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

March 20, 2019

MEMORANDUM FOR: Ronald Vitiello
Deputy Director and Senior Official
Performing the Duties of the Director
U.S. Immigration and Customs Enforcement

Michael P. Davis
Executive Deputy Principal Legal Advisor
Office of the Principal Legal Advisor
U.S. Immigration and Customs Enforcement

FROM: Cameron P. Quinn
Officer for Civil Rights and Civil Liberties

Marc Pachon
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SUBJECT: 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, 18-10-ICE-0636

The DHS Office for Civil Rights and Civil Liberties (CRCL) has received information from the DHS Office of Inspector General (OIG) alleging that Immigration and Customs Enforcement's (ICE) ICE Health Service Corps (IHSC) has systematically provided inadequate medical and mental health care and oversight to immigration detainees in facilities throughout the U.S. The purpose of this memorandum is to notify you of the complaints and describe the allegations, and inform you that, consistent with its authority described in the CRCL and Scope of Review sections below, CRCL will retain the complaints for investigation and explain how CRCL will work with ICE during our 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. 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 means 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.

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.

In addition to the specific complaint allegations, CRCL will look at IHSC's policies, procedures, and operations more generally to determine if the individual allegations or findings are indicative of systemic issues. While the complaints also contain allegations of retaliation against the complainant, CRCL will not be investigating these claims and they will be handled directly by the OIG.[1]

ALLEGATIONS

1. Complaint No. 18-10-ICE-0623

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at the Eloy Federal Contract Facility in Eloy, Arizona. According to the complaint, IHSC Medical Quality Management Unit ("MQMU") notified the facility psychiatrist several times about [REDACTED] worsening psychosis-related symptoms, but the psychiatrist failed to treat him. [REDACTED] allegedly became so unstable that he lacerated his penis, requiring hospitalization and surgery.

2. Complaint No. 18-10-ICE-0624

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at the Eloy Federal Contract Facility in Eloy, Arizona. Allegedly, [REDACTED] was not treated appropriately for serious mental illness with psychotic-like symptoms. According to the complainant, MQMU warned IHSC senior leadership on two occasions about [REDACTED] increased risk of adverse outcomes due to his auditory hallucinations and suicidal ideations. This allegedly resulted in [REDACTED] not receiving anti-psychotic medication, despite the IHSC chief psychiatrist's agreement with the MQMU's findings and recommendation that [REDACTED] receive anti-psychotic

[1] The handling of these complaints differ from CRCL standard practice in that the OIG also has open complaints on these matters. While CRCL normally stands down through the entirety of an OIG investigation, the OIG has indicated that CRCL may move forward with its investigations into the aforementioned medical care issues irrespective of the OIG investigations on separate topics.

medication. Instead, [REDACTED] received an anti-depressant which likely worsened his psychosis. The complainant further claimed that following MQMU's second notification of inadequate mental health care and treatment, IHSC senior leadership allegedly advised MQMU to "hold off" on notifying IHSC Clinical Services unless and until the detainee became psychotic and suicidal again.

3. Complaint No. 18-10-ICE-0626

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at Florence Service Processing Center (SPC) in Florence, Arizona. Allegedly, facility medical staff did not follow policies and procedures concerning withdrawal protocols for [REDACTED] opioid withdrawal. According to the complainant, the detainee was not treated until MQMU staff called the facility following a review of a significant event notification (SEN). The detainee was subsequently found to be in severe benzodiazepine withdrawal and was admitted to the hospital. Further, the complainant alleges that MQMU performed an analysis of the case and the findings included policy and procedure violations, which were forwarded to IHSC leadership for review and action, yet IHSC leadership failed to take appropriate action.[2]

4. Complaint No. 18-10-ICE-0627

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at Florence Service Processing Center (SPC) in Florence, Arizona. Allegedly, facility medical staff did not follow policies and procedures concerning withdrawal protocols for [REDACTED] benzodiazepines withdrawal. According to the complainant, medical staff did not address his withdrawal at intake, despite his reporting high levels of daily consumption of benzodiazepines. [REDACTED] subsequently went into drug withdrawal seizures and was admitted to the hospital. Further, the complainant alleges that MQMU performed an analysis of the case and the findings included policy and procedure violations, which were forwarded to IHSC leadership for review and action, yet IHSC leadership failed to take appropriate action.[3]

