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

April 28, 2021

MEMORANDUM FOR: Tae D. Johnson
Acting Director
U.S. Immigration and Customs Enforcement

John D. Trasviña
Principal Legal Advisor
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(b) (6)

FROM: Peter E. Mina
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SUBJECT: ICE Health Service Corps (IHSC) Medical/Mental Health Care and Oversight (Part II)
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, 18-10-ICE-0636

Purpose

The DHS Office for Civil Rights and Civil Liberties (CRCL) received information via the DHS Office of Inspector General (OIG) from a whistleblower alleging that U.S. Immigration and Customs Enforcement (ICE), ICE Health Service Corps (IHSC) systematically provided inadequate medical and mental health care and oversight to immigration detainees in facilities throughout the United States. Following a review of the information provided, CRCL opened and conducted an investigation examining the care and oversight provided to 17 detainees with serious medical or mental health conditions. CRCL used two medical subject matter experts and one mental health expert to review the specific care in those instances and following the experts' review sent on June 23, 2020, ICE specific findings and recommendations related to named facilities that provided the individual care. Subsequent to the issuance of the particularized recommendations, CRCL reviewed the investigative materials from a broad systemic level to assess whether any comprehensive issues needed to be addressed by ICE. This memorandum

discusses these systemic findings and makes formal recommendations addressing these concerns.

Summary

On July 18, 2018, CRCL received information via the OIG from an IHSC whistleblower who raised serious concerns regarding the quality of detainee medical and mental health care provided by IHSC at IHSC-staffed detention facilities, as well as IHSC's oversight of detainee medical and mental health care at all ICE detention facilities.[1] The allegations raised included 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;
- serious medication errors; and
- inadequate care and/or oversight for four detainees who died while in custody.

Furthermore, 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 contain allegations of retaliation against the complainant, these claims were handled directly by the OIG and CRCL did not investigate them.[2]

As mentioned above, CRCL engaged two medical subject matter experts and one mental health subject matter expert to review each of the 17 complaints in this investigation. They examined the medical care provided to each detainee, any reviews that were conducted assessing the care of those detainees, and any oversight and corrective action taken in each of the cases. In addition, where the Family Residential Standards (FRS) were deficient in medical care provisions, CRCL referred to the 2011 ICE Performance Based National Detention Standards (PBNDS 2011). Where the PBNDS 2011 or the FRS are deficient, recommendations were based on professional standards including those published by the National Commission on Correctional Health Care (NCCHC) 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.

The reports prepared by the experts and CRCL's findings and recommendations were sent to ICE on June 23, 2020, and focused on the care provided in the individual complaints. The corresponding recommendations were facility-specific in nature. ICE was to provide a response to CRCL in 60 days indicating whether it concurred or non-concurred with the recommendations. On January 5, 2021, CRCL received ICE's response and it is currently under

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[1] OIG received these allegations beginning in April 2018.

[2] While CRCL normally stands down through the entirety of an OIG investigation, the OIG agreed that CRCL should move forward with the medical-related investigations into these complaints and that the OIG would only retain the retaliation portion.

review.

After completion of the individual reviews mentioned above, CRCL reviewed IHSC's policies, procedures, and operations to determine if the individual allegations and findings were indicative of systemic issues. The corresponding systemic findings and recommendations are discussed here.

Summary of Individual Complaint Findings

Below is a summary of the individual findings contained in the expert reports. Generally, CRCL found several instances involving IHSC at the named facilities in which detainees were provided adequate access to care from multidisciplinary providers responsible for meeting the detainee's varying medical and mental health needs.[3] However, there were significant issues noted which are explained in more detail below. The specific complaint allegations, CRCL's findings, and CRCL's facility-specific recommendations are fully captured in our June 23, 2020 memorandum to ICE. For quick reference, the complaint allegations are attached to this memo as *Appendix A: Complaint Allegations* and the *Summary Expert Memorandum* can be found as *Appendix B.*

Of the 17 complaints, six involved medical care not connected to a detainee death.[4] In one complaint, CRCL's expert found that the care, which involved a 6-year old child at South Texas Family Residential Center in Dilley, Texas who developed a rare, life-threatening bone infection over several weeks while in ICE custody, was largely attentive and medically appropriate. Nevertheless, in that complaint, CRCL's medical SME did identify risk management concerns that warrant follow-up as part of the local institution's quality improvement process. [5]

