

DEPARTMENT OF HOMELAND SECURITY

Office of Inspector General

ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities





**Homeland
Security**

June 11, 2008

Preface

The Department of Homeland Security (DHS) Office of Inspector General (OIG) was established by the Homeland Security Act of 2002 (*Public Law 107-296*) by amendment to the Inspector General Act of 1978. This is one of a series of audit, inspection, and special reports prepared as part of our oversight responsibilities to promote economy, efficiency, and effectiveness within the department.

This report addresses the strengths and weaknesses of U.S. Immigration and Customs Enforcement (ICE) operations related to detainees who died in custody. We also analyzed certain medical standards and ICE's oversight of facilities that house immigration detainees. We based our report on interviews with relevant agencies, direct observations, and a review of applicable documents and data.

The recommendations herein have been developed to the best knowledge available to our office, and have been discussed in draft with those responsible for implementation. It is our hope that this report will result in more effective, efficient, and economical operations. We express our appreciation to all of those who contributed to the preparation of this report.

A handwritten signature in cursive script that reads "Richard L. Skinner".

Richard L. Skinner
Inspector General

Table of Contents/Abbreviations

Executive Summary	1
Background	2
Results of Review	4
An Analysis of Two Immigration Detainee Deaths.....	4
Recommendations.....	14
Management Comments and OIG Analysis.....	14
Oversight Can Be Improved at ICE Detention Facilities.....	19
Recommendations.....	26
Management Comments and OIG Analysis.....	26
Additional Efficiencies in Medical Operations Can Enhance Implementation of ICE’s Detention Standards.....	29
Recommendations.....	33
Management Comments and OIG Analysis.....	34
Appendices	
Appendix A: Purpose, Scope, and Methodology.....	35
Appendix B: Management’s Comments to the Draft Report.....	36
Appendix C: Recommendations.....	48
Appendix D: Comparison of Various Detention Standards.....	50
Appendix E: Major Contributors to this Report.....	54
Appendix F: Report Distribution.....	55
Abbreviations	
ABA	American Bar Association
ACA	American Correctional Association
DHS	Department of Homeland Security
DIHS	Division of Immigration Health Services
EHRs	Electronic Health Records
ICE	Immigration and Customs Enforcement
OFDT	Office of Federal Detention Trustee
OIG	Office of Inspector General
OPR	Office of Professional Responsibility
RCC	Regional Correctional Center
VA	Department of Veterans Affairs



Department of Homeland Security
Office of Inspector General

Executive Summary

Immigration and Customs Enforcement houses a daily average of 28,700 detainees in 353 facilities nationwide. Various types of detention facilities, such as service processing centers, contract detention facilities, and state and local jails, are used to house these individuals. Immigration and Customs Enforcement detention standards are used to inform facilities on expectations regarding medical care, detainee access to legal materials, and other areas related to facility management. Between January 1, 2005, and May 31, 2007, 33 immigration detainees died.

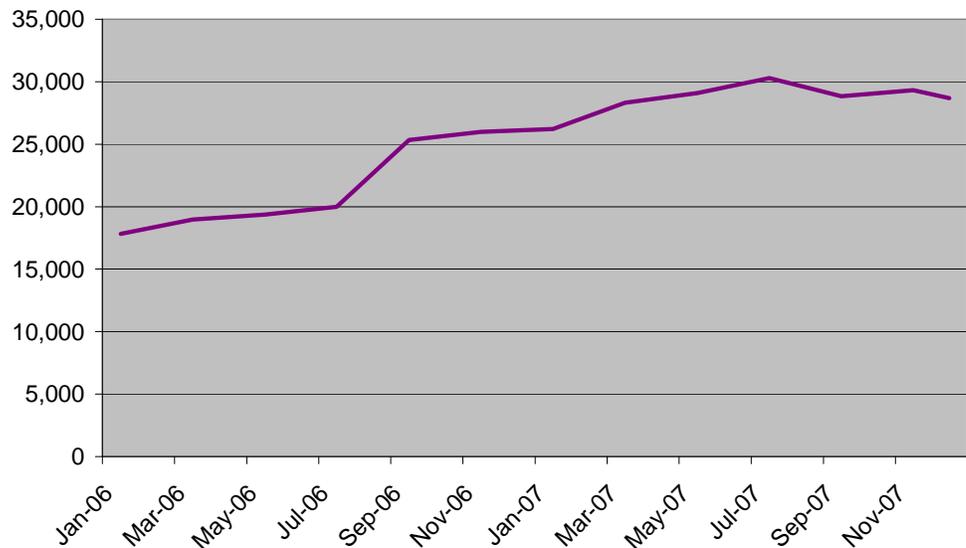
We reviewed two cases where immigration detainees died in custody. One of these incidents occurred in St. Paul, Minnesota. The second incident took place in Albuquerque, New Mexico. We evaluated how the agency and its detention partners dealt with the two cases. In addition, we examined policies related to detainee deaths, medical standards, and other issues. We gathered data from the two affected detention facilities, examined the agency's reports completed after its monitoring visits to various facilities, and had discussions with public and private-sector experts on detention standards.

Although there are compliance problems related to certain medical standards at various facilities, ICE adhered to important portions of the detainee death standard in the two cases that were the focus of this review. Based on information received from clinical experts and our analysis, the two detainees' serious pre-existing medical conditions led to their deaths. Although ICE's detention standards are comparable to other organizations, such as the American Correctional Association, we are making 11 recommendations to improve the standards, strengthen ICE's oversight of facilities, and enhance clinical operations and detainee safety.

Background

Immigration and Customs Enforcement (ICE), the largest investigative branch of the Department of Homeland Security (DHS), was created in March 2003 by combining the law enforcement functions of the Immigration and Naturalization Service and United States Customs Service. The Immigration and Nationality Act authorizes ICE to arrest, detain, and remove certain aliens from the United States.¹ The agency's average daily detainee population in December 2007 was 28,702. This was a 61% increase compared to January 2006, as shown in Figure 1.

Figure 1: ICE's Average Daily Detainee Population, January 2006-December 2007



ICE is charged with ensuring that removable aliens depart the United States. ICE uses three types of facilities to house its detainees until they are deported: Service processing centers are owned and operated by ICE; private companies operate ICE's contract detention facilities; and state and local jails with intergovernmental service agreements house ICE detainees. Most service processing centers and contract detention facilities use Commissioned Corps Officers in the Public Health Service to deliver onsite medical care. The partnership between the Public Health Service and federal immigration agencies was initially established in 1891. Local jails rely mainly on other onsite clinicians, such as contractors or staff employed by a county public health department.

¹ 8 USC §§ 1226, 1227, 1229, 1229(a), and 1357.

ICE's Detention Operations Manual stipulates the agency's detention standards, which are designed to ensure facilities provide services that will protect detainees' life and dignity. The standards contain rules on medical care, food service, access to legal materials, and various other areas. Facilities are to be inspected on an annual basis to ensure compliance with ICE's standards. ICE staff is also responsible for visiting each facility to interact with detainees on a regular basis.

In November 2000, the Immigration and Naturalization Service established detention standards to ensure the "safe, secure, and humane treatment" of detained immigrants. Discussions among federal immigration officials, the American Bar Association (ABA), the Department of Justice, and other organizations helped create the standards. Several of ICE's 36 standards have been revised or expanded. Since the creation of DHS, two additional standards have been issued: (1) staff-detainee communication requirements were established in July 2003, and (2) detainee transfer policies were approved in September 2004.

Other federal agencies have their own detention standards. The Office of Federal Detention Trustee (OFDT) in the Department of Justice ensures that federal agencies involved in detention operations provide for the safe and humane confinement of persons who are awaiting trial. OFDT is responsible for conducting annual facility reviews using Federal Performance-Based Detention Standards. OFDT and ICE inspect some of the same facilities.

Private entities also have created detention standards. The American Correctional Association (ACA) and the National Commission on Correctional Health Care have more than 150 years of combined experience in creating and revising detention standards. Both entities accredit national, state, and local detention facilities that meet existing detention standards. In some areas, such as the placement of first aid kits and defibrillators, ICE requires adherence to ACA standards.

ACA's purpose is to promote improvement in the management of correctional agencies through the administration of a voluntary accreditation program and the ongoing revision of its standards. As with ICE and OFDT standards, the ACA covers a variety of subjects pertaining to the administration and management of detention facilities. For facilities seeking accreditation, ACA conducts onsite inspections every three years. According to ACA policy facilities are required to document compliance with the standards for each month over the three-year period.

The National Commission on Correctional Health Care works to improve the quality of health care in correctional facilities. The Commission's standards

guide facilities on the delivery and management of health care in correctional systems. ICE's service processing centers and contract detention facilities are required to maintain accreditation by the Commission.

As a stakeholder in developing ICE's standards, ABA has created a commission to help review detention standards at facilities housing immigrants and asylum seekers. The ABA's Commission on Immigration ensures detainees are made aware of their rights, including access to legal materials, telephones, and group presentations. Working with volunteer law firms, the ABA visits facilities to review practices and suggest improvements. The ABA shares its site visit reports with ICE.

Results of Review

This review examined two cases of detainee death, as well as ICE's overall standards related to detainee deaths and the medical treatment of immigration detainees. The two detainees died as a result of serious pre-existing medical conditions. Although there have been problems with adherence to medical standards at the two facilities in question, ICE's overall standards are equivalent to other detention organizations. ICE has been taking steps to enhance its ability to effectively monitor immigration detention facilities. Our recommendations focus on how ICE can make further improvements to the efficiency of clinical operations by developing better oversight procedures.

An Analysis of Two Immigration Detainee Deaths

The first detainee's death occurred in April 2006, in St. Paul, Minnesota; the second death happened in September 2006, in Albuquerque, New Mexico. Although the two detainees were in ICE custody, the individuals were hospitalized at the time of death. According to ICE's standards, both the agency and its detention partners are required to take certain actions when a detainee dies. In both of these incidents, the procedures outlined in the detainee death standard were performed, with the exception of a state notification requirement that we describe in our discussion of the Albuquerque incident. Pursuant to its statutory authority, the DHS Office for Civil Rights and Civil Liberties investigated a complaint concerning the Minnesota detainee death. The Office reviewed compliance with ICE's medical care standard at the detention facility and made recommendations to ICE for possible improvements in detainee care.

ICE's Detainee Death Standard

In September 2000, the Immigration and Naturalization Service created a standard for detainee deaths. This standard remains in place. Field office personnel we interviewed reported satisfaction with the standard itself. Detainees who die in custody do not always pass away in a detention facility; therefore ICE has different rules for situations where detainees die in other locations or in transit. From the notification of family to disposition of remains and personal property, ICE standards address the sensitivity that surrounds detainee deaths.

Notifying the family is an important part of ICE's detainee death procedures. Additionally, the standard requires notification of the applicable consulate. ICE also must prepare a condolence letter for the family that describes the circumstances of the death. After completing the necessary notification requirements, ICE is required to assist in other areas, such as autopsy arrangements. Before initiation of the autopsy, facilities must determine the detainee's religious affiliation. This is important because some religions have specific restrictions involving autopsies, embalming, and cremation. When family members cannot afford the costs associated with transporting the remains, ICE may transport the remains to a location in the United States.

ICE's Office of Professional Responsibility (OPR) reviews detainee death cases. OPR's management directive does not require the reporting of deaths to the OIG, nor were we provided any ICE policy documents that require the reporting of immigration detainee deaths to our office. However, OPR can refer cases to the OIG when ICE determines an outside review is warranted. An OPR manager informed us that the Joint Intake Center may report detainee deaths to the OIG or OPR. Likewise, the OIG's Office of Investigations may refer various detainee death incidents to OPR. The DHS Office for Civil Rights and Civil Liberties also has reviewed detainee deaths and compliance with ICE standards.

OPR has helped ICE improve detention practices after some detainee deaths. However, ICE should report all detainee deaths to the OIG. In the past, we have received information about detainee deaths on a sporadic basis, mainly through complaints to the OIG Hotline. Notifying the OIG of any detainee death would keep the OIG better informed and allow it to determine whether additional review is warranted in each case. A policy in this area could outline procedures for providing relevant records to the OIG, as necessary.

ICE's detainee death standard compares well to ACA and OFDT standards. Both ACA and OFDT point out the importance of mortality reviews, which can prompt changes to facility procedures and can potentially decrease the

chance of additional deaths. Although ICE does not require mortality reviews, we noticed evidence of such reviews in the files of several detainees who died, including the two deaths that are the focus of this review. Clinicians with the Division of Immigration Health Services usually complete ICE's mortality reviews.

The St. Paul, Minnesota Case

The immigration file of the detainee, who died in April 2006, shows an initial hearing before an immigration judge in November 1997. An October 1998 letter instructed the individual to appear for deportation on November 3, 1998. The detainee did not appear for deportation. Thereafter, ICE considered the detainee a fugitive. ICE did not locate the detainee until February 2006, and arrested the detainee for not departing the United States in 1998.

ICE held the detainee at the Ramsey County Law Enforcement Center. This facility is located in downtown St. Paul, Minnesota, and houses various individuals awaiting legal proceedings in the county. When this incident occurred, the facility housed 70 immigration detainees on an average day. For the first six months of 2007, the facility accepted 177 new ICE detainees. ICE's 2006 monitoring report for the facility showed an acceptable overall rating.

