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

Homeland Security

February 12, 2018

MEMORANDUM FOR: Todd Owen
Executive Assistant Commissioner
Office of Field Operations
U.S. Customs and Border Protection

Carla Provost
Acting Chief
U.S. Border Patrol
U.S. Customs and Border Protection

FROM: Veronica Venture (b)(6)
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Office for Civil Rights and Civil Liberties

Dana Salvano-Dunn (b)(6)
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Office for Civil Rights and Civil Liberties

SUBJECT: Suicide Prevention in CBP Custody Expert Report Recommendations on Complaint Nos.
16-10-CBP-0437
16-10-CBP-0436
16-10-CBP-0435
16-01-CBP-0110
15-02-CBP-0132
14-12-CBP-0374
14-04-CBP-0053

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) conducted an investigation into attempted and successful suicides while in CBP custody. CRCL's onsite investigations occurred on March 28, 2017, and April 4-5, 2017, at the Brownsville (Gateway) Port of Entry, Marfa Border Patrol Station, Marfa Border Patrol Checkpoint, Rio Grande Valley Centralized Processing Center, and the McAllen Station Processing Center. As part of the review, CRCL reviewed policies and procedures of the Office of Field Operations (OFO) and U.S. Border Patrol (USBP) as they relate to suicide prevention and engaged the assistance of a subject-matter expert (SME) in the field of suicide prevention in a custodial environment.

Since 2014, CRCL has opened ten (10) investigations based-upon reports of attempted and/or completed suicides in CBP custody.[1] (b)(5)

(b)(5)

In response to these complaints, CRCL reviewed applicable CBP policies and procedures and related documents, conducted staff interviews, and went onsite to locations involved in the complaints.

(b)(5)

Enclosed with this memorandum are the full SME reports for OFO and USBP prepared following our onsite reviews. Below is a summary of the significant recommendations provided by the SME. CRCL requests that CBP formally concur or non-concur with these recommendations within 60 days and provide an implementation plan for all accepted recommendations.

Office of Field Operations

1) TRAINING: All officers should receive both initial and annual suicide prevention training that includes, at a minimum, instruction regarding detainee suicide research, why custodial environments are conducive to suicidal behavior, pre-disposing factors, high-risk suicide periods, warning signs and symptoms, and components of the suicide prevention policy.

2) (b)(5)

[1] Since CRCL retained these complaints, CRCL received and opened additional investigations into attempted suicides. CRCL complaints 17-04-CBP-0104 and 17-08-CBP-0308. Additionally, CRCL complaint number 15-01-CBP-0124 was kept by the Office of the Inspector General for investigation.

(b)(5)

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6) INTERVENTION: The policy regarding intervention should be threefold: 1) at least one officer one per shift posted in the CBP facility should be trained and maintain up-to-date certification in standard first aid and CPR; 2) any staff who discovers a detainee attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin life-saving measures; and 3) staff should initiate and continue appropriate life-saving measures until relieved by medical personnel. An emergency response bag containing a first aid kit, CPR mask or Ambu bag, and rescue tool (to quickly cut through fibrous material) should be located in close proximity to a housing unit.

7) REPORTING: In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the detainee and incident.

8) FOLLOW-UP/MORBIDITY-MORTALITY REVIEW: In addition to required DHS and/or CBP investigations, every completed suicide, and

serious suicide attempt (i.e. requiring hospitalization), should be examined by a morbidity-mortality review. The review, separate and apart from other formal investigations required to determine cause of serious injury or death, should include: 1) review circumstances surrounding incident; 2) review procedures relevant to incident; 3) review relevant training received by staff; 4) review pertinent health care services/reports of victim; 5) review possible precipitating factors (i.e., circumstances which may have caused victim to attempt/commit suicide); and 6) recommendations, if any, for change in policy, training, physical plant, health care services, and operational procedures.

United States Border Patrol

(b)(5)

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history) indicating the potential for self-injury, should be placed under close observation. *Constant Observation*, reserved for the detainee who is actively suicidal (threatening/engaging in the act) requires supervision on a continuous/uninterrupted basis. CCTV can be utilized as a supplement to, but never as a substitute for, these observation levels.

6) INTERVENTION: The policy regarding intervention should be threefold: 1) at least one agent per shift posted in the CBP station should be trained and maintain up-to-date certification in standard first aid and CPR; 2) any staff who discovers a detainee attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin life-saving measures; and 3) staff should initiate and continue appropriate life-saving measures until relieved by medical personnel. An emergency response bag containing a first aid kit, CPR mask or Ambu bag, and rescue tool (to quickly cut through fibrous material) should be located in close proximity.

7) REPORTING: In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the detainee and incident.

8) FOLLOW-UP/MORBIDITY-MORTALITY REVIEW: In addition to required DHS and/or CBP investigations, every completed suicide, and serious suicide attempt (i.e. requiring hospitalization), should be examined by a morbidity-mortality review. The review, separate and apart from other formal investigations required to determine cause of serious injury or death, should include: 1) review circumstances surrounding incident; 2) review procedures relevant to incident; 3) review relevant training received by staff; 4) review pertinent health care services/reports of victim; 5) review possible precipitating factors (i.e., circumstances which may have caused victim to attempt/commit suicide); and 6) recommendations, if any, for change in policy, training, physical plant, health care services, and operational procedures.

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 CBP to determine the best way to resolve these complaints. We request that CBP 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 Senior Policy Advisor (b)(6) by telephone at (b)(6) or by email at (b)(6)

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Enclosures

Appendix A – Suicide Prevention Expert Report - OFO
Appendix B – Suicide Prevention Expert Report - USBP