



**Homeland
Security**

June 23, 2020

MEMORANDUM FOR: Enrique M. Lucero
Executive Associate Director
Enforcement and Removal Operation
U.S. Immigration and Customs Enforcement
(b)(6)

FROM: Peter E. Mina
Deputy Officer for Programs and Compliance
Office for Civil Rights and Civil Liberties
(b)(6)

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

SUBJECT: CRCL Expert Recommendations regarding
ICE Health Service Corps (IHSC)
Medical/Mental Health Care and Oversight
Complaint Nos. 17-06-ICE-0582, 18-09-ICE-0615,
18-10-ICE-0613, 18-08-ICE-0614, 18-10-ICE-0623,
18-10-ICE-0624, 18-10-ICE-0626, 18-10-ICE-0627,
18-10-ICE-0628, 18-10-ICE-0629, 18-10-ICE-0630,
18-10-ICE-0631, 18-10-ICE-0632, 18-10-ICE-0633,
18-10-ICE-0634, 18-10-ICE-0635, and 18-10-ICE-0636

The DHS Office for Civil Rights and Civil Liberties (CRCL) conducted an investigation in response to information received from the DHS Office of Inspector General (OIG) alleging that U.S. Immigration and Customs Enforcement's (ICE) ICE Health Service Corps (IHSC) had systematically provided inadequate medical and mental health care, and oversight of that care, to immigration detainees in facilities throughout the United States.

We appreciate the cooperation and assistance provided by ICE during the review. As part of the review, CRCL engaged the assistance of three subject-matter experts: two medical experts and a mental health expert. The experts conducted an extensive document and medical record review to examine the medical care and/or mental health care provided to 17 detainees in eight (8) immigration detention facilities, all of which ICE IHSC provides direct medical and mental health care, for whom care was allegedly inadequate, with an emphasis on assessing the care in each case, as well as the oversight of the care and any corrective action(s) taken to address concerns identified in each case. The subject-matter experts then identified concerns regarding the cases they reviewed.

Enclosed with this memorandum are the reports prepared by our subject-matter experts. These reports focus on the reviews of each of the cases and concerns stemming from their reviews. In this memorandum, we are providing ICE with recommendations that are organized by subject area and facility. CRCL requests that ICE formally concur or non-concur with these recommendations and provide an implementation plan for all accepted recommendations within 60 days of the date of this memorandum.

In addition to the specific complaint allegations, CRCL looked at IHSC's policies, procedures, and operations more generally to determine if the individual allegations or findings are indicative of systemic issues. Separately, CRCL will provide ICE with a Recommendation Memo addressing the broader allegation of inadequate oversight and monitoring by IHSC. As this is systemic in nature and is a direct role required by ICE via IHSC, those recommendations will address the adequacy of IHSC's medical management role. The forthcoming recommendations will speak to any findings requiring improvement to the efficacy of IHSC's quality improvement and oversight measures for detention facilities in which they provide direct care to ICE detainees, as well as for facilities in which detainee care is provided by another provider, but IHSC plays a critical oversight role.¹

All the facilities reviewed had medical care provided by IHSC and are governed by the 2011 ICE Performance Based Detention Standards, with the exception of one facility for which the ICE Family Residential Standards (FRS) apply.² In addition, where the FRS were deficient in medical care provisions, CRCL referred to the ICE PBNDS 2011. Where the PBNDS 2011 or the FRS are deficient, recommendations are based on professional standards including those published by the National Commission on Correctional Health Care (NCCCHC) and American Psychiatric Association (APA), as well as over 60 years of medical and mental health experience in correctional settings shared between the three subject matter experts CRCL engaged for this investigation.

Summary

On July 18, 2018, CRCL received information from the OIG regarding the quality of detainee medical and mental health care provided directly by IHSC at IHSC-staffed detention facilities, as well as its oversight of detainee medical and mental health care. The OIG received the information and allegations beginning in April 2018 from a complainant within IHSC who raised serious claims regarding the care and oversight provided by IHSC at these facilities. The allegations involved both medical and mental health care and include the following:

- inadequate treatment and monitoring of detainees in severe withdrawal from alcohol and/or substance abuse;
- lack of psychiatric monitoring leading to mental health deterioration;
- forcible medication injections as a mean of behavior control;
- misdiagnosis of medical and mental health conditions;

¹ In this broader complaint investigation, CRCL's recommendations will not focus on individual instances, but will be based on the commonalities identified across the set of individual complaints as well as a wholistic examination of IHSC's policies, procedures, and operations.

² South Texas Family Residential Center (STFRC) in Dilley, Texas.

- serious medication errors; and
- inadequate care and/or oversight for four detainees who died while in custody.

