programs and services.** (PBNDS 2011 Population Counts: V.A.1; Multiple other PBNDS 2011, including Visitation, Recreation, Law Libraries, Food Service)

24. In 2015, CRCL recommended that ERO and ACF Management (including the Warden) develop a reporting system to ensure that facility personnel effectively respond to and resolve the detainee grievance issues assigned to them by the Grievance Coordinator and then report back to the Grievance Coordinator that the matter is resolved. This was not corrected. CRCL again recommends that **ICE and ACF should develop a reporting system to ensure that facility personnel respond and resolve detainee grievances.** (PBNDS 2011 Grievance System: II.2 and 3, II.6 and 8, V.A, V.B.7, V.C)

25. In 2015, CRCL recommended that ERO and ACF Management develop a tracking system to enable review and trend analysis of all grievances involving staff mistreatment. This was not corrected. **CRCL again recommends that ICE and ACF should develop a grievance tracking tool.** (PBNDS 2011 Grievance System: V.D and F, V.H)

26. In 2015, CRCL recommended that ICE should receive a copy of staff mistreatment grievances upon receipt by the GEO Grievance Coordinator. This was not corrected. CRCL again recommends that **detainee grievances involving staff misconduct should be submitted to ICE as mandated by the PBNDS.** (PBNDS 2011 Grievance System: V.F, V.G).

27. In 2015, CRCL recommended that ACF should hold facility staff accountable for substantiated abusive and disrespectful treatment of detainees, as determined by the Grievance Coordinator and/or other facility personnel. This was not corrected. CRCL again recommends that **ACF should hold facility staff accountable for substantiated abusive and disrespectful treatment of detainees.** (PBNDS 2011 Grievance System: V.G)

28. In 2015, CRCL recommended that ERO and ACF develop a post-assignment schedule that creates a sufficient staffing plan that resolves the current, problematic staffing deficiencies. The deficiencies are negatively affecting operational needs, including excessive count times and meal delays, and limitations in access to visitation, law library, and recreation. The post assignment schedule has been revised and additional correctional officer positions have been added, however this has not resolved the problem. **The correctional officer medical escort and transportation staffing should be increased to**

adequately support the medical and mental health escort needs within the facility and to outside appointments. (PBNDS 2011 Post Orders: V; Food Service: II.4, V.D; Visitation: II.4 and 6, V.B and J; Recreation: II.4, V.B; Law Library and Legal Material: II.2, II.4 and 5, V.C)

29. **ACF should hire staff (e.g. a Spanish-speaking law librarian) and/or develop other mechanisms to provide language assistance** to detainees who are not proficient in English so they may utilize the Law Library. (PBNDS 2011 Law Libraries and Legal Material: II.8, V.I)

30. **ACF should institute a computer training class demonstrating use of the Lexis-Nexis software and computers, and create a detainee-worker position in each housing unit** to assist detainees with using the computer system. (PBNDS 2011 Law Libraries and Legal Material: II.8, V.I)

31. **ACF should develop a Language Line logging system and require all facility staff to record Language Line use, by date and A#.** (DHS Language Access Plan, 2012) (2011 PBNDS: Multiple)

32. **ERO and ACF should ensure that all forms issued to detainees for informational purposes, but especially those requiring detainee signatures, are written and/or translated in a language the detainee comprehends, or provide oral interpretation of these forms and document the provision.** All written material provided to detainees shall generally be translated into Spanish. (DHS Language Access Plan, 2012) (2011 PBNDS: Multiple)

33. ACF's healthcare grievance process (medical, mental health and dental) is currently unreliable. **The ACF Medical Unit should designate a staff position that is responsible for timely reviews and responses to the detainees' medical grievances and ensure that timely and appropriate follow-up actions are completed**, in order to prevent further detainee injury or death. (PBNDS 2011 Grievance System: II.2 and 3, II.6 and 8, V.A, V.B.7, V.C)

34. **A separate healthcare medical grievance log should be instituted to track healthcare-related grievance submissions and ensure timely responses**. (PBNDS 2011 Grievance System: II.10, V.A, V.C.2 and 4)

35. **A monthly audit should be conducted of submitted healthcare grievances to improve timeliness of care** and ensure appropriate access to medical, mental health and dental care. (PBNDS 2011 Grievance System: V.C.4)

36. **ACF must provide access to a cold-water shower in the East and West wings for decontamination of detainees who have been exposed to OC Pepper Spray**. (PBNDS 2011 Medical Care: V.F; Use of Force and Restraints: V.A.5, V.B.6 and 11, V.B.14, V.D.2)

It is CRCL's statutory role to advise department leadership and personnel about civil rights and civil liberties issues, ensuring respect for civil rights and civil liberties in policy decisions and implementation of those decisions. We look forward to working with ICE to determine the best way to resolve these complaints. You can send your response and action plan by email. If you

have any questions, please contact Senior Policy Advisor, Moreen Murphy by telephone at (b)(6)
(b)(6)

Copies to:

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Enclosures