On April 3, 2006, at approximately 2:30 p.m., the detainee fell from a bunk bed and sustained a lump on the back of the head. The guard who arrived at the cell ensured that a nurse would see the detainee during 4:00 p.m. medical rounds. At that time, the detainee reported dizziness and headaches to the nurse. The detainee's medical file includes information from the nurse reporting that the detainee was confused when the detainee returned to the cell. Four hours later, the detainee's condition had deteriorated, prompting a nurse to order transportation to a nearby hospital.

After arriving at the hospital, physicians diagnosed a serious condition known as neurocysticercosis, which is an infection of the brain by larva of the pork tapeworm. This disease caused the detainee's death on April 13, 2006. Serious complications can result if the disease enters the central nervous system. The detainee reported a history of headaches that were not relieved by medication. The facility's clinical protocols, which called for the use of aspirin for headaches, do not account for other possibilities, such as serious, pre-existing parasitic diseases as a cause of the problem. Although seizures are a common symptom of the disease, there was no evidence of seizures in the detainee's medical file.

We identified two important facts related to the detainee’s medical care. Facility information we examined included a head trauma protocol. This document justified the detainee’s expedited transportation to the hospital after a nurse observed that the detainee was dizzy and confused. Additionally, the detainee did not receive a physical exam, which ICE medical standards require within 14 days of intake. However, after discussions with clinical experts and a review of medical literature, we concluded that neither more timely medical attention for the head trauma nor a more timely initial medical exam would have ensured the detainee’s recovery from neurocysticercosis.

The case history showed that ICE did a commendable job implementing parts of the detainee death standard. We examined two “significant incident” reports prepared for ICE headquarters by the agency’s staff in Minnesota. Field office personnel send these reports to headquarters after serious events take place. ICE also left a message with the Consulate of Ecuador in Chicago. ICE also notified the detainee’s spouse. This timely compliance with steps in ICE’s detainee death standard did facilitate necessary actions, such as the return of the remains. Documentation also showed that the detainee’s spouse received some of the detainee’s personal property less than one week after the death. The detention standards do not have a time requirement for the return of property, but ICE made a good effort to ensure that this occurred.

The death led to a debate within the Ramsey County government regarding whether to continue to house ICE detainees. The County Sheriff said that the Law Enforcement Center may not be the best place for ICE to house individuals longer than a few days. Media also reported that the sheriff was concerned about the ability to care for immigration detainees on an ongoing basis. “We’re not really prepared to translate, interpret, and assist that kind of population,” he said.² After further discussions, in December 2006, the County Board of Supervisors voted four to three to maintain its agreement with ICE.

Policy Improvements and Additional Education Efforts Would Help Identify and Treat Cysticercosis

While ICE’s medical standards recognize the need to treat infectious diseases in general, they do not specifically mention cysticercosis. Furthermore, non-emergency radiology services, such as computed tomography scans or magnetic resonance imaging—methods of making detailed images of the body to identify problems that are not readily apparent—are not included in the Division of Immigration Health Services covered services package. Although case-by-case requests for coverage and payment of diagnostic tests are

² “No immigrant detainees in Ramsey County?,” *Minneapolis Star-Tribune*, December 19, 2006.

possible, current policy does not specifically provide for proactive diagnosis of cysticercosis.

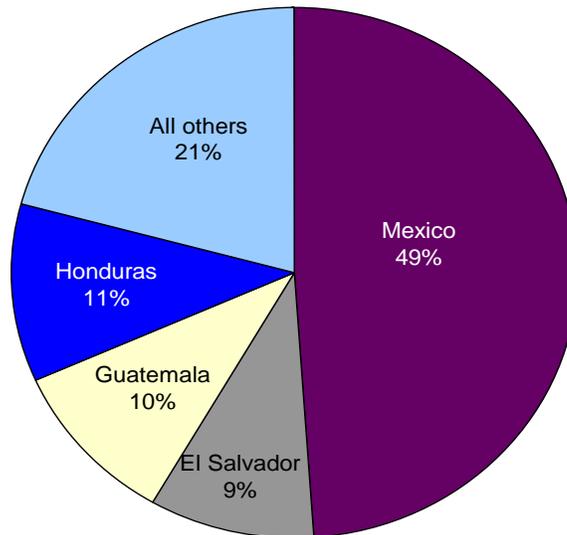
The disease, which disproportionately affects Latin American immigrants, can infect humans who come in contact with the tapeworm that causes cysticercosis. The resulting cysts can migrate to various parts of the body, including muscles, the eyes, or the brain. In the central nervous system, the disease is known as neurocysticercosis, which was the cause of death in the St. Paul case. We cannot determine with certainty whether this death could have been avoided had the detainee received immediate medical attention for head trauma. However, ICE, in conjunction with the DHS Office of Health Affairs, should engage the Centers for Disease Control and Prevention to review the medical screenings provided for detainees, with special consideration of the origins of the population.

According to medical journals and experts we interviewed, cysticercosis is expected to become more prevalent in the United States within the next decade. A neurology professor informed us that she has seen many more cases of the disease over the past five years. A leading journal also predicted that cysticercosis “will grow in clinical and public health importance” in the United States. This article reported that Latinos accounted for 85% of individuals who died of cysticercosis in the United States from 1990 through 2002. After these deaths were studied, the authors wrote that the incidents reflect “immigration patterns in states that include substantial populations of immigrants from cysticercosis-endemic areas, particularly Mexico and other areas of Latin America.”³

Based on ICE data for the period of October 2006 through November 2007, individuals from Mexico, Honduras, El Salvador, and Guatemala, countries where the disease is endemic, account for 79% of ICE’s total detainees, as shown in Figure 2.

³ “Deaths from Cysticercosis, United States,” *Emerging Infectious Diseases*, February 2007, p. 230-231, 233.

**Figure 2: Country of Origin for ICE Detainees, October 2006-
November 2007**



In a study of deceased neurocysticercosis patients in Oregon spanning six years, it was determined that 44 of 57 fatalities (77%) occurred in people who had been born in Mexico or Guatemala.⁴ A separate review of autopsies in Mexico showed a prevalence of cysticercosis in about three percent of the population.⁵ If three percent of ICE’s detainees from Mexico were infected, nearly 5,000 Mexican nationals detained in fiscal year 2007 could be carrying the parasite.

Currently, the standards used by the Office of Federal Detention Trustee (OFDT) provide a logical process for the treatment of special needs individuals. The Detention Trustee’s definition of special needs individuals includes those with communicable diseases. ICE’s standard is less detailed, and it should be revised to include individuals who carry the tapeworm that can cause cysticercosis. There is also a specific Trustee standard⁶ that requires “appropriate diagnostic testing” be done on detainees with special needs.

ICE also can educate staff at facilities housing detainees to ensure understanding of neurocysticercosis. One of the world’s leading experts on immigrant health care informed us that neurocysticercosis is “the leading cause of seizures” in adults from Mexico and Central America. Another expert, who labeled seizures as the “hallmark” symptom of the disease, informed us that the Centers for Disease Control developed an “extremely

⁴ “Neurocysticercosis in Oregon, 1995-2000.” *Emerging Infectious Diseases*, March 2004, 508-510.

⁵ “Deaths from Cysticercosis, United States,” p. 232.

⁶ B.3.29a

simple” blood test that can reveal whether an individual has the tapeworms capable of spreading the disease. The CDC has noted that the blood test may not always be accurate, and other more definitive diagnostic tools, such as brain imaging, exist. Through expanded educational efforts, as well as greater use of available diagnostic tools when deemed appropriate, ICE could facilitate faster identification of tapeworm carriers or instances of the disease among detainees. This offers a chance to improve treatment of a disease more likely found in ICE detainees than in United States citizens.

Another way ICE could better detect the disease is to ensure that questions related to cysticercosis are asked during the initial health assessment and 14-day physical exam. A neurologist who has treated neurocysticercosis said an entire family should be treated if one individual in a household has the disease. Records indicate that facility staff was informed that the detainee’s mother had surgery four years before to treat “eggs of bugs inside her head.” These comments may appear non-sensical, but they provided a clue that could have led to further questioning or diagnostic testing. Adding intake and medical screening questions about a family history of the disease would have been useful.

Greater efforts to recognize neurocysticercosis may have expedited the care the detainee received. More than a month before the detainee’s death, clinical staff was told, “Tylenol or aspirin don’t do anything [to remedy my headaches.]” Also, after falling from the bunk bed on April 3, 2006, the detainee exhibited general confusion and dizziness. Neurocysticercosis was quickly diagnosed after the detainee visited the emergency room.

The Albuquerque, New Mexico Case

In 2004, the Regional Correctional Center (RCC) in downtown Albuquerque was leased to Cornell Companies, a private correctional firm based in Houston, Texas. After making several renovations, Cornell began housing ICE and U.S. Marshals detainees at the RCC. The RCC booked 10,026 ICE detainees from July 1, 2005 through July 20, 2007.

The detainee, who died on September 11, 2006, was arrested as a result of an ICE operation on the East Coast. The individual, along with 13 others, was transferred in August 2006 to the RCC. Records show that the detainee was sent to a hospital on September 4, 2006.

The detainee died of “widely metastatic” pancreatic cancer, which means that cells broke away from the original cancerous tumor and spread to other parts of the body. This type of cancer makes survival unlikely. A physician with 25 years of oncology practice said, “I have never seen a tumor marker that

high,” after reviewing the detainee’s test results. Hospital clinicians who treated the detainee recognized that the disease was at an advanced stage before ICE took the detainee into custody. However, medical examinations received after the detainee arrived at the RCC did not reveal the illness.

A Hotline complaint we received, an affidavit from another detainee, and unsworn testimony from a former RCC employee, all alleged that the facility’s personnel did not address the detainee’s medical issues. Specifically, the Hotline complainant believed ICE and RCC staff gave “scant attention” to the detainee’s medical needs. However, it appeared that Cornell’s clinical staff addressed written medical requests identified in the detainee’s records. The detainee received antacid tablets after complaining of abdominal pain, so, like the Minnesota case, staff did not immediately recognize a more serious condition. Based on documentation from hospital staff, we concluded that the RCC’s medical team could not have saved the individual’s life, even with quicker onsite treatment or expedited transportation to the hospital.

ICE staff in Albuquerque notified managers at ICE headquarters of this incident. ICE contacted the detainee’s family and the consulate of the detainee’s country of origin. Local staff also placed a copy of the death certificate in the detainee’s file, which is required by ICE standards.

In certain cases, ICE faces challenges locating family members of detainees. This is inherent in the immigration detention process, especially when detainees are often transferred across the United States. In this case, the detainee’s son, the only family member identified in the case files, was attending a university on the East Coast during the detainee’s time in New Mexico. This led to difficulties coordinating post mortem activities, such as the transfer of remains. The records show that ICE made appropriate efforts to communicate with the family. The head of the consulate from the detainee’s country of origin thanked ICE for the professionalism exhibited by the agency’s staff during the incident.

Nonetheless, the Hotline complainant, other detainees, and a former RCC employee asserted that the RCC was not dealing with some detainee sick call requests of in a timely fashion. Based on facility data and a September 2006 site visit report by OFDT, there is merit to those concerns. OFDT reported that, due to a nursing shortage, detainees were often waiting as many as 30 days for sick call requests to be answered. Additionally, OFDT reported that only 11 of 20 detainees with chronic conditions were regularly scheduled for chronic care clinics.

This detainee's death highlighted a limitation in ICE's detainee death policy. New Mexico law requires that any death of a person in the custody of law enforcement be reported; however, New Mexico's Office of the Medical Investigator, which should have received this notification, did not have a record of the detainee's death. ICE staff said that the county should have reported the death. State officials said that the hospital could have worked with ICE to ensure compliance with the state's requirements. ICE should revise the detainee death standard to ensure that the agency and its detention partners comply with laws requiring notification to state officials. The standard requires the notification of family and the consulate, so adding language about state reporting would be suitable. Regardless of who should take the lead in contacting the state, ICE needs to ensure that detainee deaths are reported to state governments if legally required.

RCC Site Visit Reports

ICE's Office of Professional Responsibility (OPR) visited the RCC in June 2007. At that time, the facility housed 746 immigration detainees. OPR reported a variety of problems, including inadequate suicide watch observation, food service, records maintenance, and security procedures. OPR considered the RCC's overall security procedures to be "weak" and "in dire need of improvement." Based on its determinations, including the discovery of illegal drugs in the facility, ICE decided to remove all of its RCC detainees in early August 2007. We commend ICE for using its own process to identify areas of concern at detention facilities.

Cornell management acknowledged problems at the RCC. A senior manager said that a corporate audit team has helped identify and correct deficiencies. Based on recent comments by the Chief U.S. District Court Judge in New Mexico, the company's efforts have led to some improvements.⁷ Cornell said that ICE did not fully explain why all immigration detainees were transferred to other locations. However, Cornell's Chief Executive Officer said, "if we had operated RCC as we do our best facilities, no one would have had any basis for criticism. But we didn't."⁸

Prior to OPR's report, evidence existed that showed the RCC was having some difficulty in important areas. Within a six-week period in 2006, ICE and OFDT completed separate monitoring visits at the RCC. OFDT assigned the RCC an at-risk rating in its September 2006 monitoring report. This is the

⁷ "Bernalillo County's Regional Correctional Center conditions improving," *Albuquerque Tribune*, August 30, 2007, and "Red Flags Raised at Albuquerque's Downtown Jail," *Albuquerque Tribune*, September 25, 2007.

⁸ "Jail CEO explains setbacks," *Albuquerque Tribune*, August 11, 2007.

lowest possible overall rating, two levels below acceptable. ICE granted an acceptable rating to the facility after its 2006 site visit. OFDT's follow-up report, based on a February 2007 site visit, determined that RCC's operations were acceptable, which suggested that the RCC made important corrections after OFDT's September 2006 report.