Regarding the remaining five medical-related complaints, in four CRCL's experts found problems with the care and treatment of detainees who were withdrawing from alcohol and drugs.[6] In the final complaint CRCL found that the facility health care team's inadequate response could have resulted in a life-threatening bleeding event.[7]

In the nine complaints containing allegations about inadequate mental health care,[8] CRCL's experts found that the detainees requiring mental health care generally were seen regularly, their mental health visits were timely, rounds were completed timely, and sick call requests were addressed.[9] Further, clinical work was done largely on time and contacts between the detainee and provider were documented. In most cases, the facilities met basic standards. In some of the

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[3] Multidisciplinary providers are involved in a patient's overall care plan and can include a physician, psychiatrist, nurse, and other mid-level medical and mental health care professionals.

[4] Medical non-deaths: 18-10-ICE-0626, 18-10-ICE-0627, 18-10-ICE-0628, 18-10-ICE-0629, 18-10-ICE-0630, 18-10-ICE-063; Deaths: 17-06-ICE-0582, 18-09-ICE-0615, 18-08-ICE-0614

[5] 18-10-ICE-0630

[6] 18-10-ICE-0626, 18-10-ICE-0627, 18-10-ICE-0628, and 18-10-ICE-0629.

[7] 18-10-ICE-0631

[8] 18-10-ICE-0623, 18-10-ICE-0624, 18-10-ICE-0632, 18-10-ICE-0633, 18-10-ICE-0634, 18-10-ICE-0635, 18-10-ICE-0636, 18-09-ICE-0615, 18-10-ICE-0613. Note: 18-09-ICE-0615 is a detainee death that also included mental health concerns; therefore, it was reviewed by both a medical and mental health expert.

[9] 18-10-ICE-0636

cases, there was notably good collaboration between disciplines, including custody staff, to ensure that information was appropriately shared and that the disciplines were not acting at odds with one another.

Despite finding generally adequate mental health care,

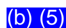
Role of IHSC

According to the Fiscal Year (FY) 2020 ICE Health Service Corps (IHSC) Annual Report, IHSC administered and managed a health care system that provided direct care to approximately 100,000 detainees housed at 20 designated facilities throughout the nation, to include medical, dental, mental health care, and public health services. [10] Further, IHSC oversaw health care for over 169,000 detainees housed in 148 non-IHSC-staffed facilities, totaling over 51,000 beds. In direct care situations, IHSC has its own policies and procedures regarding detainee care that apply only in the facilities where it directly provides medical care. In its additional oversight role, IHSC provide general oversight to facilities housing ICE detainees to ensure they meet the relevant national detention standards regarding detainee medical and mental health care. For the complaints in this investigation, IHSC provided direct care at each of the relevant facilities. [11]

Analysis

As stated above, in this memorandum, CRCL is looking across the individual complaints and addressing any larger concerns with medical or mental health care provided by or overseen by IHSC. Below are the areas CRCL believes need further attention from a systemic level.

Alcohol and Drug Withdrawal



[10] According to ICE ERO's Facility List Report dated November 9, 2020, IHSC provides direct care at the following 20 facilities: South Texas ICE Detention Center, LaSalle ICE Processing Center, Montgomery ICE Processing Center, Eloy Federal Contract Facility, Tacoma ICE Processing Center (Northwest Det Ctr), Otay Mesa Detention Center (San Diego CDF), Krome North Service Processing Center, El Paso Service Processing Center, Buffalo (Batavia) Service Processing Center, York County Prison, Port Isabel, Houston Contract Detention Facility, Caroline Detention Facility, South Texas Family Residential Center, Elizabeth Contract Detention Facility, Alexandria Staging Facility, Florence Service Processing Center, T Don Hutto Residential Center, Florence Staging Facility, and Berks County Family Shelter.