Further, the complainant alleged that IHSC leadership failed to take appropriate action and/or implement appropriate oversight measures upon notification of the specific medical or mental health concerns by IHSC personnel. While the complaints also contained allegations of retaliation against the complainant, CRCL did not investigate these claims and they were to be handled directly by the OIG.³

Recommendations

Medical Care

CRCL’s medical experts made the following recommendations regarding medical care:

Concern re: Medical Withdrawals at Florence Service Processing Center (SPC) and Elizabeth Contract Detention Facility

1. (b)(5)

(Complaint Nos. 18-10-ICE-0626, 18-10-ICE-0627, 18-10-ICE-0629)

2. (b)(5)

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(Complaint Nos. 18-10-ICE-0626, 18-10-ICE-0627, 18-10-ICE-0629)

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(Complaint No. 18-10-ICE-

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4. A slow benzodiazepine drug taper was not initially prescribed to manage the detainee's supervised withdrawal at Florence SPC. At intake, the detainee self-reported history of alprazolam usage at intake; however, Benzodiazepine withdrawal and the potential need for treatment were not raised as concerns. Florence SPC should provide multi-disciplinary, physician-led training to the health care team on the appropriate treatment of withdrawal from benzodiazepines, including the need for a prolonged taper. (*Complaint No. 18-10-ICE-0627*)

Pediatric Care at South Texas Family Residential Center (STFRC)

5. South Texas Family Residential Center (STFRC) did not dispense and administer the initially prescribed ear drops to the identified patient. STFRC should conduct a local quality improvement review of processing prescription medications at the facility to identify any procedural lapses that warrant corrective action. (*Complaint No. 18-10-ICE-0630*)
6. Available medical records from STFRC raise concerns about the urgent care provided to an identified child when he presented with somnolence (excess sleepiness) and vomiting. The child experienced a seizure four hours later and was emergently transferred to the hospital. STFRC should conduct a local physician review of the urgent care provided to the patient prior to his seizure to determine if further quality improvement measures are warranted, such as nursing and practitioner training. (*Complaint No. 18-10-ICE-0630*)

Stewart Detention Center (SDC)

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(Complaint No. 18-10-ICE-0631)

LaSalle ICE Processing Center (Jena)

8. (b)(5)

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(Complaint No. 17-06-ICE-0582)⁷

Mental Health Care

CRCL's mental health expert made the following priority recommendations related to mental health care:

Eloy Federal Contract Facility (EFCF)

9. At Eloy Federal Contract Facility (EFCF), the Serious Mental Illness (SMI) list was not used in accordance with policy or practice in multiple cases. Specifically, the detainees were not placed SMI list when they clearly exhibited symptoms of psychotic illness. EFCF should re-train its staff on criteria for placing detainees on the SMI list. *(Complaint Nos. 18-10-ICE-0623, 18-10-ICE-0624)*
10. The expert's review found that psychotropic intervention was not timely in an identified patient, despite his increasing symptoms during a period of both religious delusions and increased focus on his own sexuality related to sexual abuse and his history of serious mental illness. This detainee acknowledged a history of mental illness including current symptoms at the time intake, and although he was seen by psychiatric providers and mental health staff, medications were not started for five months after his intake. Medication was not adjusted to more adequately address the psychotic symptoms. This contributed to significant self-harm requiring hospitalization. Routine clinical case review should be initiated among EFCF prescribers, or between prescribers and IHSC psychiatric leadership, to provide feedback and oversight on prescription practices. *(Complaint No. 18-10-ICE-0623)*

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11. (b)(5)

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No. 18-10-ICE-0624)

(Complaint

12 (b)(5)

(b)(5)

(Complaint No. 18-10-ICE-0624)

13. The provision of medication following transfer to EFCF was inadequate in an instance involving a detainee who transferred into the facility with prescriptions for psychotropic medications which he reported to have been prescribed for several years. The transfer summary recognized the schizophrenia diagnosis and included packaged medications with which to travel; however, the detainee did not receive the medication for two days upon arrival. EFCF should retrain its staff on continuity of care issues specific to continuation of prescriptions upon transfer between facilities. *(Complaint No. 18-09-ICE-0615)*

LaSalle ICE Processing Center (Jena)

14. Factors indicating the need for a higher level of mental health care at Jena did not receive adequate attention. Staff appeared to not believe the veracity of the detainee's symptoms, even after returning from a psychiatric inpatient visit where antipsychotic medications were prescribed. When symptoms continued, the detainee was referred to a longer inpatient stay, but two weeks later that placement had not been made and was ultimately withdrawn. Follow up with the facility is critical to address the timeliness and adequacy of mental health care. A detainee who is determined to require health care beyond facility resources should be transferred in a timely manner to an appropriate facility. Jena should retrain its medical leadership on policies regarding referring detainees with active

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mental health concerns to facilities better able to address their needs. (*Complaint No. 18-10-ICE-0632*)