In September 2006, OFDT reported problems with the RCC's compliance with ICE's detainee death policy. OFDT concluded that the RCC's policies did not address a requirement to notify the Departments of Justice or Homeland Security in the event of detainee death. OFDT also reported that the RCC's policy did not address religious requirements or medical circumstances regarding autopsies. Finally, the facility's policy did not address the need to gain the permission from federal agencies to release the detainee's body.

ICE's November 2006 RCC report did not mention actual or pending revisions to the detainee death policy. Limitations to the detainee death policy should have been clearly written in ICE's report, especially since an RCC detainee died less than two months before ICE's site visit.

OFDT's report mentions other problems at the RCC of interest to ICE. In its discussion of detainee classification, which pertains to separating individuals by severity of their offenses, OFDT identified seven non-criminal ICE detainees housed with 136 criminal detainees. Based on a recommendation in our December 2006 report, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, ICE has taken steps to address classification problems at its facilities.⁹ However, an assistant trustee stated that OFDT has detected such problems at other ICE facilities, but there are no procedures for sharing report findings with ICE.

ICE and OFDT have different standards, but some efficiency could be gained if ICE engaged the detention trustee on facilities reviewed by both agencies. OFDT could inform ICE about issues of interest to ICE, but ICE is not taking advantage of this opportunity. No field office reported interaction with OFDT on facility monitoring, though OFDT reports mention ICE standards. Moreover, the two agencies do not share monitoring reports. The Assistant Trustee we interviewed lamented such missed opportunities by saying that there is "very minimal" information sharing between ICE and OFDT.

By developing a better relationship with OFDT, ICE could gain important perspectives about its detention facilities. Problems of mutual interest, such

⁹ DHS OIG, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, OIG-07-01, December 2006, p. 48.

as timeliness of health care delivery, could lead ICE to request more data samples, interviews, or policies to ensure compliance. A more developed relationship between the two agencies would be helpful, especially in situations where OFDT's standards differ from ICE.

Recommendations

We recommend that the Assistant Secretary for Immigration and Customs Enforcement:

Recommendation #1: Work with the Office of Inspector General to create a policy that would lead to the prompt reporting of all detainee deaths to the Office of Inspector General.

Recommendation #2: Work with the Division of Immigration Health Services, the Centers for Disease Control, and other experts, to enhance existing medical standards, rules for special needs individuals, and coverage guidance related to infectious disease.

Recommendation #3: Revise medical intake screening forms and physical exam questionnaires at detention facilities to include questions regarding the detainee's family history of cysticercosis.

Recommendation #4: Revise the notification section of ICE's detainee death standard to ensure that the agency and its detention partners report a detainee's death in states that require notification in the event of a death in custody. Documentation of this reporting should appear in a detainee's file.

Recommendation #5: Seek to enter into a memorandum of understanding with the Department of Justice, Office of Federal Detention Trustee that establishes a process that enables OFDT and ICE to regularly share information resulting from facility site visits.

Management Comments and OIG Analysis

ICE and the DHS Office of Health Affairs provided written comments on our draft report. We evaluated these comments and have made changes where we deemed appropriate. Below is a summary of ICE's written response to the report's first five recommendations and our analysis. A copy of ICE's complete response is included as Appendix B.

ICE's Comments to Recommendation #1

ICE concurred with our recommendation. A March 13, 2008, memo that was created by ICE's Office of Professional Responsibility outlines the process that will ensure OIG notification of each detainee death. ICE will make telephone contact with the OIG as quickly as possible after the death. The following day, additional details will be provided as part of an existing OIG notification mechanism.

OIG Analysis

ICE's new policy should facilitate interaction with our office on detainee death cases. As needed, we will use this new process to gain additional information about detainee death incidents.

The recommendation is resolved and closed.

ICE's Comments to Recommendation #2

ICE concurred in part and disagreed in part with our recommendation. ICE concurred with the recommendation to work with DIHS and other experts to enhance the detention standard for detainee access to medical care. ICE is updating all 38 standards and converting them into 41 performance-based standards. These revisions are being reviewed by major governmental organizations and DHS' Office for Civil Rights and Civil Liberties. DHS expects to publish the revised standards on September 1, 2008.

ICE stated that the current medical standard allows for special needs individuals to receive appropriate medical care. Regarding "medical standards," ICE said it does not have the authority to establish or alter national public health or medical health care industry standards, which are established by professional medical researchers and medical practitioners in tandem with public health and medical care governing and regulatory bodies.

Although ICE believes the current detention standard is sufficient to meet the medical needs of detainees, it believes doctors and medical staff must be cognizant of diseases. It has asked DIHS to develop a training tool to enhance the medical field's awareness and early detection of diseases that might be prevalent in aliens from particular geographic locales.

OIG Analysis

We are not recommending that ICE attempt to expand its authority and role in the development of national public health or medical care industry standards. However, it is well within the agency's authority, in consultation with experts, to revise its own policies and the medical care standard in the Detention Operations Manual. Special needs individuals may be getting adequate care, but we reaffirm our recommendation that ICE augment its policy to call more attention to those carrying infectious diseases, and help ensure that its medical

care better reflects the needs of its population. Possible changes include listing particular diseases that make someone a special needs individual, as OFDT has done. Diseases that are more common to immigrant populations, such as cysticercosis, can be the focus of such efforts. ICE's decision to ask DIHS to develop a tool to enhance the medical field's awareness and early detection of diseases is a positive step, but this tool would be most effective if it is accompanied by needed policy enhancements that respect the particular needs of ICE's unique population of detainees.

DIHS clinicians, who are now ICE employees, are committed to serving ICE's needs. ICE should take a greater interest in discussing possible changes to coverage rules for its population. The DHS Office of Health Affairs is another resource that can help ICE in these areas.

ICE's action plan should include information about its work with DIHS to alter policies that increase the probability of expedited treatment for individuals with infectious disease. Current coverage guidance does not adequately allow for coverage of conditions that do not appear to be medical emergencies. Through greater dialog with DIHS and ICE's departmental partners, the chances for improved health care outcomes will increase.

This recommendation is unresolved and open.

ICE's Comments to Recommendation #3

ICE concurred in part and disagreed in part with our recommendation. ICE agrees that DIHS should review its medical intake and physical exam forms, presumably to assess whether the forms can be modified to allow for more accurate and timely identification of certain diseases. ICE stated that present health screening tools include questions concerning family history. The agency stated that there is sufficient space on the forms to record any information provided to alert medical professionals of any possible problems that are not readily apparent. ICE's current intake form is based largely on questions that are not only related to family history of various diseases, but symptoms that may lead medical professionals to diagnose an illness. Given its large, diverse detainee population, it is not clear to ICE whether a specific designation of family history of cysticercosis is warranted on medical intake forms or that amending the form is the most appropriate manner to respond to this particular disease. Furthermore, ICE questioned the OIG's conclusions regarding the scope and danger of cysticercosis. It stressed that the disease is still quite rare, even after the large increase in Latin American immigrants over the last 30 years. ICE reported that technological improvements, not a prevalence of cysticercosis, led to increased detection of the disease.

ICE noted that DIHS' commitment to enhance the medical field's awareness and early detection of diseases that might be prevalent in aliens from particular geographic locales is a major step forward. ICE believes the best approach to address our concerns about cysticercosis or infectious diseases is to request that DIHS reevaluate the current medical form in order to determine whether amending these forms is appropriate.

OIG Analysis

ICE questioned the value of incorporating any family history of cysticercosis on forms currently in use, but also agreed that DIHS should review its medical intake forms and physical exam forms in order to better identify certain diseases. ICE will request that DIHS review current medical forms in order to determine whether amending these forms is appropriate. ICE did not indicate how it would respond to a decision by DIHS to amend the forms, whether it would revise any forms, or how such changes would be communicated to local facilities, which often use their own screening forms. ICE should provide documentation of its request, and the results of DIHS' evaluation.

We do not expect ICE to make cysticercosis the focus of its health care program. However, the disease, rare even in ICE's population, is a far greater risk to immigrants from Latin America than the general population, and amending intake screening and physical exam forms is a step ICE can take to help detect the disease.

Greater awareness and detection of the disease might not decrease morbidity or mortality in a specific case, but this is not a reason to omit specific language related to cysticercosis on intake and physical exam forms. The disproportionate risk of cysticercosis in ICE's population is not "anecdotal," as ICE notes, but rather a well-documented fact, based on decades of research by highly credible public health and medical experts. ICE should do more to respect this risk and take steps to mitigate it through the possibility of quicker detection and treatment for detainees carrying the disease.

Because cysticercosis remains rare, clinicians in various parts of the country may have limited experience with diagnosis, as was evident in the Minnesota case. No information in Ramsey County's treatment protocols, ICE's medical standard, or the DIHS covered services package could help a facility diagnose or proactively treat the disease, even though it is a disproportionate risk to the bulk of ICE's detainees. ICE can help its detention partners by providing more details about the disease as well as enhanced means for facilities to detect infected detainees.

This recommendation is unresolved and open.

ICE's Comments to Recommendation #4

ICE did not concur with our recommendation. ICE believes that its standards are appropriate in this area. The agency stated that a medical examiner, a hospital, or a physician, is responsible for implementing any state notification requirement. In the New Mexico case, ICE noted that any rule of its own would not have facilitated action by state or local entities to make notification to the proper authority.

OIG Analysis

We reaffirm our recommendation. ICE acknowledged the importance of state notification, but believes it is not its responsibility to do so. ICE can rely on other entities to ensure state notification. However, ICE's standard currently does not mention reporting detainee deaths to states. Although other officials or a hospital can help satisfy the requirement, the detainee is ICE's responsibility. It is possible that some hospitals or medical examiners may not realize that ICE is a law enforcement agency. ICE is not prohibited from proactively ensuring that detainee death notification occurs, especially since the agency's standards require staff to comply with state rules on infectious disease reporting and other areas. ICE could take the step of articulating the importance of death notification. This would also provide ICE an additional opportunity to collaborate with states.

This recommendation is unresolved and open.

ICE's Comments to Recommendation #5

ICE concurred with our recommendation. The agency is pursuing a Memorandum of Understanding with OFDT. ICE also provided details on its work with OFDT, as well as efforts to improve the compliance at the Regional Correctional Center. ICE stated that our recommendation was incorrectly based on a perception that OFDT provided information that led to ICE's decision to remove detainees from the facility. ICE stressed that it relied on its own standards, rather than input from OFDT, in the decision to remove all immigration detainees from the RCC.

OIG Analysis

Our recommendation is not based on a belief that OFDT has better standards. We reported that OPR findings led to the removal of ICE's RCC detainees. The purpose for this recommendation was that OFDT had indentified medical access problems that ICE did not. Without knowing about these problems, ICE admitted nearly 3,500 detainees to the RCC. Through greater interaction with OFDT, the two agencies can facilitate improvements across federal detention facilities. A formalized partnership, along with the improvements that ICE is making, can facilitate higher levels of compliance at facilities. When the final MOU is completed, ICE should forward the document to the OIG. We could close this recommendation at that time.

This recommendation is resolved and open.

Oversight Can Be Improved at ICE Detention Facilities

ICE conducts annual monitoring visits to determine a facility's compliance with the detention standards. Staff conducting routine oversight of facilities has not been effective in identifying certain serious problems at facilities. Moreover, ICE's reports, based mainly on checklists that divulge little about the area reviewed, do not provide much information to facilities or outside reviewers. In December 2006 we reported that ICE did not find medical access problems and other non-compliance at detention facilities. Although ICE is taking steps to improve facility oversight, the agency should revise certain policies and standards to gain a more complete understanding of facilities' compliance status. By improving its oversight methodology, ICE will improve both standards compliance and detainee safety.

An Overview of ICE's Detention Facility Monitoring Efforts

Each facility housing ICE detainees is scheduled to receive an annual monitoring visit. Site visit teams use various worksheets to report on a

facility's adherence to ICE's standards. For contract detention facilities and service processing centers, a team from ICE headquarters leads the site visits. Field office staff is charged with monitoring of facilities that house detainees under an intergovernmental service agreement. Reviews usually take three or four days to complete.

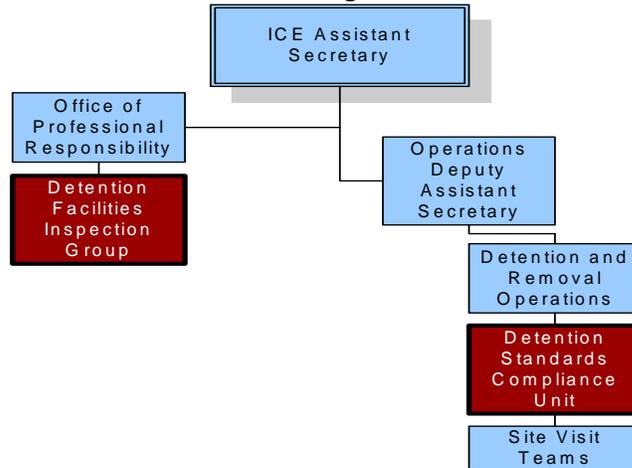
Within 14 days of completing a facility review, the team submits a report to ICE's Detention Standards Compliance Unit. The unit examines the report for completeness and the soundness of the team's conclusions. This leads to a rating of the facility's performance against general areas of the standards, such as food service, the detainee handbook, and detainee access to medical care. If the review team determines that there is a deficiency in a particular area, the facility is required to undertake corrective action. After review of the report by headquarters staff, the facility also receives one of five overall ratings:

- Superior – The facility exceeds expectations based on exceptional performance and excellent internal controls.
- Good – The facility performs all of its functions with few deficient procedures.
- Acceptable – The facility's detention functions are performed adequately. ICE considers this level the baseline for its facility rating system.
- Deficient – The facility is not performing one or more detention functions, with inadequate internal controls.
- At Risk – The facility's detention operations are impaired to the point where mission performance is not being accomplished.