[11] Florence Service Processing Center (SPC), Elizabeth Contract Detention Facility, South Texas Family Residential Center (STFRC), Stewart Detention Center (SDC), LaSalle ICE Processing Center (Jena), Eloy Federal Contract Facility (EFCF), El Paso Service Processing Center (SPC), Tacoma ICE Processing Center ("Northwest Detention Center")

For example, in Complaint No. 18-10-ICE-0627, (b) (5)

[12]

In Complaint No. 18-10-ICE-0629, a detainee reported at intake a history of opiate use and dependence and history of opiate withdrawal. (b) (5)

In Complaint No. 18-10-ICE-0628, (b) (5)

CRCL is not drawing the conclusion that all instances of withdrawal are not properly treated by IHSC based upon the above complaints. (b) (5)

Mental Health

(b) (5)

Segregation Screening

12 (b) (5)

(b) (5)

For example, in Complaint No. 18-10-ICE-0613, the detainee was placed in segregated housing despite having a serious mental illness with active symptoms, being off all medications, and having just returned from a psychiatric inpatient stay. The detainee had self-reported a serious mental illness (schizophrenia with hallucinations) and regularly shared his symptoms with officers, nurses, and mental health practitioners. A Registered Nurse (RN) cleared the detainee for disciplinary segregation placement shortly after his return from an inpatient psychiatric hospital stay and the clearance occurred without the RN having personal contact with the detainee or taking his vitals (b) (5)

In Complaint No. 18-10-ICE-0624, the detainee was cleared for disciplinary segregation after threatening an officer. The RN completed the screening for placement and reflected on the screening form that he had no history of mental health care; however, CRCL's review shows that the detainee arrived at the facility with anxiety and depression, acknowledging a history of self-harm via cutting, and reporting hallucinations. He was not stable on medications when the incident resulting in placement in disciplinary segregation occurred.

In Complaint No. 18-10-ICE-0633, the detainee arrived at the facility acknowledging frequent suicide watch placements, depression and self-harm via cutting while stressed. He was seen by the mental health provider then placed in the mental health unit and given forced injectable medications. He was cleared by an RN for disciplinary segregation with a note stating, "no history of mental illness or mental health encounters at current facility" despite having been seen by a psychiatrist one day prior.

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[13] Administrative or disciplinary

[14] Per IHSC Directive 03-06: Health Evaluation of Detainees in Special Management Units.

Involuntary Administration of Psychotropics

IHSC policy requires that the involuntary administration of psychotropic medications can only occur when a physician has declared that the detainee is experiencing a psychiatric emergency and poses a risk of harm to self or others, and all less restrictive options have been exercised without success.[15] b (5)

[16] For example, in Complaint No. 18-10-ICE-0633, (b) (5)

In Complaint No. 18-10-ICE-0632, (b) (5)

In Complaint No. 18-10-ICE-0634, the detainee was given a forced IM medication as a primary means to address his behavioral concerns. The detainee was placed into segregation after becoming agitated with officers and engaging in head banging. He was then moved to a padded cell nearby for observation where he tied a sweatshirt around his neck. A team of four officers entered the cell, took him down to the floor to remove the sweatshirt, and medical staff gave one or two IM Haldol injections (the record is unclear). (b) (5)

SMI Lists

SMI lists, when used as intended, provide another layer of oversight, adequate documentation and consultation, and service plans to address detainee serious mental health concerns. According to IHSC policy, IHSC is responsible for 1) providing consistent and continued care of all detainees who are identified with serious mental disorders or conditions, 2) ensuring detainees with a serious mental illness (SMI) are referred for mental health services, and 3) evaluating and monitoring patients with an SMI closely to provide consistent, timely, and adequate care.[17]

Facility behavioral health care providers are responsible for completing and submitting an SMI list on a weekly basis for continued monitoring of their seriously mentally ill detainees. The

[15] IHSC Directive 07-02: Behavioral Health Services (Overview), 4-15: Forced Emergency Psychotropic Medication states "Involuntary administration of psychotropic medications to a detainee can only occur when a physician has declared a psychiatric emergency with a risk of harm to self or others, and all less restrictive options have been exercised without success."

[16] IHSC Directive 07-02: Behavioral Health Services (Overview), 4-15: Forced Emergency Psychotropic Medication states "Involuntary administration of psychotropic medications to a detainee can only occur when a physician has declared a psychiatric emergency with a risk of harm to self or others, and all less restrictive options have been exercised without success."