15. The use of forced injectable medication (IM) at Jena was not consistent with IHSC policy or practice in multiple cases. In one case, Jena was quick to use IMs a first resort rather than making other treatment efforts. The detainee was brought to medical after being seen crying and IM medication was given despite there being no evidence of uncontrolled psychotic behavior at the time warranting this intervention. In another case, the detainee received a forced IM after becoming belligerent with an officer and did not have any reported mental health or suicidal issues that would warrant use of IM. IHSC should follow up with the facility to address the timeliness and adequacy of mental health care including assessing the need to utilize forced medication as a primary intervention or for behavioral management. Jena should retrain medical providers on utilization of forced IM medication. (*Complaint Nos. 18-10-ICE-0632, 18-10-ICE-0633*)
16. The SMI list was not used in accordance with policy or practice at Jena. Specifically, a detainee was placed on the list and removed 15 days later when she was reported to no longer meet certain criteria despite continuing to report voices and having recent experience of psychiatric hospitalization, forced medications, and recent self-harm ideation. Jena should retrain its staff on criteria for placing detainees on the SMI list. (*Complaint No. 18-10-ICE-0632*)
17. There was inadequate evaluation of a detainee before placement into segregation at Jena. Prior to the detainee receiving an initial psychiatric evaluation and upon release from the mental health unit, he was placed into segregation with a nurse clearance that inaccurately stated, “no history of mental illness or mental health encounters at current facility.” Jena should review its policy on conducting medical or mental health reviews before a detainee is placed into a segregated status, conducting additional training with all medical and mental health staff, and conducting regular audits of placements. (*Complaint No. 18-10-ICE-0633*)

El Paso Service Processing Center

18. The use of forced IM medication at El Paso SPC was not consistent with policy or practice in multiple cases. The documentation of IM Haldol use is poor, it is unclear if in one instance an identified detainee received one injection or two, and there was a lack of documented monitoring following the injection. Follow up with the facility is critical to address utilization of forced IM medications as a primary means to address behavioral concerns. El Paso SPC should retrain medical providers on utilization of forced IM medication. (*Complaint Nos. 18-10-ICE-0634, 18-10-ICE-0635*)

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(Complaint No. 18-10-ICE-0634)

20. The SMI list was not used in accordance with policy or practice at El Paso SPC. An identified detainee was not placed on the SMI list when he clearly exhibited symptoms of psychotic illness and met criteria for the status. After returning from an inpatient psychiatric hospitalization, he was taking multiple medications and reported no suicidal or homicidal ideation. He was then placed into mental health observation and the Licensed Clinical Social Worker (LCSW) indicated he met criteria for the SMI list until being removed from it almost a month later for unknown reasons. El Paso SPC should retrain its staff on criteria for placing detainees on and taking detainees off the SMI list. *(Complaint No. 18-10-ICE-0635)*

Tacoma ICE Processing Center (“Northwest Detention Center”)

21. The SMI list was not used in accordance with policy or practice at Northwest Detention Center. The detainee in this case had an SMI, which was noted by staff from intake; however, he was not flagged on the SMI list until a year and a half later. Luckily the detainee was having daily contact with RNs and regular contact with prescribers, mental health clinicians, and medication adjustments, however being on the SMI list would have resulted in timely reports to the Behavioral Health Unit in IHSC about his condition, status, and plan. This important layer of oversight and consultation for challenging cases is valuable, and in this case, it was not added until MQMU requested a file review by IHSC psychiatry leadership. Northwest Detention Center should retrain its staff on criteria for placing detainees on the SMI list. *(Complaint No. 18-10-ICE-0636)*

22. (b)(5)

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(Complaint No. 18-10-ICE-0636)

Stewart Detention Center (SDC)

23. (b)(5)

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(b)(5) *(Complaint No. 18-10-ICE-0613)*

24. (b)(5)

(b)(5) *(Complaint No. 18-10-ICE-0613)*

25. (b)(5)

(b)(5) *(Complaint No. 18-10-ICE-0613)*

26. (b)(5)

(b)(5) *(Complaint No. 18-10-ICE-0613)*

The complete expert reports and recommendations are contained in the enclosed expert reports.

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. We request that ICE provide a response to CRCL 60 days whether it concur or non-concur with these recommendations. If you concur, please include an action plan. You can send your response by email. If you have any questions, please contact Policy Advisor (b)(6) by telephone at (b)(6) or by email at (b)(6)

Copies to:

Tae Johnson
Deputy Executive Associate Director
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
(b)(6), (b) (7)(C)

Dr. Stewart D. Smith
Assistant Director, ICE Health Service Corps
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
(b)(6), (b) (7)(C)

Dr. Ada Rivera
Medical Director, ICE Health Service Corps
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
(b)(6), (b) (7)(C)

Russell Hott
Acting Assistant Director, Custody Management
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
(b)(6), (b) (7)(C)

Monica Burke
Deputy Assistant Director, Custody Programs
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
(b)(6), (b) (7)(C)

Alison Walder
Chief of Staff, Custody Management
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
(b)(6), (b) (7)(C)

Enclosures