



Homeland  
Security

July 11, 2022

MEMORANDUM FOR: Corey A. Price  
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Enforcement and Removal Operation  
U.S. Immigration and Customs Enforcement

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SUBJECT: Krome North Service Processing Center  
Complaint Nos. 002533-22-ICE, 002304-21-ICE, 002175-21-ICE,  
001227-21-ICE, and 21-06-ICE-0306

The U.S. Department of Homeland Security (DHS), Office for Civil Rights and Civil Liberties (CRCL) conducted an investigation into conditions of detention for U.S. Immigration and Customs Enforcement (ICE) detainees at Krome North Service Processing Center (Krome) in Miami, Florida. CRCL's virtual onsite investigation occurred December 6-9, 2021 and was in response to complaints regarding conditions of detention, medical and mental health care, suicide prevention and intervention, sexual abuse and assault prevention, and environmental health and safety issues.

We greatly appreciate the cooperation and assistance provided by ICE and its contractors before and during the virtual onsite investigation. As part of the investigation, CRCL engaged the assistance of four subject-matter experts: a conditions of detention expert, an environmental health and safety expert, a medical expert, and a mental health expert. As a result of detainee and staff interviews, document and record reviews, and virtual direct observation, the subject-matter experts identified concerns in each of their areas.


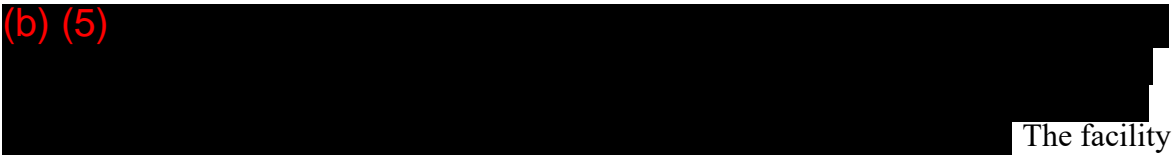
On December 9, 2021, as part of the virtual onsite closing discussion, CRCL and the subject-matter experts discussed preliminary findings and recommendations with ICE field office management, personnel from ICE Enforcement and Removal Operations (ERO) headquarters, and facility contractor Akima Global Services (AGS) personnel. Shortly following the onsite, CRCL sent an email to ICE on January 11, 2022, summarizing these initial recommendations, to ensure ICE had sufficient information to begin to initiate proposed changes.

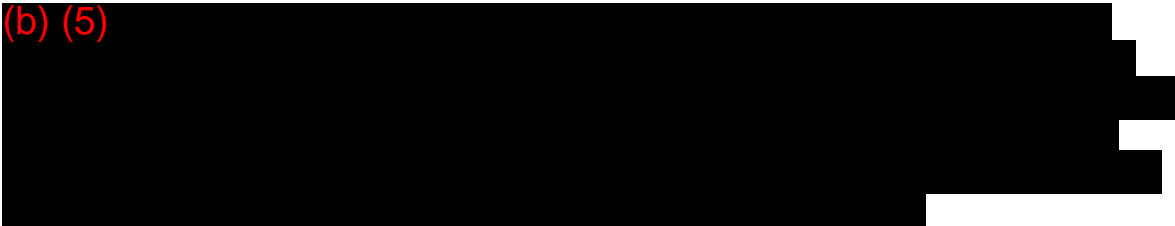
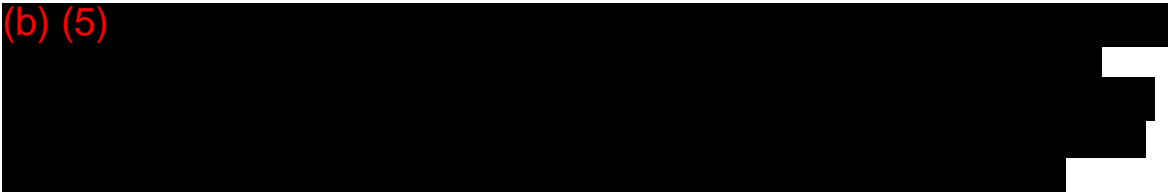
Enclosed with this memorandum are the reports prepared by our subject-matter experts.<sup>1</sup> Recommendations are listed in the body of this memorandum, and CRCL requests that ICE formally concur or non-concur with these recommendations and provide an implementation plan for all accepted recommendations within 120 days of issuance.