[17] IHSC Directive 07-05: Serious Mental Disorders or Conditions

Behavioral Health Unit (BHU) at IHSC is charged with monitoring detainees with significant psychiatric impairments via the SMI lists. (b) (5) The six complaints include:

Complaint No. 18-10-ICE-0623: The detainee expressed psychotic symptoms over time at the facility.

Complaint No. 18-10-ICE-0624: The detainee presented with a high risk of suicide, suicidal threats, and reported symptoms of psychosis.

Complaint No. 18-10-ICE-0632: The detainee was placed on the SMI list, but removed approximately two weeks later when she was reported to no longer meet the criteria despite continuing to report voices and having recent experience of psychiatric hospitalization, forced medications, and recent self-harm ideations.

Complaint No. 18-10-ICE-0635: The detainee experienced major depressive disorder with psychotic features, had two inpatient psychiatric hospitalizations, and was involuntarily medicated at the detention facility.

Complaint No. 18-10-ICE-0636: Despite reporting hallucinations, active psychotic symptoms, reporting threats to harm self, and being inconsistently medicated, the detainee was not placed on the SMI list.

Complaint No. 18-10-ICE-0613: The detainee was placed on the SMI list by a Licensed Clinical Social Worker (LCSW) when he exhibited psychotic symptoms, religious delusions, paranoia, and threats of self-harm. A week later, he was removed from the list by a Nurse Practitioner (NP) while still exhibiting the same symptoms. The following week, a LCSW placed him back on the SMI list.

Psychotropic Medication Administration and Adjustment

(b) (5)

For example, in Complaint No. 18-10-ICE-0623, while the detainee acknowledged a history of mental illness, including current symptoms at the time of intake, the facility did not provide him with medications until five months after intake, despite being seen by psychiatric providers and mental health staff. (b) (5)

In Complaint No. 18-09-ICE-0615, the detainee's transfer summary recognized the detainee's schizophrenia diagnosis and included packaged medications with which to travel. The Nurse Practitioner (NP) at the facility continued his medication order; however, the detainee did not receive those medications and was two days without psychiatric medications that he had been reportedly taking for several years. Several days later, the detainee was seen by the psychiatrist who continued the medications and reportedly intended to add another medication to mitigate any side effects of the antipsychotic medications; however, that order was never completed.

Specialized Mental Health Care Services and Referrals

(b) (5) The need for a higher level of care—including circumstances when mental health staff made written recommendations for increased care—were not regularly noted, and did not result in appropriate referrals or placements per IHSC policy.[18] Additionally, IHSC medical staff did not pay consistently adequate attention to factors indicating this need, including increased hallucinations, psychotic symptoms, recent psychiatric hospitalizations, and recent self-harm ideation.

For example, in Complaint No. 18-10-ICE-0632, (b) (5).

Initially, following an IM of Ativan, the detainee was placed in the medical housing unit (MHU) for observation. During rounds over the next days, she was seen with active symptoms of psychotic illness including crying, pounding on the door, making bizarre hand movements, stomping her feet, and vacillating between yelling and crying. The mental health staff is noted as having instructed the detainee to stop acting out and seeking attention. During ensuing visits, the detainee was observed to be flapping her arms like a bird with a blank stare, being non-responsive to staff, doing "karate chops" with her hands, and mumbling to herself. She also attempted to choke herself with her hands and screamed that she deserved to die. A referral to inpatient care was made for the detainee. She was sent to the hospital and returned the same day with an antipsychotic medication. The same day, the detainee was observed to be eating toilet paper and Styrofoam, and she was referred for a longer inpatient stay. Two weeks later, after not being transferred, the detainee was removed from the SMI list and the referral was cancelled when the detainee was noted to have "finally stopped her behaviors."

In Complaint No. 18-10-ICE-0636, the detainee was recommended for inpatient psychiatric placement, but was not referred or placed in the hospital until nearly two months later and experienced mental health deterioration as he waited which included hallucinations, active psychotic symptoms, and threatening to harm himself.

In Complaint No. 18-10-ICE-0613, the detainee had an inpatient psychiatric facility stay during his detention where a medication regimen was initiated. Upon returning to the facility, he

[18] IHSC Directive 07-02: Behavioral Health Services (Overview), 4-15.

continued to experience religious delusions and a fixation on death. Twice in the last days of his life, a social worker indicated that he could benefit from a higher level of care; however, he was not referred. On the day of his death, the detainee reported to a social worker that he was going to die and subsequently committed suicide via hanging by use of his socks.