5. Complaint No. 18-10-ICE-0628

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at Elizabeth Contract Detention Facility in Elizabeth, New Jersey. Allegedly, facility medical staff did not follow policies and procedures concerning withdrawal protocols for [REDACTED] alcohol withdrawal. [REDACTED] stated during his intake screening that he consumed one bottle of vodka and two bottles of beer daily. [REDACTED] subsequently went into severe alcohol withdrawal and delirium and was admitted to the hospital in the intensive care unit (ICU). Further, according to the complainant, MQMU performed an analysis of the case and the findings included policy and procedure

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[2] 1) Directive by Deputy Assistant Director Dr. Rivera dates 11/3/2017 regarding physician supervision of detoxifications and transfer of detainees experiencing a severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal to a licensed acute care facility and 2) *IHSC Directive: 03-13 section 4-7: Monitoring of Detainees in Withdrawal*

[3] 1) *IHSC Directive: 03-13 Section 4-7: Monitoring of Detainees in Withdrawal,* 2) Directive by Deputy Assistant Director Dr. Rivera dates 11/3/2017 regarding physician supervision of detoxifications and transfer of detainees experiencing a severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal to a licensed acute care facility, and 3) *IHSC Directive: 03-10: Intake Screening and Intake Reviews Section 4-4(a)*

violations, which were forwarded to IHSC leadership for review and action, yet IHSC leadership failed to take appropriate action.[4]

6. Complaint No. 18-10-ICE-0629

CRCL received a referral from the DHS OIG regarding [redacted], an ICE detainee at Florence Service Processing Center (SPC) in Florence, Arizona. Allegedly, facility medical staff did not follow policies and procedures concerning withdrawal protocols for [redacted] opioid withdrawal, and a medication error occurred during the course of his treatment. Further, according to the complainant, MQMU performed an analysis of the case and the findings included policy and procedure violations, which were forwarded to the IHSC leadership for review and action, yet IHSC leadership failed to take appropriate action.[5]

7. Complaint No. 18-10-ICE-30

CRCL received a referral from the DHS OIG regarding [redacted], an 8-year old resident at South Texas Family Residential Center (STFRC) in Dilley, Texas. Allegedly, delayed medical care and misdiagnosis led to an infection that spread from the child's ear to his facial bone, requiring a partial bone resection. According to the information provided, on December 5, 2017, the child's mother first reported that her child had a progressively worsening earache for the past two weeks. The child was subsequently treated using nursing guidelines for Allergies/Fever/Pain, diagnosed with Swimmer's Ear, and given ear drops. However, on December 23, 2017, the child was noted to have seizure activity and was transferred to the hospital where he was diagnosed with Pott's Puffy Tumor with epidural and subdural abscess resulting in partial frontal bone resection. Further, the complainant alleged that MQMU performed an analysis of the case and found that the inadequate medical care provided by STFRC was a contributory factor resulting in harm. MQMU's report was forwarded to IHSC leadership and MQMU requested findings and/or interventions from Clinical Services, yet IHSC leadership failed to take appropriate action.

8. Complaint No. 18-10-ICE-0631

CRCL received a referral from the DHS OIG regarding [redacted], an ICE detainee at Stewart Detention Center in Lumpkin, Georgia. Allegedly, a delay in care occurred after medical staff were notified of the detainee's critical lab result that should have resulted in immediate medical intervention. [redacted] was reportedly bleeding through his skin and having vision changes. Despite having extremely thin blood, the physician allegedly kept him on aspirin regimen for six days, resulting in his coughing up large amounts of blood. [redacted] was taken to the hospital in critical condition and not expected to survive. MQMU performed an analysis of the case

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[4] MQMU reportedly found that: 1) Nursing staff did not specify the frequency of use of alcohol on intake, 2) Physician oversight was not initiated, 3) the CIWA-A score was not obtained at intervals recommended by the Federal Bureau of Prisons withdrawal guidelines, 4) the detainee was housed in the dormitory and not in a MHU setting, and 5) initiation of a benzodiazepine was not considered even though the detainee has a history of alcohol use.

[5] 1) *IHSC Directive 03-13: Detainee with Substance Dependence or Abuse: Section 4-7: Monitoring of Detainees in Withdrawal, 2) IHSC Directive 03-13: Detainees with Substance Dependence or Abuse: Section 4-3: Behavioral Health Evaluation, 3) IHSC Guide 09-02-G-01: Pharmaceutical Services and Medication Management Guide Section C: Verbal Orders and 4) IHSC Directive 03-13: Detainees with Substance Dependance or Abuse: Section 4-6: Housing*

and determined that that Asprin therapy may have caused harm that could have resulted in a fatality. The findings were forwarded to IHSC leadership for consideration of a root cause analysis, yet IHSC leadership failed to take appropriate action.