With this memorandum, and consistent with our standard practice, we request that ICE indicate whether it concurs with the expert recommendations, and that for those agreed to, ICE provide an action plan within 120 days.

### Conditions of Detention

CRCL's conditions of detention expert made the following priority recommendations related to the Performance Based National Detention Standards 2011 Rev. 2016 (PBNDS 2011/16) and (General Duty Clause, Section 5(a)(1) of the OSHA Act of 1970):

1. (b) (5) 
  
2. (b) (5) 

The facility should purchase privacy curtains and recommends that all entities involved expedite this purchase (PBNDS 2011/16 Section II, 2.11 Sexual Abuse and Assault Prevention and Intervention).
  
3. (b) (5) 
  
4. (b) (5) 

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<sup>1</sup> In general, CRCL's experts relied on the applicable PBNDS 2011/16 and related professional standards in conducting their work and preparing their reports and recommendations. Some of their analyses or recommendations, however, may be based on constitutional or statutory requirements that exceed the detention or professional standards.

(b) (5)

5. (b) (5)

6. (b) (5)


7. (b) (5)

8. (b) (5)

9. The Krome grievance officer does not maintain English translations of grievances in the grievance/detainee file. This lack of translations may inhibit others who are involved in the grievance appeal process or involved in quality control reviews. The grievance officer should retain a version of the grievance and response translated to English for retention in the detainee file or grievance files (PBNDS 2011/16 Section VI, 6.2 Grievance System).
10. A grievance response reviewed during the onsite was inappropriate and not in compliance with PBNDS 2011/16 because it lacked critical information. The response reminded the grievant that it was the grievant who decided to come to the U.S. and then squandered those opportunities, committed acts which resulted in criminal charges and therefore impacted the grievant's chances for successful integration into the country. Grievance responses must refer to the facts, reference laws, policies, or procedures, and eliminate any language which might be considered editorial comments. Krome should train the grievance officer and administrators to ensure that responses are factual, show responsiveness and exclude any appearance of retaliation or harassment for the filing of a grievance (PBNDS 2011/16 Section VI, 6.2 Grievance System).

## Environmental Health and Safety

CRCL's environmental health and safety expert made the following recommendations related to the PBNDS 2011/16, Environmental Health and Safety standard.

11. (b) (5) 
12. During interviews, detainees reported that they were frequently served individual prepackaged juice cups that are frozen and that they do not thaw during the allotted meal period time. Krome food service staff and all staff members responsible for transporting and serving meals should ensure that food, including beverages, are "ready for consumption" and that problems are communicated to the food service department for immediate corrective action to ensure compliance with the PBNDS 2011/16 (2011/16, 4.1 Food Service, 2. Display and Service).
13. During interviews, numerous detainees reported that rice is served too frequently. A review of the 2021 Cycle Menu, approved by the Registered Dietitian on December 8, 2020, reveals that rice dishes are served an average of 10.5 times per week. In accordance with PBNDS 2011/16, "The food service program significantly influences morale and attitudes of detainees and staff and creates a climate for good public relations between the facility and the community." The food service manager should consult with the registered dietitian to evaluate the cycle menu (PBNDS 2011/16, 4.1 Food Service, E. Menu Planning, 1. General Policy).
14. The exteriors of the Igloo style plastic coolers used to dispense drinking water in the out-processing area and main barber shop were found to be dirty, especially around the spout, which could lead to contamination of the spout and/or the water contained therein. Krome should ensure that the water containers are regularly and thoroughly cleaned and sanitized (PBNDS 2011/16, 4.1 Food Service, V. Expected Practices, J. Safety and Sanitation, 7. Equipment and Utensils, g. Mechanical Cleaning and Sanitizing).
15. The detainee housing units were inspected and found to be generally clean except for a heavy buildup of dust and dirty grime on the hardware that bolts the bunkbeds to the floors and heavy accumulations of dust and dirt on the drawers of many of the bunkbeds. Numerous empty bunkbeds were also found to be dirty with accumulations of debris and dust. A high level of sanitation is required in detainee living areas to ensure good health. Krome should improve the sanitation in the facility to ensure compliance with the PBNDS (PBNDS 2011/16 2011/16, 1.2 Environmental Health and Safety standard, II. Expected Outcomes, 1).
16. The main barbershop was inspected on December 6, 2021, and numerous loose hair clippings were observed on the clipper guards and accumulated on the floor adjacent to the