After-Action Reporting

Each of the seven complaints reviewed by CRCL's mental health expert that did not involve a detainee death lacked complete after-action reporting to address issues related to the facility's care, such as a Root Cause Analysis (RCA)[19] or Uniform Corrective Action Plan (UCAP).[20] Having one of these in place improves patient safety by preventing future harm and avoiding undesirable outcomes.

In one of the complaints,[21] based on the information provided to CRCL, a "Documentation of Review of Adverse Events" was initiated by IHSC, but there was no evidence that any of the follow-up actions were completed as a result of the report. Specifically, the IHSC Medical Quality Management Unit (MQMU) performed an analysis of the detainee's IM; the findings including policy and procedure violations were forwarded to IHSC leadership for review and action, but none was taken. MQMU also made a separate request to IHSC's Chief Psychiatrist to review the case who, upon doing so, subsequently detailed his own concerns, including that involuntary medications were administered without first trying less invasive options ; that the documentation was inadequate; that medications were ordered in an inappropriate order;[22] and that the provider did not provide appropriate follow-up, including no follow-up medical examination of the detainee. The Chief Psychiatrist also noted that there was no on-site psychiatry services at the facility and reported that the mid-level provider may have ordered the medication without consulting with a physician.

[19] Root Cause Analysis (RCA) and Uniform Corrective Action Plan (UCAP) are both defined in IHSC's December 2019 Risk Management Activities Program Guide. The Guide, which was designed to promote patient safety and the utilization of evidence-based risk analysis within the IHSC health care system, sets forth a Risk Management Event Flow Process (beginning with an incident report generated by facility medical personnel), and outlines the RCA Process. RCA is defined as a multidisciplinary analysis tool utilized to identify basic and/or contributing causal factors associated with an unwanted outcome and sentinel event. A Risk Manager (RM) is responsible for initiating the RCA processes for all high to extreme risk events. Additionally, an RCA may be initiated for moderate events at the discretion of the facility's leadership and/or Risk Management Director (RMD).

[20] An IHSC Uniform Corrective Action Plan (UCAP), or "Action Plan" (AP), is defined as a strategy for correcting or eliminating a problem that has already occurred or been identified (as opposed to a preventive action plan which defines the steps taken to eliminate the root cause of a problem). A UCAP may arise from an RCA, review, inspection, etc., and involves providing an assessment and findings of deficiencies, a corresponding recommendation, a corrective plan of action, and completion date. Methods used to implement UCAPs may include training, staffing, equipment, communication, or SOP/policy.

[21] 18-10-ICE-0635

[22] Injectable medications were administered on three separate occasions in an order that was noted to be less effective (Haldol, then Benadryl followed by Ativan).

Death Cases

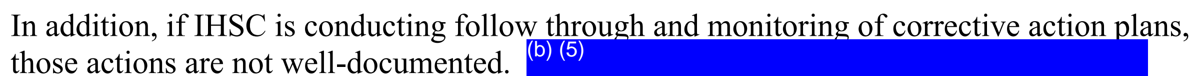
The complainant's principal allegation regarding deaths in ICE custody was that IHSC does not appropriately respond to allegations or findings of inappropriate medical and mental health treatment that were found during detainee death reviews. CRCL does not substantiate that allegation in the three deaths reviewed here.

Overall, CRCL found that the IHSC and ICE's Office of Detention Oversight (ODO) appropriately investigates detainee deaths and related allegations of inappropriate medical and mental health care. (b) (5)

Regarding substantive follow-up to the RCAs and UCAPs, when problems are identified, a corrective action plan with specific interventions and measurable outcomes should be well-documented and followed up on to re-evaluate and document its effectiveness. This requires internal policies and processes in place to ensure that RCAs and UCAPS are appropriately shared and tracked, but based on information provided by IHSC, there is not a Standard Operating Process (SOP) in place to do this.