ICE is strengthening its oversight of detention facilities. A manager in ICE's Office of Professional Responsibility informed us that a new unit, the Detention Facilities Inspections Group, will focus on standards compliance at detention facilities. The group will also conduct independent reviews of certain incidents at detention facilities. At the time of our fieldwork, only six employees were assigned to the new group, with projections for 12 additional

staff members. ICE officials asserted that the Detention Facilities Inspections Group is a “high priority.” The group must have sufficient resources to inspect detention facilities. Figure 3 highlights the placement of ICE’s detention facility monitoring units in the agency’s organizational structure.

Figure 3: Excerpt of ICE Organizational Chart Showing Detention Facility Monitoring Units



OPR participated in an ICE site visit after a March 2006 detainee death in Texas. According to the review, which took place less than a week after that incident, serious issues compromised detainee safety. A subsequent report concluded that the facility “has experienced a complete breakdown in communication, leadership, and supervision,” prompting difficulties “on every level.” ICE no longer uses the facility to house detainees.

ICE is also in the process of contracting with outside experts to relieve ICE staff of the annual onsite facility monitoring function. This new process is now in place. ICE management believes that this new approach will be similar to how OFDT implements its monitoring visits. ICE’s contractor will use existing ICE monitoring instruments and protocols.

Better Review of Medical Exam Timeliness is Needed

ICE’s medical care detention standards require facilities to conduct a health appraisal and physical examination on each detainee within 14 days of the detainee’s arrival at the facility. This exam is designed to gather details about a detainee’s health beyond the screening questions asked during the intake process. The physical examination offers an important opportunity to gauge the health status of detainees. Timely delivery of the physical exam enhances a facility’s identification and treatment of communicable or chronic illnesses.

We examined data on the timeliness of the 14-day exam from the Regional Correctional Center and the Ramsey County Law Enforcement Center. Because it had a considerably larger number of detainee intakes, we only requested three months of data from the RCC, April through June 2007. Ramsey County provided timeliness data for all detainees entering the facility for the first six months of 2007. Both facilities had difficulty meeting ICE's physical exam timeliness standard. Officials at various detention facilities reported that staffing shortages, overworked clinicians, or an excessive facility intake can cause delays in delivery of this service.

There were 1,118 new ICE detainees booked at the RCC during our three-month sample. Of these, 997 stayed longer than 14 days. We determined that 830 of the 997, or 83%, received a timely physical exam and 167, or 17%, did not. During its September 2006 monitoring visit, OFDT determined that the RCC met the 14-day standard in 18 of 20 cases, a 90% rate.

For the Ramsey County facility, only 43 ICE detainees admitted in the first 6 months of 2007 were housed for more than 14 days. Of the 43 detainees, 10, or 23%, had information regarding a physical exam in their medical file. Those with a completed physical often received the exam beyond 14 days. Table 1 lists the 10 detainees who had medical exam information documented in their file. In 3 of the 10 cases, no physical exam had been provided. For the seven cases with an exam date, an average of 40 days elapsed between the detainees' intake and the exam.

Table 1. Ten Cases from the Physical Exam Timeliness Sample, Ramsey County Law Enforcement Center

	Intake date	Exam date	Days Elapsed	Days Detained
Detainee #1	3/26/2007	3/27/2007	1	23
Detainee #2	3/29/2007	5/14/2007	46	94
Detainee #3	4/16/2007	6/18/2007	63	76
Detainee #4	4/16/2007	6/18/2007	63	76
Detainee #5	5/4/2007	5/22/2007	18	58
Detainee #6	5/4/2007	7/16/2007	73	Unknown
Detainee #7	5/15/2007	No exam	NA	47
Detainee #8	6/4/2007	No exam	NA	27
Detainee #9	6/11/2007	6/28/2007	17	20
Detainee #10	6/12/2007	No exam	NA	16

The data provided by Ramsey County showed additional problems with timely tuberculosis screening. One element in ICE's monitoring protocol asks if the facility has ever needed more than one business day to conduct this screening test. For the 43 individuals in our sample, only 14 cases showed a date for the initial skin test used to detect tuberculosis. Ten of these detainees were not given a test within one business day. In one of these cases, the facility did not test a detainee for more than two months.

ICE monitoring reports contained limited evidence that staff conducting site visits actually reviewed facility compliance with the 14-day exam standard. We concluded that sampling is not done on a consistent basis. A manager in ICE headquarters said that sampling is discussed during reviewer training, but ICE's monitoring protocols do not require sampling to test a facility's compliance. ICE should examine sample data during each of its monitoring visits to test compliance with the 14-day exam and other standards.

Our December 2006 report on detainee treatment discussed problems with the 14-day exam standard at two facilities. The Berks County Prison was compliant on only 38 of 42 sample cases, while an ICE facility in San Diego met the standard in only eight of 19 cases. Two other facilities met the standard in all 50 cases examined.¹⁰ Using sampling to gain a better understanding of a facility's compliance level would be a valuable measure of how well detainees receive services designed to improve health outcomes.

Since compliance can fluctuate over time, ICE needs to ensure that facilities continuously comply with detention standards. Although we are not recommending regular reporting by facilities, such information could be helpful to discern the ability of a particular location to house more detainees. ICE should also take larger and more frequent samples of other medical standards at those facilities that have exhibited problems. Developing sampling guidance in other areas would benefit ICE's monitoring program.

ICE Can Improve Detention Facility Monitoring Reports

Questions regarding the materiality of findings are undermining the quality and usefulness of ICE's monitoring reports. Current policy emphasizes that the materiality of a finding is based on the reviewer's analysis of available evidence, extent of the problem, risk to the program's efficient and effective management, review objectives and any other factors. This is a credible approach, but additional policy is needed to ensure ICE reviewers, who must determine whether a facility's performance warrants deficient ratings, target areas of particular importance. Improvements in this area would also make a facility's final rating more objective.

In some monitoring reports, reviewers deemed the facility's performance on certain elements acceptable, despite identifying notable deficiencies. For example, the November 2006 report for Ramsey County said the facility did not abide by ICE's standards on tuberculosis screening. Screening for

¹⁰ DHS OIG, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, OIG-07-01, December 2006, pp. 3-4.

tuberculosis is central to the safety of facility staff and other detainees. Compliance in this area should be a leading factor in a facility's overall rating in the access to medical care area. However, the facility received an acceptable rating for that general standard.

In its September 2006 report, OFDT raised concerns about the ability of the RCC's medical unit to provide timely care with the number of clinicians on staff. ICE's November 2006 report, on the other hand, simply gave a "yes" answer, with no other comment, for the standard requiring all detainees have access to and receive medical care. Had ICE been aware of the health care access problems at the RCC, it might have considered different locations for some of the 3,465 detainees who entered the facility from January through July 2007.

There were some questionable conclusions in ICE's November 2006 RCC monitoring report. For several elements, no examples of a particular event were evident, yet ICE concluded that the RCC met the standard. For such situations, it would be more accurate to conclude that a particular element was not applicable. ICE reported that the facility met other requirements, even though reviewer comments suggested otherwise. For example, the RCC did not have certain emergency plans, but the report concluded that the RCC met the requirement for such plans. Also, ICE reported that the RCC met the standard requiring storage of medical records in a locked area, even though the reviewers found one cabinet unlocked. Although corrective action was immediate, the issue was serious enough to warrant a finding that the RCC did not meet the standard.

ICE drew questionable conclusions in monitoring reports of other facilities. One report listed several deficiencies regarding a facility's medical treatment, even though ICE granted an acceptable rating in this area, including:

- Absence of intake tuberculosis screening;
- Absence of privacy blinds in exam rooms;
- Insufficient oversight to ensure medical records were always secured;
- The need to update certain policies, including 24-hour access to emergency services; and,
- Improvements needed to policies related to special needs individuals.

Another ICE monitoring report graded a facility's security inspections acceptable, while noting the need for improvement in a non-compliant visitor pass system, the absence of documentation showing vehicles entering or departing secured areas, and incomplete vehicle searches. With such information, we have determined that the facility was deficient in this area.

Further explanation of these problems in an expanded narrative section in the report would have been beneficial.

In comparing overall ratings given to facilities, changes are also needed to explain why particular facilities receive a given rating. Some field offices perceive the final rating process used by ICE headquarters as arbitrary. The Ramsey County Law Enforcement Center received a good rating in 2005, but only acceptable in 2006. The later report did not explain why the compliance status fell one level. In another example, in June 2006, one facility with uncorrected problems with staff-detainee communication still received a good rating. Another facility without any notable deficiencies only received a rating of acceptable. After reviewing the reports, we could not determine the justification for the second facility receiving a lower rating.

Enhancements to site visit reports would permit a better understanding of a facility's particular rating. In most of the reports we examined, the review team did not make use of the Remarks section found after each general standard. The narratives that appear in OFDT reports offer a more detailed assessment of a facility's compliance status. This is especially important in instances where a facility could use more guidance.

An ICE Standard on Internal Review at Facilities Would be Beneficial

ICE currently does not have a requirement that facilities perform assessments of their operations. Through review of its own operations, a facility could more quickly discover problems, such as untimely access to health care. Developing a standard in this area would help ensure that facilities achieve and maintain compliance improvements.

Both ACA and OFDT have standards that address the need for facilities to review their operations continually. ACA's policy on Health Care Internal Review and Quality Assurance establishes the collecting, trending, and analyzing of data as a central feature of a successful review program. On-site monitoring of health service outcomes on a regular basis is the central component of ACA's standard. According to OFDT's policy, a facility's internal review process is separate from external or continuous inspections or reviews conducted by other agencies. These standards for internal review could guide ICE's development of its own standard in this area.

Notable problems at one facility demonstrate the utility of self assessments. In March 2006, the facility received a deficient rating based on non-compliance in 11 of the 38 detention standards. Later that year, two detainees died at the facility. ICE's reviews of these two incidents discussed serious problems with access to medical care and the oversight of clinical operations.

ICE reported that the facility did not perform basic supervision and provide for the safety and welfare of ICE detainees. Had the facility reviewed its own operations, it might have uncovered issues related to insufficient medical staffing, problems with staff training, or other deficiencies. ICE discovered these issues only after two detainees died. ICE's March 2007 monitoring review at the facility noted that five detainee deaths had occurred in the previous calendar year.

Two recent monitoring reports of another facility highlight the importance of ongoing detention facility oversight. In August 2006, ICE granted a superior rating to one facility after a routine monitoring visit. After the November death of a detainee, ICE identified a variety of problems related to this facility's medical care. The review team noted that the facility does not routinely do physical examinations on detainees who are in the facility more than 14 days. Additionally, ICE's review team concluded that the facility has failed on multiple levels to perform basic supervision and provide for the safety and welfare of ICE detainees. Further, the line of communication in the medical department at this facility was deemed to be poor, placing detainee health care in jeopardy.

Maintaining a complete and current picture of its facilities' clinical operations should become a priority for ICE and its detention partners. Detecting deficiencies before problems arise is vital to detainee protection and standards compliance. As one correctional expert wrote, "Delayed or inadequate treatment of persons with medical conditions often results in liability exposure and publicity."¹¹ Investments in internal reviews can diminish such negative effects through continual corrective action by the facility itself, outside of ICE's regular monitoring process.

Recommendations

We recommend that the Assistant Secretary for Immigration and Customs Enforcement:

Recommendation #6: Revise monitoring protocols and the medical detention standard to require sampling and continuous oversight of the 14-day physical exam standard across ICE's detention facilities.

Recommendation #7: Revise monitoring policies and other guidance given to reviewers regarding the materiality of site visit report findings to ensure that standards, such as tuberculosis screening and others related to access to medical care, weigh more heavily on a facility's compliance level.

¹¹ *Clinical Practice in Correctional Medicine*, 2nd ed., 2006, p. 42.

Recommendation #8: Require reviewers preparing monitoring reports to use narratives to illuminate special areas of concern and provide additional details about issues relevant to a facility's compliance status.

Recommendation #9: Develop a standard that requires facilities housing ICE detainees to implement an internal review function.

Management Comments and OIG Analysis

ICE's Comments to Recommendation #6

ICE concurred with our recommendation. The agency will use three steps to improve oversight of the 14-day physical exam standard.

- Regular sampling by on-site clinical staff and remote sampling for facilities served by a regional contractor.
- Findings of OPR's Detention Facility Inspection Group inspections through its facility oversight role, and
- Detention and Removal Operations will provide OPR information on this recommendation during Self Inspection Program reporting.

OIG Analysis

In its action plan, ICE should provide sufficient evidence of the policy revisions and site visit reports, showing that the required sampling is taking place to satisfy the intent of this recommendation.

This recommendation is resolved and open.

ICE's Comments to Recommendation #7

ICE concurred with our recommendation, noting that findings with significant consequences are weighed more heavily in a facility's overall compliance rating. ICE's pending performance-based standards will improve the accuracy and credibility of performance ratings. ICE also relies on immediate correction of serious life and safety issues found during monitoring visits.