9. Complaint No. 18-10-ICE-0632

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at Jena/LaSalle Detention Facility in Jena, Louisiana. [REDACTED] was sent to the hospital Emergency Room due to erratic behavior and convulsions. When she returned to the facility, she was observed eating toilet paper and styrofoam in the Medical Housing Unit (MHU). According to the complainant, [REDACTED] was placed at higher than normal risk for mental status deterioration and given forced intramuscular injection of Ativan. Further, the complainant alleged that MQMU performed an analysis of the case and the findings included policy and procedure violations, which were forwarded to IHSC leadership for review and action, yet IHSC leadership failed to take appropriate action.[6]

10. Complaint No. 18-10-ICE-0633

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at Jena/LaSalle Detention Facility in Jena, Louisiana. Allegedly, [REDACTED] was forcibly medicated with multiple Ativan injections for repeated behavioral issues. Further, MQMU performed an analysis of the case and the findings included policy and procedure violations, which were forwarded to IHSC leadership for review and action, yet IHSC leadership dialed to take appropriate action.[7]

11. Complaint No. 18-10-ICE-0634

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at El Paso Service Processing Center (SPC) in El Paso, Texas. According to the information provided, [REDACTED] was observed with a sweatshirt around his neck and four correctional officers held him down while medical staff administered a haloperidol intramuscularly by force. According to the complainant, MQMU performed an analysis of the case and

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[6] 1) *IHSC OM 19-025: Forced Emergency Psychotropic Medication*, 2) *IHSC OM Section 4-1 Consideration of Alternatives to Forced Emergency Psychotropic Medication*, 3) *IHSC OM Section 4-2: Ordering of Forced Emergency Psychotropic Medication*, 4) *IHSC OM* Section 4-3: *Direct Observation of Detainees given Forced Emergency Psychotropic Medication*, subsection (a), 5) *IHSC OM Section 4-5*: *Maximum use of Forced Emergency Psychotropic Medication*, 6) *IHSC OM Section 5-7: Forced Emergency Psychotropic Medication Debriefing*, and 7) I*HSC Directive: 07-05: Serious Mental Disorders or Conditions*

[7] 1) *IHSC OM 19-025: Forced Emergency Psychotropic Medication*, 2) *IHSC OM Section 4-1 Consideration of Alternatives to Forced Emergency Psychotropic Medication*, 3) *IHSC OM Section 4-2: Ordering of Forced Emergency Psychotropic Medication*, 4) *IHSC OM* Section 4-3: *Direct Observation of Detainees given Forced Emergency Psychotropic Medication*, subsection (a), 5) *IHSC OM Section 4-5: Maximum use of Forced Emergency Psychotropic Medication*, 6) *IHSC OM Section 5-7: Forced Emergency Psychotropic Medication Debriefing*, and 7) *IHSC Directive: 07-05: Serious Mental Disorders or Conditions*

the findings included policy and procedure violations, which were forwarded to IHSC leadership for review and action, yet, IHSC leadership failed to take appropriate action.[8]

12. Complaint No. 18-10-ICE-0635

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at El Paso Service Processing Center (SPC) in El Paso, Texas. Allegedly, [REDACTED] was forcibly medicated for reported behavioral issues. MQMU performed an analysis of the case and the findings included policy and procedure violations, which were forwarded to IHSC leadership for review and action, yet IHSC leadership failed to take appropriate action.[9]

13. Complaint No. 18-10-ICE-0636

CRCL received a referral from the DHS OIG regarding [REDACTED], an ICE detainee at Northwest Detention Facility in Tacoma, Washington. According to the complainant, MQMU noted that despite [REDACTED] having a significant psychiatric history and medication non-compliance, he was not being monitored by facility mental health staff. MQMU notified IHSC senior leadership in the Behavorial Health Unit (BHU) that based on their review, [REDACTED] was at high risk for suicide. Allegedly, BHU leadership was unable to appropriately identify him as seriously mentally ill (SMI). This resulted in facility mental health staff not being notified that the detainee should be flagged for possible treatment, close monitoring, and tracking.[10]

14. Complaint No. 17-06-ICE-0582

CRCL received a referral from the DHS OIG regarding the death of Roger Rayson (A206 839 071), an ICE detainee at Jena/LaSalle Detention Facility in Jena, Louisiana. According to the complainant, Mr. Rayson's healthcare was "deplorable." Mr. Rayson's preliminary cause of death was ruled as subdural hemorrhages resulting in a traumatic brain injury. The complainant claimed that multiple requests for the Uniform Corrective Action Plan (UCAP) and Root Cause Analysis (RCA) were made to IHSC leadership, but IHSC did not respond.