CRCL found that IHSC's data collection process for detainee death investigations is comprehensive and often results in concrete recommendations. While IHSC's Mortality Reviews and ODO's Detainee Death Reports link their findings to relevant detention standards including the relevant ICE detention standards, NCCHC, and IHSC Directives, the IHSC RCAs and/or UCAPs were often missing these benchmarks, as evidenced in the documents pertaining to Complaint Nos. 18-09-ICE-0615 and 18-08-ICE-0614.

In addition, if IHSC is conducting follow through and monitoring of corrective action plans, those actions are not well-documented. (b) (5)



Continuous Quality Improvement

Data driven quality improvement processes are considered a foundational principle and practice of modern medicine, yet the seriousness of the medical and mental health issues that the detainees experienced in these complaints demonstrates the need to develop or improve policies and procedures in this area that might prevent similar outcomes.

Continuous quality improvement requirements related to the provision of medical and mental health care for ICE detainees is included in the 2011 Performance Based National Detention

Standards (PBNDS). PBNDS 2011, Section 4.3 BB. 2, stipulates that such systems include, among other things:

- Collection, trending and analysis of data along with planning, interventions and reassessments;
- Analysis of the need for ongoing education and training;
- *Monitoring of corrective action plans;*
- Reviewing all deaths, suicide attempts and illness outbreaks;
- *Developing and implementing corrective-action plans* to address and resolve identified problems and concerns;
- *Reevaluating problems or concerns, to determine to determine whether the corrective measures have achieved and sustained the desired results;*
- Incorporating findings of internal review activities into the organization's educational and training activities;
- Maintaining appropriate records of internal review activities.

[Emphasis added]

Separately, IHSC Directive 11-06, Risk Management Policy, directs the Regional Compliance Specialist to oversee the implementation of action plans associated with RCAs.

The relevant NCCHC standard, P-A-06, Continuous Quality Improvement (CQI) Program, outlines the required components of a CQI program in the correctional setting. The standard emphasizes the importance of a structured process to identify areas in need of improvement; developing and implementing corrective action plans; and restudying identified problems to assess the effectiveness of the corrective action plan.

NCCHC Standards for Mental Health Services (MH-A-06, an essential standard) requires that "a continuous quality improvement (CQI) program monitors and improves mental health care delivered in the facility." Further, in order to be compliant with the standard, "the mental health care delivery system is systematically analyzed for needed improvement, and when a need is identified, that staff develop, implement, and monitor strategies for improvement."

Specifically, "the [NCCHC] CQI program for mental health services completes: an annual review of the effectiveness of the CQI program by reviewing CQI studies, minutes of administrative and staff meetings, results of mental health record reviews, and other pertinent written materials; at least one process quality improvement study and one outcome quality improvement study each year; and an annual review of deaths and serious incidents involvement inmates with mental illness to identify trends and needed corrective actions." A robust mental health quality assurance/quality improvement program including routine monitoring, target improvement studies, and case reviews would have assisted in identifying and addressing some of the issues noted in reviewing these records.

IHSC's Updated Quality Improvement Policies

On May 6, 2020, IHSC provided CRCL with the following updated policies and guidance: Quality Improvement Program Guide (Effective Date: August 12, 2019); IHSC Directive: 11-02, Quality Improvement Program (Effective Date: August 12, 2019); IHSC Directive: 11-06, Risk Management Policy (Effective Date: December 2, 2019); and Risk Management Activities Program Guide (December 2019). These updated policies were implemented after the complaints and address many of the quality improvement concerns we identified in our investigation.

(b) (5) The Regional Compliance Specialist is key to ensuring that RCA Action Plans are fully implemented with CQI oversight. Our medical experts found the tools, particularly Appendix F (QI Program) and Appendix G (Risk Management Program), to be excellent. Both appendices include detailed tracking of information that can serve to drive accountability.