OIG Analysis

Our recommendation focused on the scoring of particular elements in a way that inaccurately reported a facility's actual status. Examples in our report showed facilities with obvious medical access problems still scoring at an acceptable level for that specific element. In its action plan, ICE should provide more detailed policy guidance and examples of site visit reports to demonstrate that both overall and specific elements are more accurately graded during the monitoring process. Upon doing so, we will close this recommendation.

This recommendation is resolved and open.

ICE's Comments to Recommendation #8

ICE concurred with our recommendation. As a result of improvements made in late 2007, ICE is expanding the use of narratives in its site visit reports. This new process, which uses contracted experts in facility oversight, will lead to greater use of narratives to expound on areas of concern. Such additional information can clarify findings and enhance a facility's ability to comply with necessary standards.

OIG Analysis

ICE has taken positive steps in this area, as it now uses the narrative field in its monitoring reports. We will close this recommendation on receipt of a copy of an inspection that demonstrates the use of the report's narrative feature.

This recommendation is resolved and open.

ICE's Comments to Recommendation #9

ICE concurred with the premise of our recommendation, but did not concur with the need to create a standard on facility self-assessments. ICE is concerned that a self-assessment policy could diminish the consistent implementation of its national standards. The agency noted that it uses quality assurance experts at large facilities to help ensure local compliance in key areas. ICE believes that the participation of third party experts is necessary for local conditions to be monitored appropriately. In addition, ICE relies on its own monitoring practices to examine the compliance of facilities housing immigration detainees.

OIG Analysis

We reaffirm our recommendation that ICE develop a facility self-assessment policy. The agency's response states, "We concur that there needs to be a sound internal review mechanism, but we disagree to the extent that the review process should be conducted by facility personnel." In the health care compliance field, self-assessments are performed by a facility's own staff. ICE's regular site visit monitoring process and internal review are different concepts, to be performed by different individuals. What we are recommending in no way replaces those reviews. The Health Care Compliance Association notes that internal reviews "test compliance with internal policies and procedures and with federal, state, and local laws regulations and rules." These programs are "often critical" in finding a problem before "it creates significant risk to the organization." A facility can

use a self assessment to measure current compliance, ensure correction of deficiencies, or confirm ongoing compliance. Clinical staff at a local facility has the expertise to determine whether rules on the timeliness of physical exams and screenings have been met. Many standards do not require interpretation or the intervention of outside experts. Thus, ICE should not be concerned that self assessments are contrary to national consistency. It is also important to note that an internal review need not place exorbitant demands on detention facilities. For example, after receiving data from Ramsey County and Cornell, we quickly judged the facilities' timeliness in providing physical exams and tuberculosis screening, two areas central to a facility's medical care access.

ICE's quality assurance experts are not used in most local facilities. ICE should help facilities use their own processes to ensure basic standards are met on an ongoing basis – outside of the routine monitoring processes. Onsite experts or ICE site visits do not provide this level of ongoing assessment. Since ICE endeavors to follow ACA standards, it should create a facility self assessment standard to match the mandatory nature of ACA's guidance in this area, which has existed since 2004.

This recommendation is unresolved and open.

Additional Efficiencies in Medical Operations Can Enhance Implementation of ICE's Detention Standards

ICE can develop a more efficient and productive oversight process for its detention facilities and enhance the standards that are appropriate and generally equivalent to the standards of ACA and OFDT. Further steps, such as the creation of electronic health records and increased staffing of clinical operations, offer additional means for ICE to strengthen standards compliance and improve detainee care.

ICE's Standards Are Credible Compared to Other Organizations

Our analysis of several ICE detention standards, compared to the ACA and OFDT standards, is provided in Appendix E. In some instances, ICE's standards are more detailed than those of ACA and OFDT. For example, a recent article noted that ICE's standard on hunger strikes provides important details that are missing from similar ACA standards.¹² We found that ICE's standard on HIV/AIDS offers more specific guidance to facilities, as well. ICE requires that only a licensed physician will make a diagnosis of AIDS

¹² "What They Can Do About It: Prison Administrators' Authority to Force-Feed Hunger-Striking Inmates," 24 *Washington University Journal of Law and Policy* 151 (2007).

based on a medical history, current clinical evaluation of signs and symptoms, and laboratory studies. ICE also identifies procedures for treating the detainee within and outside the facility's clinic. Staff responsibilities and precautions are also outlined. ACA's standard specifies only that the detention facility will have a written plan that addresses the management of HIV infection and procedures for dealing with the detainee. Specific procedures for treatment and staff responsibility are not developed. OFDT's standard simply classifies HIV as a chronic medical condition, requiring regular treatment.

Additionally, the ICE standard on detainee grievances has important details that are not discussed by ACA or OFDT. The ICE standard specifies a formal and informal procedure for resolving detainee grievances. In the formal process, the detainee completes a form that discusses in writing the particular issue of concern. An informal grievance is delivered orally, offering detainees the opportunity to resolve their concerns before resorting to the longer formal procedure. Detainees can communicate their informal grievances to ICE staff, and all grievances can be appealed. OFDT's process is similar to that of ICE, although an informal process is not developed. Based on ICE data, no grievances were filed by the 33 detainees who died between January 1, 2005 and May 31, 2007.

ICE, ACA, and OFDT understand the importance of identifying detainees with special medical needs. However, the three entities have different definitions of a special needs individual. According to ICE's standard in this area, the facility's officer in charge will be notified when detainees are diagnosed with special needs. OFDT echoes this point, but it gives more specific examples of types of conditions that affect individuals with special needs. Additionally, OFDT requires additional health care for detainees diagnosed with special needs.

The ABA has encouraged ICE to make the agency's detention standards enforceable through regulation. The ABA contends that, even though intergovernmental services agreements require compliance with standards, the standards currently in place are only advice to facilities on ensuring detainee welfare. There may be merit to creation of a regulatory mechanism to enforce ICE's standards. We are not persuaded by the department's memorandum in reply to the ABA, which discussed problems this course would create, such as staffing issues and the cumbersome regulatory update process. However, ICE is considering the feasibility of making the standards regulatory.

ICE has already taken some steps to enhance its standards. The agency is moving toward the creation of performance-based standards similar to those used by ACA and OFDT. These standards provide an opportunity to articulate more clearly the specific actions that facilities are expected to take.

Performance-based standards are goal-oriented and include outcomes measures, which can provide facilities with guidance on the implementation. This should bring about improvements in facilities' adherence to specific goals. Improvements to ICE's facility monitoring process should be enhanced when the updated standards are finalized.

Electronic Medical Records Would Create Efficiencies for ICE

We reviewed the utility of electronic health records (EHRs) for ICE's detention facilities. EHRs digitally store individual health information, either in a transferable card or a centralized database. ICE and its facilities currently rely on traditional paper-based medical records. However, ICE, including its Division of Immigration Health Services (DIHS), has taken preliminary steps toward electronic records, including development of systems requirements. ICE has spent more than \$2.2 million on the development of an electronic records system, including software and training expenses. DIHS determined this initial systems design was less than sufficient. ICE has noted its interest in making improvements on its initial system.

Efficiencies created by EHRs would provide ICE many advantages in the management of detainee care, especially when detainees are transferred to other facilities. For example, EHRs can be easily transmitted. An individual's records would be immediately available to clinical staff at a new detention facility. This would allow for a more rapid assessment of a detainee's current medical needs, reduce duplication of intake screenings or physical exams, and improve detainee safety. By expediting the development of EHRs, ICE and its detainees would receive long-term benefits.

The Veterans Health Information Systems and Technology Architecture enabled the Department of Veterans Affairs (VA) to create EHRs for individuals receiving care at VA hospitals and clinics. The VA's EHRs provide patient-specific information that permits time and context sensitive clinical decision-making. The VA has achieved important safety improvements through its use of electronic information. For example, electronic prescriptions have reduced medication errors and helped to identify incompatible medications. The VA has reported a medication error rate of 0.003%, well below the three to eight percent national average.¹³

ICE facilities managed by the Correctional Corporation of America use EHRs. When an ICE detainee is transferred between facilities managed by the company, clinical staff can access an electronic records system. One of the company's facility wardens said that less paperwork and more timely

¹³ "The Best Medical Care in the U.S.," *Business Week*, July 17, 2006.

information about detainees has improved operations at the company's detention facilities. An ICE review of a Houston detainee's suicide provides an example of how rapid access to health records can be vital. According to the incident report:

A major area of concern was a lack of medical records . . . Following the death, the detainee's health records from his previous institution revealed the detainee had been diagnosed and treated for Schizophrenia and had at least one documented suicide attempt . . . Such information would have been valuable to the mental health provider and medical staff at Houston.

Although the individual was transferred from a Bureau of Prisons facility to Houston, rather than from another ICE facility, the report provides keen insight into the utility of EHRs.

Additionally, EHRs would not be subject to disruption or destruction. This was especially important to the VA during Hurricane Katrina, when clinicians around the country had electronic access to records of the 40,000 veterans who had received care or ordered prescriptions at VA facilities in Louisiana and Mississippi. A 2007 study by the State of California also discussed how EHRs could ensure the maintenance of medical records during natural disasters or other catastrophic events.¹⁴

ICE and DIHS have recently taken steps to create a system of electronic health records. An ICE official suggested that more detailed discussions are needed to define systems requirements, and ICE needs to understand DIHS's perspective on the limitations of the electronic records system. The proposed integration of DIHS into ICE should enhance progress toward development of EHRs for ICE detainees. This integration is anticipated in early FY 2008.

ICE is a natural candidate for implementation of EHRs. By enhancing the efficiency of clinical operations, ICE would provide better care for its detainees. We recognize that complicated systems decisions are necessary before an effective electronic records system can be fully implemented, including concerns about the privacy of electronic records. Thus, ICE should consult outside experts, such as the VA, as needed.

¹⁴ The State of California, Legislative Analyst's Office, "A State Policy Approach: Promoting Health Information Technology in California," February 2007.
http://www.lao.ca.gov/2007/health_info_tech/health_info_tech_021307.aspx

Some ICE Facilities Are Experiencing Clinical Staffing Problems

Two ICE facilities included in our review have staffing problems, raising concerns about not only the slow pace of hiring, but the agency's ability to provide proper health care. DIHS personnel said that they need a better understanding of ICE's vision for detention services. They said that understanding the vision would help determine where additional or new personnel resources should be placed.

Nationally, contract detention facilities and service processing centers using Public Health Service clinicians had a 36% vacancy rate in October 2007. The contract detention facility in Pearsall, Texas, which housed more than 1,500 detainees the day we visited, had 22 medical staff vacancies. Given its rural location and the nation's high demand for nurses, staff in Pearsall said that they will endure medical staff shortages indefinitely.

Staff from the San Diego Field Office also expressed concern about recruiting and retaining clinical staff for its contract detention facility. In its December 2006 ICE site visit report, the facility earned an overall rating of deficient after receiving a good rating in 2005. Health care access problems caused by insufficient medical staff were a primary reason for the low level of performance. According to the site visit report, nearly 260 detainees did not receive a physical examination during a three-month period in 2006. Field office staff suggested that DHS' lengthy security clearance process is an obstacle to filling vacant medical staff positions. To offset not having sufficient medical staff, the current staff work extended hours in an attempt to improve compliance with ICE's medical standards. ICE did provide data showing that recent progress has been made on the issue of clearance processing, but the general concerns expressed by staff in Pearsall and elsewhere warrant further scrutiny by ICE management.

Immigration attorneys we interviewed said that their primary concern is ICE's ability to deliver timely health services. In June 2007, the American Civil Liberties Union filed a class action suit against ICE as a result of problems at the San Diego Detention Center. Agencies can be exposed to legal liability if medical standards are not properly implemented. As one expert wrote, "Most cases in which courts have found constitutional violations of inmates' rights to health care were fostered by the exigencies of an overburdened staff coping with too few resources."¹⁵ Even in those areas where ICE has a credible treatment standard, such as care for detainees with AIDS, other organizations have determined that medical care can be inadequate. A human rights group recently alleged several examples of problems with ICE's treatment of

¹⁵ *Clinical Practice in Correctional Medicine*, 2nd ed., 2006, p. 524.

detained individuals with AIDS. This group's report detailed cases where detainees were denied medications or where needed care was delayed.¹⁶ We did not review any of these cases for this report.

We discussed various medical access issues with Public Health Service clinicians, who provide care at some of ICE's facilities, and officials from DIHS headquarters. Some DIHS officials believe that greater involvement in ICE's detention management strategic planning would help with staffing problems. This would give DIHS a better idea of where clinical staff would be needed. Although our interviewees described the relationship between ICE and DIHS as very positive, ICE should ensure that clinical staffing efforts are aligned with ICE's strategic planning for detention management.

Recommendations

We recommend that the Assistant Secretary for Immigration and Customs Enforcement:

Recommendation #10: Expedite all necessary discussions and resources to develop a system of electronic health records for ICE detainees.

Recommendation #11: Work with the Division of Immigration Health Services to identify all clinical staff shortages, then work with ICE's clinical partners to develop and implement a strategy to fill clinical staff shortages at immigration detention facilities.

Management Comments and OIG Analysis

ICE's Comments to Recommendation #10

ICE concurred with our recommendation. The agency continues to work with DIHS and other experts to create the electronic records system. The department's Investment Review Board must approve the system.