wall. Krome supervisors and staff should ensure continuous compliance with the PBNDS, which requires proper sanitization of barbering equipment and supplies (PBNDS 2011/16 2011/16, 1.2 Environmental Health and Safety, E. Barber Operations, 3).

### Medical Care

CRCL's medical expert made the following recommendations related to PBNDS 2011/16 and the National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Jails.

17. Medical complaints were not always addressed timely. Almost one-third of the complaints reviewed took four to six days to address after sick call requests were submitted. All medical complaints especially those involving pain should be addressed within 48 hours of the submission of the complaint (PBNDS 2011/16, section V.A.6).

18. Plain x-rays done on site are not accomplished within a reasonable time frame. One file review showed that a provider ordered an x-ray of a detainee's finger which took two weeks to complete. (b) (5)

19. There is a lag time between initial intake screening and initial provider visits. Initial provider visits for detainees with medical conditions, such as chronic back pain, must occur within 72 hours. Again, tracking/trending and reports indicating the time lag between initial intake screening and initial provider visits are needed to identify weak points and outliers (PBNDS 2011/16, 4.3.V.M.).

20. Detainee medical needs are not properly assessed prior to transfer to other facilities. One file review included the transfer of a detainee while an oncology appointment was still pending without proper follow-up. Krome should ensure that serious medical conditions are appropriately reviewed prior to transferring detainees to other facilities. Krome should also ensure that appropriate follow up is arranged or, at the very least, that the medical information is communicated with the accepting entity (PBNDS 2011/16, std. 4.3. V. Z).

21. (b) (5)

22. Some serious medical conditions were not addressed timely. One detainee waited nearly five months for an appointment to address a serious eye injury, despite filing multiple sick call requests. Krome should enhance its quality improvement activities by establishing a tool to allow for tracking and trending important quality indicator measures to identify in real time outlier instances so that medical issues do not go unattended for longer than

absolutely needed. Serious medical conditions should receive expedited evaluation and prompt referrals for specialty care (PBNDS 2011/16, std. 4.3. II. 12) (NCCHC 2018. Std. J-D-08).

23. Timeliness of medication administration is lacking due to the use of a pill line that unnecessarily extends the time needed for medication administration. This leads to morning and evening medications being administered late as all detainees from the entire facility arrive at one location to receive their medications. In the usual scenario of using medication carts, several nurses can take carts to different housing locations, and the time to administer all medications to all detainees is markedly reduced. This process also markedly reduces the need for detainee movement. Krome should consider the use of medication carts (vs. pill lines) and Pyxis machines to improve the timeliness of medication administration and access to urgent/emergent and first dose medications in a manner that is trackable and safe (PBNDS 2011/16, 4.3.V.G.12).
24. Chronic care clinic follow-ups are not based on severity of illness or the degree of control. Lack of adherence to a system in which chronic care medical conditions are followed based on acuity or degree of control exposes the detainees to potential delay in care where more acute conditions may go unaddressed while less acute conditions are evaluated too frequently. Frequency of chronic care follow-up for medical evaluation must be based on the acuity of illness and status of disease control (NCCHC 2018, J-F-01.6.a).

### Mental Health Care

CRCL's mental health expert made the following recommendations related to PBNDS 2011/16 and the National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Jails 2018, and IHSC Directive 07-02.