CRCL is very pleased that its planned recommendations regarding quality improvement as outlined below are consistent with IHSC's December 2019 Risk Management Activities Program Guide, and thus, these recommendation have largely been proactively satisfied. That said, because a complete CQI process requires constant review and improvement, (b) (5)

Findings and Recommendations

1. (b) (5)

2. Medical and mental health staff across multiple facilities did not initially engage a physician soon after intake to manage patients' supervised withdrawal from multiple substances. **IHSC should implement strategies, such as policy changes, targeted training, or other steps, to ensure timelier physician engagement when managing detainees who have recently arrived and require supervised withdrawal from substances.**

3. In their review of the individual cases, CRCL's medical experts found a recurring problem with inadequate management of patients withdrawing from substances, such as alcohol, opioids, and benzodiazepines. The issues identified were dispersed across

multiple facilities, suggesting that they were pervasive in nature rather than simply a matter of addressing a poor practice at one particular facility or with an individual provider, therefore, indicating that potential policy and training issues exist and the need for additional oversight is required. **IHSC should conduct a broad review to determine the need for system-wide quality improvement measures for managing newly detained patients withdrawing from substances.**

4. The use of the SMI list was concerning in the majority of the mental health related cases that were reviewed, and showed lapses such as, not placing detainees on the SMI list when they were clearly exhibited symptoms of psychotic illness and met criteria for the status, or removing detainees from the SMI list while still exhibiting symptoms. The reasons for inconsistent and inappropriate use of the list are unknown; therefore: **IHSC should conduct a Root Cause Analysis (RCA) to understand the reason the list is underutilized and efforts should be made to mitigate the identified concerns; and IHSC should retrain its staff on criteria for placing detainees on the SMI list.**

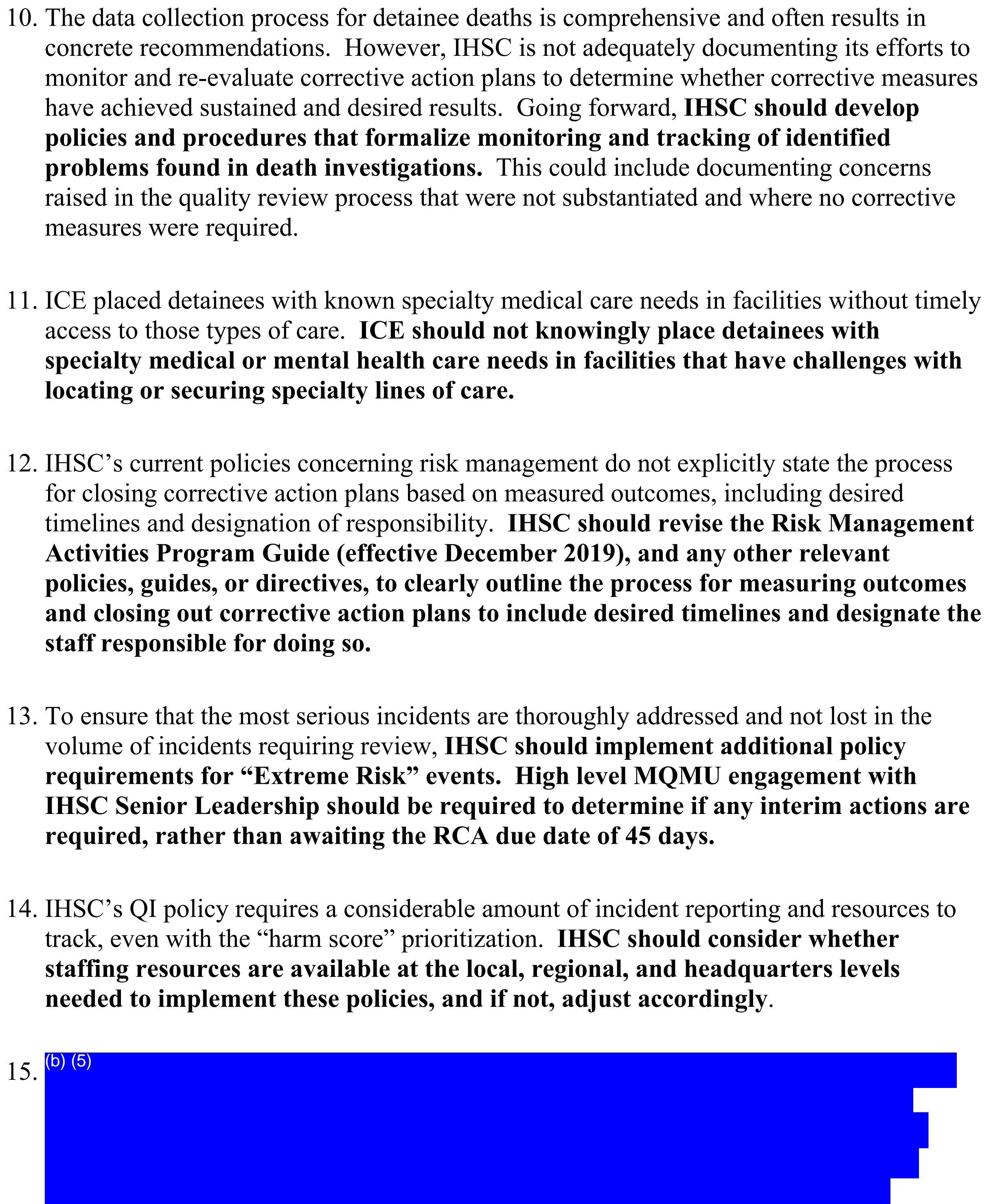
5. Medical and mental health staff across multiple facilities did not conduct a medical and/or mental health review prior to a detainee's segregation placement. **IHSC should review its policy on conducting medical or mental health reviews before a detainee is placed into a segregated status, conduct additional training with all medical and mental health staff, and conduct regular audits of placements.**