OIG Analysis

In its corrective action plan, ICE should provide details on the progress it is making regarding acquiring the necessary technology and designing the protocols for the EHRs. Once we receive evidence of ICE's commitment to establishing an EHR system, we will close this recommendation. This recommendation is resolved and open.

¹⁶ Human Rights Watch, *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, December 2007.

ICE's Comments to Recommendation #11

ICE concurred with our recommendation. Through interaction with DIHS, ICE is creating a strategic plan to examine a variety of issues related to the recruitment and retention of clinical staff. This plan will include improvements to the processing time of background investigations, considerations for the use of incentives such as signing bonuses, student loan repayment, hiring additional health care recruiters, and collaborating with the U.S. Public Health Service for hiring and placing health care professionals to support ICE detention operations.

OIG Analysis

We look forward to receiving ICE's staffing strategic plan. This plan should help ICE correct the difficult staffing problems that confront many health care providers across the country. In its action plan, ICE should set a timetable for completing the strategic plan.

This recommendation is resolved and open.

ICE provided data showing that 33 immigration detainees died in custody between January 1, 2005 and May 31, 2007. We examined incident reports and other data about these cases, and interviewed field office personnel to gain further insight into some detainee deaths. The two instances of detainee death that were the focus of this report were referred to us through the OIG Hotline.

We examined:

- Documentation regarding detainee death cases, including detainees' detention and medical files;
- Detention standards used by ICE and other entities;
- Legal cases and international human rights agreements; and
- Facility monitoring reports and data held by detention facilities.

We conducted 53 interviews, including discussions with ICE headquarters and field office staff. Conversations with field office staff covered detention standards, detainee death incidents, and resource issues. We interviewed staff from DHS' Office for Civil Rights and Civil Liberties, public and private sector clinical experts, immigration attorneys, and experts in correctional facility oversight.

We toured seven facilities that house ICE detainees. These facilities were:

- Ramsey County Law Enforcement Center, St. Paul, Minnesota;
- Sherburne County Jail, Elk River, Minnesota;
- El Paso Service Processing Center, El Paso, Texas;
- Regional Correctional Center, Albuquerque, New Mexico;
- Central Texas Detention Facility, San Antonio, Texas;
- South Texas Detention Complex, Pearsall, Texas; and
- Laredo Processing Center, Laredo, Texas.

We conducted our review between May 2007 and August 2007 under the authority of the *Inspector General Act of 1978*, as amended, and according to the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

Appendix B
Management's Comments to the Draft Report

Office of the Assistant Secretary

U.S. Department of Homeland Security
425 I Street, NW
Washington, DC 20536



U.S. Immigration
and Customs
Enforcement

MAR 19 2008

MEMORANDUM FOR: Richard Skinner
Inspector General

FROM: ^{NDS}_{for} Julie L. Myers
Assistant Secretary

SUBJECT: Office of Inspector General Audit Draft Report
"ICE Policies Related to Detainee Deaths and the Oversight of
Immigration Detention Facilities," dated Jan. 11, 2008

I wish to thank the Office of Inspector General (OIG) for this opportunity to review and comment on your draft report concerning ICE's policies relating to detainee death and oversight of our facilities. I am pleased to know that OIG confirmed that ICE adhered to the important portions of the detainee death standard that were the focus of this review. I am committed to considering any suggestions that will allow ICE to improve the oversight of all facilities that house individuals in our care. I am particularly committed to ensuring that the U.S. Department of Health and Human Services' Division of Immigration Health Services (DIHS), ICE's Detention and Removal Operations (DRO), and our contract facilities take all appropriate steps to recognize and respond to evidence of life-threatening illnesses in order to avoid the lamentable death of an individual in ICE's care.

I also wish to inform you that ICE has made significant strides in improving overall oversight of our facilities. Your report briefly mentioned the Detention Facilities Inspection Group and the Detention Standards Compliance Unit, but I wanted to highlight some of the other progress we have made toward strengthening overall internal review and compliance of our facilities that were not considered in your report, but merely mentioned briefly.

ICE entered into a contract that has placed subject matter experts in selected facilities on a daily basis to monitor both the detention standards and the detainees' quality of life. These reviewers serve as professional on-site compliance personnel in each Service Processing Center (SPC), Contract Detention Facility (CDF) and large Intergovernmental Service Agreement (IGSA) facility. On-site compliance for the smaller IGSA facilities will be achieved through a regional monitoring plan. This program will also support contractual compliance review for contract detention facilities by use of a performance-based concept.

Specifically, ICE has contracted with the Nakamoto Group to provide on-site National Detention Standards (NDS) compliance verification for all ICE detention facilities. This program features

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008

Page 2

a five-person management team at ICE headquarters that provides program management, staffing coordination, reports, and analytical and administrative services for staff members stationed at facilities throughout the United States. Nakamoto Group personnel are posted on-site at all SPCs, CDFs, and larger IGSAAs. Smaller IGSAAs will be serviced on a regional basis. The contractor is also currently in the final development stage of an automated reporting function that will allow DRO to monitor the most-current compliance status of ICE detention facilities.

Our other partner, Creative Corrections, conducts annual inspections of all detention facilities that house ICE detainees. Each inspection is conducted by a five-member team of subject-matter experts and is performed over a two to three-day period depending on the type of facility being inspected. As of today, Creative Corrections has conducted over 141 facility reviews. ICE requires Creative Corrections to perform eight annual inspections per week.

Additionally, ICE is working closely with major non-governmental organizations and DHS' Office of Civil Rights and Civil Liberties (CRCL) in order to revise our 38 current national detention standards and convert them into 41 performance-based standards. After we consider comments from NGOs and CRCL, we hope to publish these standards by September 1, 2008. As your report correctly noted, we expect these performance-based standards to improve a facility's adherence to specific, measurable goals. Also, our revised detainee handbook is slated to be released in May 2008. Prior to distributing these handbooks, ICE will consult with major NGOs and the American Immigration Lawyer's Association for their input as well. This handbook, which is written in English and Spanish, will provide an overview of the general rules, regulations, policies and procedures in place at detention facilities as well as an overview of the programs and services available at the facilities.

We also note that your report differentiates ICE's standards from those of the American Correctional Association and the Office of Federal Detention and Trustee (OFDT), particularly when your report discusses OFDT's review of the Regional Correctional Center (RCC) facility. We request that your report also highlight that these different standards are based on the needs of each federal agency that was involved in developing OFDT's current standards. To be sure, when OFDT developed its current performance-based standards, it worked with ICE, the U.S. Marshals Service and the Bureau of Prisons. These three federal agencies have developed standards to meet the needs of the population they serve consistent with their overall missions. The U.S. Marshals Service is concerned with the housing and transportation of prisoners and the Bureau of Prisons is primarily charged with the custody and care of federal prisoners who have been convicted of crimes and face criminal trials. ICE, on the other hand, detains individuals who are facing civil removal proceedings in order to ensure their appearance in immigration court or to ensure their appearance for removal from the United States. Our detention standards were developed with the needs of this agency in mind. OFDT recognized the varying levels of standards when developing their own key standards that apply to all federal facilities. In so doing, OFDT noted that "the purpose for detention varies across agencies; accordingly, the standards adopted addressed only the most basic and critical elements common to all agencies. The standards are intended to supplement policies, procedures, and practices that were specific to the needs of each agency." As such, we note that our decision to remove aliens from the RCC was not based on the basic standards OFDT set, but rather upon our in-depth review, which went far beyond OFDT's minimal findings.

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 3

Below, please find ICE's response to each recommendation your office has made in its draft report. I look forward to continued collaboration with you and members of your office to improve our policies.

Recommendation 1: Work with the Office of Inspector General to create a policy that would lead to the prompt reporting of all detainee deaths to the Office of Inspector General.

ICE Response: ICE concurs with the recommendation. We are committed to prompt and accurate reporting to OIG whenever a detainee dies in our facilities. Under current ICE policy, the death of any detainee in our custody is considered a significant event that must be reported to the Joint Intake Center (JIC). ICE must notify the JIC of this event within two hours by phone and within 24-hours in writing. Once the JIC receives a Significant Incident Report, it will prepare a Rapid Reach Report, which is sent to the Office of Professional Responsibility (OPR) for any action deemed appropriate, as well as to other ICE components.

To clarify our commitment to timely report all deaths to OIG, the Director of OPR issued a memorandum on March 13, 2008, instructing the OPR OIG investigative liaison at the JIC to telephonically notify OIG of any detainee death and provide any relevant facts concerning the death. Additionally, the death will be reported in the daily activity report that is compiled by OPR and transmitted to OIG each business day.

It is requested that this recommendation be considered resolved and closed. Attached, please find OPR's memorandum to the JIC.

Recommendation 2: "Work with the Division of Immigration Health Services, the Centers for Disease Control (CDC), and other experts, to enhance existing medical standards, rules for special needs individuals, and coverage guidance related to infectious disease."

ICE Response: ICE concurs in part and disagrees in part with this recommendation. As the recommendation pertains to NDS, ICE concurs with the recommendation to work with DIHS and other experts to enhance the detention standard for detainee access to medical care. The NDS is routinely scrutinized for improvement. Currently, ICE is updating all 38 standards and converting them into 41 performance-based standards. These draft standards are currently being reviewed by major NGOs and CRCL for their substantive comments. We expect the revised National Detention Standards to be published and available by September 1, 2008.

The current medical standard, which was developed with the input and guidance of medical professionals, allows for special needs individuals to receive appropriate medical care. In fact, DIHS has consulted with the Centers for Diseases Control and Prevention (CDC) in the past and has incorporated many of the CDC's guidelines into protocols for detecting and treating aliens with infectious or communicable diseases in facilities with DIHS staffing. Also, in general, the standard requires that all facilities employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees. The standard requires the detention facility officer-in-charge, with the cooperation of the Clinical Director, to negotiate and maintain arrangements with nearby medical facilities or healthcare providers to provide required

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 4

healthcare not available within the facility. Under the standard, a healthcare specialist shall determine medical treatment, except when there is disagreement on the type or extent of treatment that is medically necessary. In instances of disagreement, DIHS makes the final determination in consultation with the Chief of Medical Staff and in accordance with the medical policies of the U.S. Department of Health and Human Service's Public Health Service (USPHS).

As the recommendation specifically pertains to "medical standards," ICE advises that this appears to be beyond the scope of what the agency can do. National public health or medical care industry standards are established by professional medical researchers and medical practitioners in tandem with public health and medical care governing and regulatory bodies. ICE has no inherent authority to establish or alter such standards, nor does the agency directly employ persons qualified to provide input to do so. ICE relies upon the professionals of the DIHS and USPHS to coordinate with other health organizations, such as the CDC, in determining and applying healthcare and disease prevention standards.

While we believe the current detention standard is sufficient to meet the medical needs of detainees, ICE continues to be committed to improving standards and care at all ICE detention facilities. To that end, ICE believes doctors and medical staff must be cognizant of diseases unique to immigrant populations, as much as is practical, so as to promote early detection of diseases. Accordingly, ICE has asked DIHS to develop a training tool to enhance the medical field's awareness and early detection of diseases that might be prevalent in aliens from particular geographic locales. DIHS has advised ICE that it is willing to seek advice from the CDC and other subject-matter experts, as it has done in the past, to develop this training tool. ICE will follow-up with DIHS to ensure this training is conducted.

It is requested that this recommendation be considered resolved and closed.

Recommendation 3: "Revise medical intake screening forms and physical exam questionnaires at detention facilities to include questions regarding the detainee's family history of cysticercosis."

ICE Response: ICE concurs in part and disagrees in part with the recommendation. ICE agrees that DIHS should review its medical intake forms and physical exam forms in order to better identify certain diseases that may allow us to provide better medical care to our detained population.

DIHS' intake health screening form was developed by medical professionals for the purpose of identifying those medical issues that pose the greatest risk to an overall detention facility population. The health screening tools presently in use include questionnaires concerning family health histories and there is sufficient space on the forms to memorialize any information provided so as to alert medical professionals of any possible problems that are not readily apparent. Obtaining a family history of cysticercosis is one of many important pieces of medical information which a medical provider may collect using the current intake form. That form is primarily used to quickly collect signs or symptoms for which a serious illness may be the cause. Should these signs and symptoms be observed, more probative and specific questions can be asked to help identify and possibly diagnose an illness.

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 5

Our current intake form is based largely on questions that are not only related to family history of various diseases, but symptoms that may lead medical professionals to diagnose an illness. In the specific case described in the report, we note that even if assuming the mother had been diagnosed with cysticercosis and that the individual knew of this diagnosis, it is not evident how including a specific question explicitly related to family history of cysticercosis would have resulted in a different outcome. As your report correctly notes, there was nothing ICE could have done to prevent this unfortunate death of a person with this serious pre-existing medical condition.

Considering the large, diverse, and very fluid population that comes into ICE custody on a daily basis, and the fact that our current form solicits general family medical history information, it is not clear whether a specific designation of family history of cysticercosis is warranted on medical intake forms or that amending the form is the most appropriate manner to respond to this particular disease or other diseases that may be common in developing countries.

We also note that your reliance on two journals cited in the report as a basis for singling out family history of cysticercosis is misplaced. The first journal studied neurocysticercosis discharge information from certain Oregon hospitals over a six-year period. See John M. Townes, *Neurocysticercosis in Oregon, 1995-2000*, EMERGING INFECTIOUS DISEASES (2004). The journal revealed that the annual number of cases of neurocysticercosis did not change during the study period, despite the Hispanic population increasing in Oregon by an estimated 67%. The second journal notes that cysticercosis is not nationally reportable, few local jurisdictions require reporting of it, and surveillance systems have rarely been implemented. See Frank J. Sorvillo, *Deaths from Cysticercosis, United States*, EMERGING INFECTIOUS DISEASES (2007). This journal also concluded that cysticercosis remains an uncommon form of premature death in the United States and its prevalence is unknown.