25. Krome's confidential treatment space, staff's office space, and equipment were currently adequate but limited in the main clinic. Given the low detainee census and staff's willingness to coordinate utilization of confidential space, the delivery of mental health care was adequate; however, after COVID related restrictions are lifted and the population reaches capacity, both space and equipment would likely be inadequate. Krome should conduct a study on mental health's space and equipment needs, prior to the detainee moratorium being lifted (NCCHC, MH-D-03).
26. Medical record reviews of five detainees who were psychiatrically hospitalized revealed two detainees did not have a hospital discharge summary, or any follow-up documentation related to their hospitalization. Hospital discharge summaries and recommendations need to be filed in the medical record and the rationales for any changes to the treatment protocol need to be clearly documented by the treating clinician (PBNDS 2011/16, 4.3 Z) (NCCHC MH-E-09).
27. Record reviews of 4 detainees receiving outpatient services revealed an absence of structured treatment plans. Without these plans, treatment lost its direction, tending to focus on short term goals, while ignoring long term goals. The main clinic providing mental

health services to detainees living in general population and the special management unit needs to adopt a structured treatment plan (i.e., the plan used in KBHU). (NCCHC 2000, III, A and NCCHC essential standard J-G-04).

28. Record reviews of detainees placed on suicide watch revealed an absence of structured suicide watch treatment plans. To ensure quality and continuity of care, a CQI study is recommended to determine the scope of this finding and to develop an improvement plan that ensures structured suicide watch treatment plans are developed, added to the medical record, and implemented by the treatment team. These plans must include follow-up suicide risk assessments for patients on suicide precautions, completed by a behavior health professional, the clinical director, or an appropriate designee. They must also include secure housing accommodations which are least restrictive and meet the patient's special needs, individualized interventions, and step-down protocols (IHSC Directive 07-02) (BHS Guide, September 2020, VI-C, Treatment Planning).
29. Krome's suicide watch cell had two safety concerns. The first safety concern involved a metal box which could be used by detainees to injure themselves, and the second concern involved a sink which could be used to anchor a ligature as a means for hanging. The sink and metal utility box in the suicide watch cell should be replaced with a sink and box which cannot be used by detainees to harm themselves (PBNDS 2011/16 2011/16 Significant Self-Harm and Suicide Prevention Intervention, II Expected Outcomes).
30. There were bars on the sides of the beds in the two mental health observation cells which could be used as ligature anchors. Anchor points in the mental health observation cells should be removed (PBNDS 2011/16 2011/16 Significant Self-Harm and Suicide Prevention Intervention, II Expected Outcomes) (IHSC Directive 07-04, Suicide Prevention and Intervention).
31. As noted in the Conditions of Detention section above, staff who work in the medical housing unit which contains the suicide watch cell and two suicide observation cells, do not have access to cut-down tools. Custody officers should carry a cut-down tool on their person when assigned to the medical area, where detainees are placed on suicide watch or mental health observation (PBNDS 2011/16 2011/16 Significant Self-Harm and Suicide Prevention Intervention, II Expected Outcomes).
32. The Facility Health Care Program (FHPM) produced minutes from the last quarterly quality improvement committee meeting which included an update on a psychotropic medication compliance study and further opportunities for improvement. Despite this documentation, the Health Services Administrator (HSA) and frontline-mental healthcare providers from the main clinic and Krome Behavioral Health Unit (KBHU) were unaware of completed quality improvement studies involving mental health. The CQI committee's interdisciplinary composition, the meeting's comprehensive agenda, and updates to a data-based quality improvement study on psychotropic medication compliance suggested Krome's CQI program was well-developed. The CQI committee should examine why leadership and clinicians were unaware of mental health's quality improvement studies and develop a plan to engage critical staff. The CQI committee should educate staff on the value of CQI, noting that it is an industry standard with tools to improve the quality and

efficiency of care (NCCHC Standards 2008, MH-A-06, essential. Continuous Quality Improvement Program).

33. During the on-site visit, requests for a report identifying detainees receiving mental health services by diagnoses and medication had to be manually created. The CQI committee should work with IT and Eclinicalworks to reduce manual tabulation of data by optimizing automation of data collection to identify areas in need of improvement, to analyze data from improvement studies, to produce reports that could enhance the delivery of mental health services, and to identify what works well so staff could build on it, repeating success (NCCHC Standards 2008, MH-A-06, essential. Continuous Quality Improvement Program).

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 within 120 days indicating whether it concurs or does not concur with these recommendations. If you concur, please include an action plan. Please send your response and any questions to (b) (6). CRCL will share your response with (b) (6), the Policy Advisor who conducted this investigation.

Enclosures

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