6. The use of forced IM medication in multiple instances across facilities is not consistent with policy or practice. This includes using IM as a first resort or primary intervention rather than making other treatment efforts first. Alternatively, forced IM was also found to be used as a primary means to address behavioral concerns for a detainee with no reported mental health conditions or suicidal issues exhibited. **IHSC should re-train medical providers on utilization of forced medication.**

7. IHSC did not pay adequate attention to the factors indicating a need for a higher level of care, including increased hallucinations, psychotic symptoms, recent psychiatric hospitalizations, and recent self-harm ideations. **IHSC should retrain its medical leadership on policies regarding referring detainees with active mental health concerns to facilities better able to address their needs.**

8. IHSC did not appropriately adjust medication for detainees across multiple facilities to address their increasing psychotic symptoms. (b) (5)

9. IHSC does not appear to have a standard process to effectively share and track RCAs and UCAPs. **IHSC should implement a standard operating procedure (SOP) for appropriately sharing and tracking both RCAs and UCAPs.**



10. The data collection process for detainee deaths is comprehensive and often results in concrete recommendations. However, IHSC is not adequately documenting its efforts to monitor and re-evaluate corrective action plans to determine whether corrective measures have achieved sustained and desired results. Going forward, **IHSC should develop policies and procedures that formalize monitoring and tracking of identified problems found in death investigations.** This could include documenting concerns raised in the quality review process that were not substantiated and where no corrective measures were required.

11. ICE placed detainees with known specialty medical care needs in facilities without timely access to those types of care. **ICE should not knowingly place detainees with specialty medical or mental health care needs in facilities that have challenges with locating or securing specialty lines of care.**

12. IHSC's current policies concerning risk management do not explicitly state the process for closing corrective action plans based on measured outcomes, including desired timelines and designation of responsibility. **IHSC should revise the Risk Management Activities Program Guide (effective December 2019), and any other relevant policies, guides, or directives, to clearly outline the process for measuring outcomes and closing out corrective action plans to include desired timelines and designate the staff responsible for doing so.**

13. To ensure that the most serious incidents are thoroughly addressed and not lost in the volume of incidents requiring review, **IHSC should implement additional policy requirements for "Extreme Risk" events. High level MQMU engagement with IHSC Senior Leadership should be required to determine if any interim actions are required, rather than awaiting the RCA due date of 45 days.**

14. IHSC's QI policy requires a considerable amount of incident reporting and resources to track, even with the "harm score" prioritization. **IHSC should consider whether staffing resources are available at the local, regional, and headquarters levels needed to implement these policies, and if not, adjust accordingly**.

15. (b) (5)

It is CRCL's statutory role to oversee DHS's compliance with constitutional, statutory, regulatory and policy requirements relating to the civil rights and civil liberties of all individuals affected by DHS programs and activities. In turn, CRCL advises 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. The above recommendations are made pursuant to that role; we believe they will assist you in meeting ICE's important mission. Please inform CRCL within 60 days whether you concur or non-concur with the recommendations; if you concur, please provide an action plan. Both communications can take place by emailing or calling CRCL Policy Advisor b (5) or (b) (5)

Enclosures

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