Your report makes anecdotal and general conclusions about the possible growth of cysticercosis, but both articles upon which you rely make no such finding. In fact, in one article cited within the Townes article, the author concludes that the detection of neurocysticercosis is based primarily on the advancement of technology that detected this disease in immigrants arriving in the United States in the 1970s and 1980s. See, also A.C. White, Jr., *Neurocysticercosis: Updates on Epidemiology, Pathogenesis, Diagnosis, and Management*. 51 ANN. REV. MED. 187 (2000) (finding that three developments led to the recognition of neurocysticercosis as a major cause of neurologic disease: 1) development of computerized brain studies (MRIs and CAT scans); 2) large numbers of rural immigrants from developing countries arriving in the United States during the 1970s and 1980s; and 3) more accurate diagnosis and reporting in foreign countries to demonstrate prevalence in Latin America, Africa, and Asia.)

In addition, we believe DIHS' commitment to enhance the medical field's awareness and early detection of diseases that might be prevalent in aliens from particular geographic locales is a major step forward. These medical professionals are in the best position to identify all diseases that may be of concern to individuals in our custody, and those diseases should not be limited to cysticercosis only. This commitment is outlined in Recommendation #2, above. We also believe that the best approach to address your concerns about cysticercosis or infectious diseases

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 6

is to request that DIHS reevaluate the current medical forms in order to determine whether amending these forms is appropriate. In this regard, we hope these additional educational efforts and reviews will allow ICE to provide the most appropriate level of medical care for individuals in our custody. At this point in time; however, ICE cannot concur with the specific recommendation to include questions regarding a family history of cysticercosis for the reasons noted above.

It is requested that this recommendation be considered resolved and closed.

Recommendation 4: "Revise the notification section of ICE's detainee death standard to ensure that the agency and its detention partners report a detainee's death in states that require notification in the event of a death in custody. Documentation of this reporting should appear in a detainee's file."

ICE Response: ICE concurs in part and disagrees in part with the recommendation. We believe that notifications to state officials are very important, but believe that our current standard makes this requirement clear. Upon the death of a detainee within an ICE facility, including IGSAs, a medical examiner of the local jurisdiction is summoned to pronounce the death. This process constitutes notification pursuant to OIG's recommendation since it is the responsibility of this sworn public official to make any further notifications as required by state law. Similarly, in those instances when a detainee dies while at a hospital, it is the responsibility of the hospital and the physician who makes the declaration of death to make any additional notifications as required by state or local law.

It is important to note that in the case referenced in the report – where the proper state officials were not made aware of the death – a local official was properly notified but had failed to further report the death to the state officials as required under New Mexico laws and regulations. We do not believe a revision to our standard could have cured this official's failure to follow the law in his jurisdiction.

Based upon this information, it is requested that this recommendation be considered resolved and closed.

Recommendation 5: "Seek to enter into a memorandum of understanding with the Department of Justice, Office of Federal Detention Trustee that establishes a process that enables OFDT and ICE to regularly share information resulting from facility site visits."

In fact, ICE meets regularly with OFDT and has coordinated with OFDT in the past. Presently, there are no barriers to OFDT obtaining facility inspection reports and OFDT has never been denied access to any information it might need for its own mission or strategic objectives. Nevertheless, ICE will request that OFDT agree to a Memorandum of Understanding regarding facility site visits and ICE will work toward a better working relationship with OFDT, particularly on issues of mutual interest, such as timeliness of health care delivery.

Appendix B Management's Comments to the Draft Report

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 7

While the OIG report correctly indicates that ICE and OFDT have different standards, it seems to indicate that enhanced sharing of information will primarily benefit ICE. We believe we have shared valuable information with OFDT, particularly about the RCC. We also believe that OFDT can benefit greatly from our own reviews of ICE facilities because we have such rigorous oversight policies, although this was not discussed in the report. These oversight policies include hiring third-party experts bearing experience similar to the experience OFDT requires of its own Quality Assurance Specialists.

We note that many of the deficiencies identified by ICE's inspection of the RCC were not identified in OFDT reports. ICE's inspection under our own rigorous standards directly led to our decision to remove all detainees from RCC by August 5, 2007. OFDT's reviews of the RCC facility were not the impetus for our decision. Still, we believe we can always benefit from the reviews OFDT conducts at facilities housing ICE detainees as oversight of detention facilities is an ongoing endeavor that requires continual refinement.

As your report correctly noted, OFDT conducted two reviews of the RCC. OFDT assigned the RCC an "at risk" rating in its September 2006 monitoring report. OFDT conducted a follow-up site visit in February 2007, and determined that RCC operations were acceptable. An OFDT follow-up review noted that the facility had problems in discrete areas.

OFDT determined that these areas relate to minimum requirements to ensure that detainees are housed in a safe, secure, and humane environment as defined by OFDT's Federal Performance Based Detention Standards Review Book. In June 2007, U.S. District Court Chief Judge Martha Vasquez and your office forwarded to ICE allegations concerning the RCC that we believed were beyond OFDT's basic standards.

ICE took immediate action in response to these allegations of misconduct and serious deficiencies. ICE stationed full-time DRO officers and supervisors at the facility and met daily with RCC staff to ensure these issues were resolved in Plans of Action. ICE conducted regular audits of the facility and reported all deficiencies to RCC staff during mandatory daily meetings. After overseeing much of RCC's day-to-day operations, no appreciable improvements were made that assured ICE that its detainees remained in a safe, secure, humane environment. As correctly noted in your report, all ICE detainees were removed from the RCC facility. ICE has notified OFDT that it does not intend to renew a contract with the RCC until that facility meets our standards.

Put simply, OFDT's basic reviews would not have made a difference in our decision to remove these detainees. We do not believe your recommendation should be primarily based on the peculiar events that occurred at the RCC by comparing OFDT's review and ICE's oversight of the RCC. We note that U.S. Marshals' prisoners remain at the RCC facility. The fact that U.S. Marshals prisoners remain at the RCC and ICE detainees have been removed stresses that differing standards often result in different results.

It is requested that this recommendation be considered resolved and open until ICE provides its request that OFDT agree to a Memorandum of Understanding regarding the sharing of facility site visits reports.

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 8

It is requested that this recommendation be considered resolved and open until such time as ICE provides OIG with the MOU solicitation.

Recommendation 6: "Revise monitoring protocols and medical detention standard to require sampling and continuous oversight of the 14-day physical exam standard across ICE's detention facilities."

ICE Response: ICE concurs with the recommendation. ICE will use a combination of the following in order to address this recommendation and ensure that the 14-day examination standard is followed. First, contracted on-site oversight staff will be required to conduct regular sampling and monitoring at the facilities they oversee to determine levels of compliance with the 14-day exam window standard. For those facilities that are serviced by a regional contractor, sampling will be conducted remotely. Second, the OPR Detention Facility Inspection Group (DFIG) will also examine this area as part of its compliance monitoring. Finally, OPR will include a question as to this recommendation on the Self Inspection Program (SIP) survey instruments prior to the next DRO SIP reporting cycle.

It is requested that this recommendation be considered resolved and open until such time as ICE can demonstrate that the required sampling and monitoring are taking place.

Recommendation 7: "Revise monitoring policies and other guidance given to reviewers regarding the materiality of site visit report findings to ensure that standards, such as tuberculosis screening and others related to access to medical care, weigh more heavily on a facility's compliance status."

ICE Response: ICE concurs with the recommendation. Under the current annual review process, areas that have significant life-safety consequences are weighed more heavily than other items when assigning final ratings or determining overall compliance level. In this way, it is possible for a facility to receive an overall acceptable rating despite deficiencies in a narrow programmatic area. As part of ICE's new performance-based detention standards, meaningful performance indicators will be assigned to each standard so as to generate a final score or rating of a facility's overall performance that is both accurate and credible. Lastly, we also note that any life and safety deficiencies found during an inspection must be corrected before the inspection team leaves the facility.

It is requested that this recommendation be considered resolved and open pending the agency-wide implementation of the new performance-based detention standards. ICE will provide a copy of these new standards to OIG to fully close the recommendation.

Recommendation 8: "Require reviewers preparing monitoring reports to use narratives to illuminate special areas of concern and provide additional details about issues relevant to a facility's compliance status."

ICE Response: ICE concurs with this recommendation. We began to use these narratives to provide the reader with important, relevant information concerning facility reviews late last year. As part of ICE's improved management and oversight of detention facilities, ICE implemented a

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 9

robust detention compliance program in October 2007, under the immediate oversight of the DRO Detention Standards Compliance Unit (DSCU). The program includes an annual external inspection program to be performed by contracted inspectors of Creative Corrections, Inc. This contracted inspectional force is comprised of former wardens, nurses, correctional facility personnel, and other subject-matter experts. This program has eliminated the need to assign collateral inspection compliance duties to more than 400 DRO officers. Each inspection report already contains narratives that are extensive and specify: 1) any standard not being met; 2) those areas of deficiency that were the cause of the facility's non-compliance; and 3) the corrective actions that would have to be completed to return the facility to compliance. DSCU staff officers also distill the salient points of the reports and task the appropriate personnel with initiating corrective action.

It is requested that this recommendation be considered resolved and closed. A copy of an inspection by Creative Corrections, Inc. will be sent under separate letterhead to demonstrate the ICE's actions in this area.

Recommendation 9: "Develop a standard that requires facilities housing ICE detainees to implement an internal review function."

ICE Response: ICE concurs in part and disagrees in part with this recommendation. We have implemented a procedure that requires a facility to provide a detailed plan of action after receiving an annual review in order to address any and all noted deficiencies. We disagree to the extent that a local facility can independently take such remedial action without the input and assistance of subject-matter experts trained in our detention standards and policies.

We note that our standards are *national* standards. Accordingly, ICE strives to provide consistent, uniform conditions of confinement that meet or exceed those standards at every facility housing ICE detainees. To meet this goal, we have Quality Assurance specialists from the Nakamoto Group on-site at 31 large IGSA's and expect these specialists to be at all of our major IGSA's by the end of the year. These Quality Assurance professionals are responsible for reviewing a facility's performance. ICE has also contracted with Creative Corporations to conduct annual reviews of our facilities. These third-party reviewers allow ICE to obtain a true and accurate picture of the performance of our facilities, while at the same time maintaining a consistent level of care pursuant to our standards. We do not believe a local facility can self-monitor its performance against our national standards without the input of third party experts, a headquarters component, and the added level of oversight the Detention Facilities Inspection Group and your office may provide. We believe these independent reviewers will produce more candid, consistent, and reliable reports than would a process conducted by a facility's own personnel.

Our current practice addresses the concern you raised in your recommendation. When deficiencies are identified during annual reviews, facilities are required to submit a Plan of Action (POA) that identifies the corrective action to be taken to remedy all areas of concern. Once the POA is approved at the HQ level, the field office is required to ensure that all noted deficiencies have been corrected within 90 days of notification that the POA is approved. Additionally, when the noted deficiencies are severe enough to result in an overall rating of

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 10

"deficient" or "at risk" being assigned, a full follow-up inspection of the facility will be required within six-months from the date of last annual review.

As stated above, ICE has already developed a policy that will place Quality Assurance professionals in large IGSA's. These Quality Assurance professionals are responsible for reviewing a facility's performance. ICE currently has these Quality Assurance specialists on-site in 31 large facilities and expects all 40 large IGSA's to be staffed with these professionals by July 2008. We believe these independent reviewers will produce more candid, consistent, and reliable reports than would a process conducted by a facility's own personnel.

We concur that there needs to be a sound internal review mechanism, but we disagree to the extent that the review process should be conducted by facility personnel. Put simply, we do not believe an internal review process by a facility will ensure that ICE maintains safe and humane conditions of confinement consistent with our national detention standards.

Based upon this information, it requested that this recommendation be considered resolved and closed.

Recommendation 10: "Expedite all necessary discussion and resources to develop a system of electronic health record for ICE detainees."

ICE Response: ICE concurs with the recommendation. Currently, ICE is working with DIHS and information technology experts to facilitate the deployment of electronic health records for ICE detainees. This process of obtaining the technology to implement such a system must first be approved by DHS' Investment Review Board. ICE will work diligently with other DHS components to ensure deployment of electronic health records as soon as possible.

It is requested that this recommendation be considered resolved and closed.

Recommendation 11: "Work with the Division of Immigration Health Services to identify all clinical staff shortages, and then work with ICE's clinical partners to develop and implement a strategy to fill clinical staff shortages at immigration detention facilities."

ICE Response: ICE concurs with the recommendation. ICE's healthcare service providers are not immune to the effects of the national shortage of qualified healthcare professionals. ICE is presently working with DIHS to complete a strategic plan that will meet the intent of the recommendation. The issues currently being explored by the strategic plan includes:

- Hiring additional healthcare recruiters, including a commissioned officer of the USPHS;
- Reviewing current medical staffing profiles to determine how closely staff qualifications align in the areas of accreditation, NDS, and industry standards;
- Improving communication and processing of background investigations;
- Providing healthcare professional recruitment and retention incentives such as signing bonuses and student loan repayment; and
- Collaborating with the USPHS for the hiring and placement of medical professionals to support ICE's detained populations.