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[8] 1) *IHSC OM 19-025: Forced Emergency Psychotropic Medication*, 2) *IHSC OM Section 4-1: Consideration of Alternatives to Forced Emergency Psychotropic Medication*, 3) *IHSC OM Section 4-2: Ordering of Forced Emergency Psychotropic Medication*, 4) *IHSC OM Section 4-3: Direct Observation of Detainees given Forced Emergency Psychotropic Medication*, subsection (a) *IHSC OM Section 4-5: Maximum use of Forced Emergency Psychotropic Medication*, 6) *IHSC OM Section 5-7: Forced Emergency Psychotropic Medication Debriefing*, and 7) *IHSC Directive 07-05: Serious Mental Disorders or Conditions*

[9] 1) *IHSC OM 19-025: Forced Emergency Psychotropic Medication*, 2) *IHSC OM Section 4-1: Consideration of Alternatives to Forced Emergency Psychotropic Medication*, 3) *IHSC OM Section 4-2: Ordering of Forced Emergency Psychotropic Medication*, 4) *IHSC OM Section 4-3: Direct Observation of Detainees given Forced Emergency Psychotropic Medication*, subsection (a) *IHSC OM Section 4-5: Maximum use of Forced Emergency Psychotropic Medication*, 6) *IHSC OM Section 5-7: Forced Emergency Psychotropic Medication Debriefing*, and 7) *IHSC Directive 07-05: Serious Mental Disorders or Conditions*

[10] Note: IHSC BHU staff are responsible for supervising BHU field staff and review their charts daily to determine if appropriate care and follow-up is provided. In this case, IHSC leadership did not know key identifiers to designate SMI status.

15. Complaint No. 18-09-ICE-0615

CRCL received a referral from the DHS OIG regarding the death of [redacted], an ICE detainee at Eloy Federal Contract Facility in Eloy, Arizona. According to the complainant, IHSC leadership was informed of multiple concerns regarding the care provided at the facility, particularly the facility's psychiatrist misdiagnosing, failing to treat detainees appropriately, and the lack of readily available emergency medications. [redacted] preliminary cause of death was ruled as coronary artery disease. The complainant alleged that during a briefing with ERO on the preliminary cause of death, IHSC leadership's report was "very misleading," and the more likely causes of death given the detainee's medication and symptoms (neuroleptic malignant syndrome and/or serotonin syndrome) were not raised.

16. Complaint No. 18-10-ICE-0613

CRCL received a referral from the DHS OIG regarding the death of Efrain De La Rosa (A209 910 301), an ICE detainee at Stewart Detention Facility in Lumpkin, Georgia. Mr. De La Rosa's preliminary cause of death was ruled a suicide. According to the complainant, IHSC leadership was notified of Mr. De La Rosa's deteriorating mental health condition via SEN report on several occasions between April 25, 2018 and May 6, 2018. On April 26, 2018, a SEN report indicated that while on suicide watch, Mr. De La Rosa had stated to staff that he would be dead in three days. The complainant noted that several months earlier, IHSC leadership directed MQMU to cease reviewing SEN and segregation reports, despite concerns raised to IHSC leadership that this restriction could negatively impact detainee safety.

17. Complaint No. 18-08-ICE-0614

CRCL received a referral from the DHS OIG regarding the death of Ronald Cruz (A078 963 293), an ICE detainee at Port Isabel Detention Center in Los Fresnos, Texas. According to the complainant, the medical care rendered to Mr. Cruz was "grossly negligent." Mr. Cruz's preliminary cause of death on May 16, 2018 was ruled as meningitis. The complainant alleged that the mortality review committee was erroneous in concluding that the care rendered to Mr. Cruz was appropriate.

CRCL

CRCL mission. CRCL supports the Department's mission to secure the Nation while preserving individual liberty, fairness, and equality under the law. CRCL integrates civil rights and civil liberties into all the Department's activities:

- Promoting respect for civil rights and civil liberties in policy creation and implementation by advising Department leadership and personnel, and state and local partners;

- Communicating with individuals and communities whose civil rights and civil liberties may be affected by Department activities, informing them about policies and avenues of redress, and prompting appropriate attention within the Department to their experiences and concerns;

- Investigating and resolving civil rights and civil liberties complaints filed by the public regarding Department policies or activities, or actions taken by Department personnel;

- Leading the Department's equal employment opportunity programs and promoting workforce diversity and merit system principles.