Appendix B
Management's Comments to the Draft Report

SUBJECT: OIG Draft Report "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," dated Jan. 11, 2008
Page 11

Consistent with this strategic plan, ICE and its clinical partners have already implemented an aggressive hiring plan to ensure that these important positions are filled as quickly as possible. ICE requests that this recommendation be considered resolved and open until a formal plan to address clinical staffing shortages is submitted to OIG.

ICE would also like to take this opportunity to address the questions raised in your report for not developing a regulatory scheme for the national detention standards as requested by the ABA. As you correctly noted in your report, ICE continues to look into ABA's request. ICE simply emphasizes that there has been significant progress in ICE's oversight of its detention facilities, which OIG merely mentioned briefly. ICE believes that our multi-layered facility oversight has greatly improved the conditions of confinement. ICE also notes that simply converting our standards into regulations does not necessarily result in action or improvement. Finally, we disagree with the ABA's contention that our current IGSA contractual language to adhere to detention standards is merely advisory. Current IGSA contractual language provides termination upon written notice. This language states the following:

This Agreement shall become effective upon the date of final signature by the ICE Contracting Officer and the authorized signatory of the Service Provider and will remain in effect for a period not to exceed sixty (60) months, unless terminated in writing, by either party. Either party must provide written notice of its intention to terminate the agreement, sixty (60) days in advance of the effective date of formal termination, or the Parties may agree to a shorter period under the procedures prescribed in Article X.

(emphasis added).

ICE is grateful for the overview and insight OIG has provided in its draft report and we will continue to ensure our facilities provide adequate conditions of confinement. Within 90 days of the issuance of the OIG's final report on this audit, ICE will generate and submit to OIG a Mission Action Plan that specifies the issues to be resolved, the corrective action to be taken, and the associated deadlines for completion.

Appendix B
Management's Comments to the Draft Report

Office of Professional Responsibility

U.S. Department of Homeland Security
425 I Street, NW
Washington, DC 20536



U.S. Immigration
and Customs
Enforcement

MAR 13 2008

MEMORANDUM FOR: Jan Borris
Section Chief/OIG Liaison

FROM: William F. Reid *W. Reid*
Acting Director

SUBJECT: Timely Notification to DHS Office of Inspector General
Regarding ICE Detainee Deaths

As a reminder, please continue to ensure that all notifications received at the Joint Intake Center regarding information related to the death of a detainee while in ICE custody is accurately communicated to the DHS Office of Inspector General (OIG) telephonically at the first available opportunity. In addition, all relevant information concerning such deaths will be transmitted on the next business day as part of the daily OIG activity notification. Please ensure that this important process is adhered to.

Recommendation #1: Work with the Office of Inspector General to create a policy that would lead to the prompt reporting of all detainee deaths to the Office of Inspector General.

Recommendation #2: Work with the Division of Immigration Health Services, the Centers for Disease Control, and other experts, to enhance existing medical standards, rules for special needs individuals, and coverage guidance related to infectious disease.

Recommendation #3: Revise medical intake screening forms and physical exam questionnaires at detention facilities to include questions regarding the detainee's family history of cysticercosis.

Recommendation #4: Revise the notification section of ICE's detainee death standard to ensure that the agency and its detention partners report a detainee's death in states that require notification in the event of a death in custody. Documentation of this reporting should appear in a detainee's file.

Recommendation #5: Seek to enter into a memorandum of understanding with the Department of Justice, Office of Federal Detention Trustee that establishes a process that enables OFDT and ICE to regularly share information resulting from facility site visits.

Recommendation #6: Revise monitoring protocols and the medical detention standard to require sampling and continuous oversight of the 14-day physical exam standard across ICE's detention facilities.

Recommendation #7: Revise monitoring policies and other guidance given to reviewers regarding the materiality of site visit report findings to ensure that standards, such as tuberculosis screening and others related to access to medical care, weigh more heavily on a facility's compliance level.

Recommendation #8: Require reviewers preparing monitoring reports to use narratives to illuminate special areas of concern and provide additional details about issues relevant to a facility's compliance status.

Recommendation #9: Develop a standard that requires facilities housing ICE detainees to implement an internal review function.

Recommendation #10: Expedite all necessary discussions and resources to develop a system of electronic health records for ICE detainees.

Recommendation #11: Work with the Division of Immigration Health Services to identify all clinical staff shortages, then work with ICE's clinical

partners to develop and implement a strategy to fill clinical staff shortages at immigration detention facilities.

Appendix D
Comparison of Various Detention Standards

We compared various standards from ICE’s *Detention Operations Manual*, ACA’s *Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition*, and OFDT’s *Federal Performance-Based Detention Standards Review Book*.

This analysis focused on standards of particular interest to this review. The following table outlines and compares standards across the three organizations. The table is divided into three primary areas: standards related to physical exams and access to care, standards related to detainee mortality, and certain standards related to medical issues and grievances.

Standards Related to Physical Exams and Access to Care			
Standard Element	ICE	ACA	OFDT
Health Appraisals <i>In addition to general requirements regarding intake screening when the detainee is admitted to a facility, requirements include a more detailed medical exam of the detainee within 14 days.</i>	A health care provider will conduct a health appraisal and physical examination on each detainee within 14 days of arrival at facility. All appraisals will be performed according to National Commission on Correctional Health Care and the Joint Commission on the Accreditation of Health Organization standards. Standards for these exams are not detailed. In Service Processing Centers and Contract Detention Facilities, the In-Processing Health Screening Form (I-794) is followed up and the health care provider will provide treatment accordingly.	A health care provider will conduct a health appraisal on each detainee within 14 days of arrival at facility. In addition to following up on the intake screening, criteria regarding the appraisal are discussed.	The facility director ensures that medical, dental, and licensed health care professionals complete mental health assessments within 14 days of arrival. Criteria are outlined by each assessment for the appraisals to be conducted.
Emergency Services	In local jails, a written plan for the delivery of 24-hour emergency health care is required. No standards are specified. Service Processing Centers and Contract Detention Facilities will prepare plan in consultation with the facility’s routine medical provider. The plan will include an on-call provider, contact information for local ambulances and hospitals; and procedures for	A plan to provide 24-hour emergency medical, dental, and mental health services is required. Emergency evacuation procedure is also required. Criteria are identified that includes use of an emergency medical vehicle, hospitals, on-call physicians, dentists, and mental health professionals.	Ensures that written policies and procedures exist for emergency health care, including emergency evacuation and transportation. A plan to provide 24-hour emergency response is not identified. Criteria are not identified for written policies and procedures that are to be in place. However, staff will practice medical

Appendix D
Comparison of Various Detention Standards

	facility staff to use providers consistent with security and safety. Additionally, first aid and medical emergency standards and criteria are identified.	Additionally, back-up facilities and providers should be predetermined.	emergency plans; bi-annual trial runs are documented.
Requests for Medical Care	Request slips will allow detainees to request health care services. Slips must be received by medical facility in a timely manner. If necessary, detainees will be provided with assistance in filling out the request slip. Clinical staff is to be available on scheduled basis to respond to requests. In Service Processing Centers and Contract Detention Facilities, request slips will be made freely available for detainees to request health care services on a daily basis. Request slips will be made available in English, and the foreign languages most widely spoken among detainees. If necessary, detainees will be provided assistance in filling out the request slip.	All detainees are informed about how to access health care services during the admission/intake process. This is communicated orally and in writing. Information is translated into those languages spoken by significant numbers of inmates. No member of the correctional staff should approve or disapprove inmate requests for health care services.	Detainees have daily opportunities to request health care services. Detainee requests are documented and are triaged by a healthcare professional within 24 hours on weekdays. Appropriate health care professionals triage requests in a timely manner.
Standards Related to Detainee Mortality			
Standard Element	ICE	ACA	OFDT
Detainee Deaths	ICE's detainee death standards articulate a variety of notification requirements for the facility and ICE staff. Although mortality reviews by the facility are not specifically required, the overall policy includes commendable levels of detail about how the facility and ICE are to address detainee death cases.	ACA's policy focuses on notification of proper authorities. Also, the mandatory internal review policy requires that all deaths in custody are to be examined by the facility.	Like ICE and ACA, OFDT stresses the importance of notifying proper authorities. Staff is to be trained to respond to serious illness or detainee death. Examination of required mortality reviews are part of site visit team's assessment of facility's compliance. Results of mortality review are acted on immediately.
Suicide Prevention <i>All three entities recognize the</i>	Staff training requirements are similar to ACA and OFDT. Staff is required to observe	Staff is required to be trained on suicide risk and intervention. Mental	Policy specifically requires that the facility is to have a sufficient

Appendix D
Comparison of Various Detention Standards

<i>importance of training, observation, and notification of authorities.</i>	"imminently suicidal" detainees no less than every 15 minutes.	health appraisals are to include assessment of suicide risk. Continuous observation required for suicidal inmates until intervention by clinicians.	number of clinicians to deal with suicidal cases. Family members are to be notified of an attempted suicide.
Certain Standards Related to Medical Issues and Grievances			
Standard Element	ICE	ACA	OFDT
Dental Care, Assessments	Initial dental screening due within 14 days. If dentist not available, a physician, physician's assistant, or nurse practitioner can perform the assessment.	Initial dental screening due within 14 days. A dentist or trained personnel under the supervision of a dentist should perform the screening.	Like ICE's policy, OFDT standard does not require that a dentist perform the assessment.
Dental Care, Routine	Routine care may be provided for individuals detained for more than 6 months	Requires "defined scope of services" for detainees without reference to length of stay.	Routine care is to be provided if the individual is detained greater than one year.
First Aid Kits	Kits are to be placed according to ACA policy.	Designated health authority and facility administrator collaborate to determine locations for kits. Health staff determines contents of kits. Defibrillator must be available to facility staff.	Not as specific as ACA. Standard requires that supplies for medical emergencies are to be readily available.
Grievances	ICE's process is outlined in more detail than ACA and OFDT standards. Facilities are to use an informal grievance process in an attempt to resolve concerns quickly, but detainees have a right to file a formal written grievance. Also, requirements at Contract Detention Facilities and Service Processing Centers are more detailed than for county detention facilities. One specific difference for contract detention facilities and service processing centers is that only detainees can file a grievance. ICE's policy on staff-detainee communication permits detainees to make informal	ACA's grievance standard does not have specificity. Facilities are required to have grievance procedures that include one level of appeal, but specific requirements are not outlined.	Grievance standard includes many of the elements found in ICE's standard, although an informal process is not specified. Standards in other areas, such as discrimination prevention, require review of all grievances alleging discrimination based on race, gender, religion, and national origin.

Appendix D
Comparison of Various Detention Standards

	grievances to ICE. Formal grievances are to be resolved by the facility.		
HIV/AIDS	<p>A detailed standard for “the accurate diagnosis and medical management” of HIV/AIDS. The standard requires that detainees with active tuberculosis should be evaluated for HIV infection. Facilities are also directed to report cases per state and federal rules.</p> <p>According to DIHS coverage policy, follow-up care is covered. HIV testing is covered if a clinician documents the need.</p>	A mandatory standard that is not as specific as ICE's HIV policy. The written plan required under the standard must include procedures for identification, surveillance, treatment, and other areas.	Policy on chronic conditions requires that individuals with AIDS are to receive regular care by physicians who provide for individual treatment plans.
Mental Health <i>In September 2006, the Bureau of Justice Statistics reported that half of jail and prison inmates have mental health needs.</i>	Initial health screening is to include mental health assessment. Facility staff is to be trained to recognize the signs and symptoms of mental illness as a means to decrease suicide risk. The standard establishes that mental health care will generally be provided in a hospital or community setting, rather than the detention facility.	Establishes that an “appropriate mental health authority” approves mental health services. Standards are to ensure that facility staff can identify mental health needs, proper care is provided (generally through referrals for outside care).	OFDT standards include additional details on specific mental health policies. For example, OFDT provides details on the contents of mental health appraisals and the need to provide needed medications for routine and emergency situations.
Special Needs Individuals <i>Detainees who have certain specific medical issues are considered to have “special needs.” The concept is mentioned by all three entities, but defined differently by each.</i>	The Officer in Charge is to be notified when individuals are diagnosed with special needs. Examples of conditions requiring “special attention” are pregnancy, special diets, medical isolation, and AIDS.	Clinical and facility personnel are to ensure “maximum cooperation” on individuals who are chronically ill, disabled, geriatric, or seriously mentally ill. Special needs individuals are granted a hearing and additional due process steps before transfer to another facility.	OFDT has the most specific policy in this area, including steps to providing health care for the special needs population. These include targeted physical exams, use of chronic care clinics, necessary subspecialty visits, and preventive care.

Appendix E
Major Contributors to this Report

William McCarron, Chief Inspector, Department of Homeland Security,
Office of Inspections

Darin Wipperman, Senior Inspector, Department of Homeland Security,
Office of Inspections

Jacob Farias, Inspector, Department of Homeland Security,
Office of Inspections

Department of Homeland Security

Secretary
Deputy Secretary
Chief of Staff
Deputy Chief of Staff
General Counsel
Executive Secretary
Director, GAO/OIG Liaison Office
Chief Security Officer
Assistant Secretary, U.S. Immigration and Customs Enforcement
U.S. Immigration and Customs Enforcement Audit Liaison
Assistant Secretary for Public Affairs
Assistant Secretary for Policy
Assistant Secretary for Legislative Affairs

Office of Management and Budget

Chief, Homeland Security Branch
DHS OIG Budget Examiner

Congress

Congressional Oversight and Appropriations Committees, as appropriate

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