CRCL authorities. Under 6 U.S.C. § 345 and 42 U.S.C. § 2000ee-1, CRCL is charged with investigating and assessing complaints against DHS employees and officials of abuses of civil rights, civil liberties, and profiling on the basis of race, ethnicity, or religion. In investigating complaints, if CRCL believes that the complaints raise similar issues, CRCL may look into whether there are systemic problems that justify a broader investigation. Pursuant to its authority under 6 U.S.C. § 345(a)(3), CRCL shall assist components to "periodically review Department policies and procedures to ensure that the protection of civil rights and civil liberties is appropriately incorporated into Department programs and activities" [11] Additionally, pursuant to DHS Delegation Number 19003, issued October 26, 2012, the Secretary has delegated to the Officer of CRCL the authority to "assess new and existing policies throughout the Department for the policies' impact on civil rights and civil liberties" and "review . . . programs within any Component to ensure compliance with standards established by the Officer for CRCL to protect civil rights and civil liberties." Issues such as appropriate treatment by ICE officials, access to medical care, lack of arbitrary punishment, and religious accommodations for ICE detainees are examples of issues that raise civil rights and liberties concerns. The procedures for CRCL investigations and the recommendations those investigations may generate are outlined in DHS management Directive 3500, DHS Instruction 046-01-001, and DHS Instruction 046-01-002.

Access to information. 42 U.S.C. § 2000ee-1(d) grants CRCL access to the "information, material, and resources necessary to fulfill the functions" of the office, including the complaint investigation function. Management Directive 3500 further authorizes CRCL to:

- "Notify[] the relevant DHS component(s) involved of the matter and its acceptance by CRCL and whether the matter will be handled by CRCL or by the component organization".

- "Interview {] persons and obtain[] other information deemed by CRCL to be relevant and require[e] cooperation by all agency employees"; and

- "Access {] documents and files that may have information deemed by CRCL to be relevant."

Further guidance is contained in DHS Instruction 046-01-002, and, pursuant to § 3.3 of ICE Directive 8010.1, "Administration and Management of Inquiries from the Office for Civil Rights and Civil Liberties," this is a request for information or assistance. Under § 3.3 of Directive 8010.1. ICE will provide the requested information and materials to CRCL within the timeframe indicated below, and not

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[11] In addition, pursuant to 42 U.S.C. § 200ee-1(a)(2), CRCL has the authority to "periodically investigate and review department, agency, or element actions, *policies, procedures, guidelines,* and related laws and their implementation to ensure that such department, agency, or element is adequately considering privacy and civil liberties in its actions" (emphasis added)

edit or otherwise limit review of the information that is responsive to CRCL's request. Pursuant to § 2 of Directive 8010.1, CRCL understands that this request will be handled by the appropriate ICE program office or ICE's Office of Diversity and Civil Rights (ODCR).

Reprisals forbidden. In addition, 42 U.S.C. § 2000ee-1(e) forbids any Federal employee to subject a complainant or witness to any "action constituting a reprisal, or threat of reprisal, for making a complaint or for disclosing information to" CRCL in the course of this investigation.

This memorandum and the accompanying request for documents and information are issued pursuant to these authorities.

Privilege and required transparency. Our communications with ICE personnel and documents generated during the review, particularly the final report, will be protected to the maximum extent possible by attorney-client and deliberative process privileges. Under 6 U.S.C. § 345(b), however, we submit an annual report to Congress—also posted on the CRCL's Web site—that is required to detail "any allegations of [civil rights/civil liberties] abuses . . . and any actions taken by the Department in response to such allegations."

We look forward to working with your staff on this matter and will report back to you our findings and any recommendations.

SCOPE OF REVIEW

The purpose of our review is to: determine if the allegations in the complaints can be verified or disproven; determine whether the facts we find suggest that the Constitution, a federal statute, or a Departmental policy has been violated; and to determine what steps, if any, should be taken to address the complaints, both individually (if the problem is ongoing) and as a matter of policy. It is our goal to produce a report that will assist you in making ICE the best agency possible.

QUESTION PRESENTED

Did IHSC employees or officials conform to ICE standards, policies and procedures, and to civil rights requirements, in the provision and oversight of medical and mental health care in immigration detention?

It is possible that our investigation will reveal other matters of concern; if this occurs, we will inform you.

INITIATING THE INVESTIGATION

CRCL will be in contact with ICE ERO staff about this complaint and CRCL's plans for reviewing the matter, which is assigned to [redacted]. We look forward to working together to determine all the facts surrounding these matters and if appropriate, the best way forward. If you have any questions, please do not hesitate to contact [redacted].

Copies to:
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