



U.S. Department of Homeland Security
Immigration and Customs Enforcement
Office of Professional Responsibility
Inspections and Detention Oversight
Washington, DC 20536-5501

Office of Detention Oversight Compliance Inspection

Enforcement and Removal Operations
Denver Field Office
Denver Contract Detention Facility
Aurora, Colorado

May 15 – 17, 2012

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**COMPLIANCE INSPECTION
DENVER CONTRACT DETENTION FACILITY
DENVER FIELD OFFICE**

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EXECUTIVE SUMMARY

The Office of Professional Responsibility (OPR), Office of Detention Oversight (ODO) conducted a Compliance Inspection (CI) of the Denver Contract Detention Facility (DCDF) in Aurora, Colorado, from May 15 - 17, 2012. DCDF opened in May 1987. In July 2010, the facility moved from an older building to the current building after construction of the current building was completed. Both the old and new buildings are located in the same complex. The old building is no longer in operation. U.S. Immigration and Customs Enforcement (ICE), Office of Enforcement and Removal Operations (ERO) has housed detainees at DCDF since the opening of the current facility in 2010. DCDF exclusively houses ICE detainees. The 1,116 bed, 202,000 square foot facility is owned and operated by The Geo Group, Inc. (GEO). Although the facility has a capacity of 1,116 beds, DCDF is currently under contract with ICE to house a maximum of 525 detainees of all security classification levels (Level I – lowest threat; Level II – medium threat; Level III – highest threat) for over 72 hours. Of the 525 contracted beds, 477 are designated for males, and 48 are assigned to females. The average daily detainee population at DCDF is 408. The average length of stay is 25 days. At the time of inspection, the facility housed 358 male ICE detainees (221 Level I; 116 Level II; 21 Level III) and 33 female ICE detainees (24 Level I; 9 Level II). All services, including medical care, are operated and supervised by GEO. The facility holds accreditations from the American Correctional Association and the National Commission on Correctional Healthcare.

The ERO Field Office Director, Denver, Colorado (FOD/Denver) is responsible for ensuring facility compliance with ICE policies and the Performance Based National Detention Standards (PBNDS). An Assistant Field Office Director (AFOD) is located onsite at DCDF and is the highest ranking ERO official at the facility. ERO staff at DCDF is comprised of (b)(7)e Supervisory Detention and Deportation Officers (SDDO) (b)(7)e Deportation Officers (DO), and (b)(7)e Enforcement and Removal Assistants (ERA). A permanently assigned ERO Detention Service Manager (DSM) monitors facility compliance with the PBNDS.

The Warden is the highest ranking official at DCDF and is responsible for oversight of daily operations. In addition to the Warden, GEO supervisory staff consists of (b)(7)e Assistant Wardens (b)(7)e for Operations (b)(7)e for Support Services), a Chief of Security (b)(7)e Lieutenants (b)(7)e Shift Supervisors, an Office Records Manager/Programs Coordinator, an Assistant Business Manager, a Maintenance Supervisor, a Food Services Administrator, a Clinical Director (CD), and a Health Services Administrator (HSA). Detention staff consists of (b)(7)e Detention Officers and (b)(7)e Transport Officers. The total number of non-ICE staff employed at NGDC is (b)(7)e. Medical staff consists of the HSA and CD, as well as a Nurse Practitioner, a psychiatrist, a psychologist, a Physician Assistant (PA) (b)(7)e Registered Nurses (RN) (b)(7)e Licensed Practical Nurses (LPN), an x-ray technician, and (b)(7)e administrative staff. The HSA is serving in an acting capacity, because the permanent HSA is on administrative leave. Medical oversight is provided by the Corporate Chief Medical Officer. A part-time contract physician serves as the onsite CD. The PA, NP, psychiatrist, and psychologist are part-time employees. The RNs, LPNs, x-ray technician, and (b)(7)e administrative staff are full-time employees. A part-time dentist and a part-time dental assistant provide dental care onsite. Remaining GEO staff is comprised of non-detention personnel assigned to Support Services, such as Food Service Officers, Maintenance Technicians, and Clerks.

The clinic is operated by GEO and is open 24 hours a day, seven days a week. On-call medical coverage is provided 24 hours a day, seven days a week by the CD; the psychiatrist is available on the same duty rotation for mental health consultations. Medical staffing is sufficient to meet the basic healthcare needs of all detainees housed at DCDF. The clinic contains a nursing station, two examination rooms, a trauma room, two mental health interview rooms, and ten medical observation beds, five of which are negative air flow cells for isolation of detainees with airborne illnesses such as tuberculosis (TB). The facility utilizes color-coded Progress Notes to easily identify documentation generated while a detainee is housed in the medical unit. All mental health documentation is recorded on blue Progress Notes. This system efficiently organizes medical records and provides immediate access to medical information. ODO cites this as a best practice.

In March 2011, ODO conducted a Quality Assurance Review (QAR) at DCDF of 24 PBNDS. Of the standards reviewed, nine were in full compliance. The remaining 15 standards accounted for 41 deficiencies.

In September 2011, ERO Detention Standards Compliance Unit contractor, MGT of America, Inc., conducted an annual review of the PBNDS at DCDF. The facility received an overall rating of "Meets Standards" and was found compliant with all 39 standards reviewed.

During this CI, ODO reviewed 16 PBNDS. Eight standards were determined to be fully compliant. Eleven deficiencies were identified in the following eight standards: Disciplinary System (2 deficiencies), Environmental Health and Safety (1), Grievance System (2), Medical Care (2), Special Management Units (1), Staff-Detainee Communication (1), Suicide Prevention and Intervention (1), and Terminal Illness, Advance Directives, and Death (1). Three of the deficiencies identified during this CI were repeated deficiencies from the March 2011 QAR.

This report details all deficiencies and refers to the specific, relevant sections of the PBNDS. ERO will be provided a copy of this report to assist in developing corrective actions to resolve the 11 identified deficiencies. These deficiencies were discussed with DCDF personnel onsite during the inspection, as well as during the closeout briefing conducted on May 17, 2012.

Overall, ODO found DCDF well-managed and in compliance with the standards inspected. Many of the deficiencies identified were minor, with minimal impact to life-safety issues and the overall operational readiness of the facility. Deficiencies requiring immediate attention were identified in the areas of Environmental Health and Safety, Grievance System, Medical Care, Special Management Units, Staff-Detainee Communication, and Suicide Prevention and Intervention. There were inaccurate inventories of hazardous substances; medical grievances were screened and reviewed by non-medical staff; a female detainee did not receive a pregnancy test; status reviews were not conducted in a timely manner for detainees placed in administrative segregation; a detainee placed on suicide watch was not re-evaluated by medical personnel on a daily basis; and medical staff without the appropriate qualifications downgraded the status of a potentially suicidal detainee and discontinued a suicide watch. Details of these deficiencies are described in the corresponding standards contained in this report.

A detainee death occurred at DCDF on April 12, 2012. On that day, a male detainee complained of chest pains and was transported to the emergency room (ER). The detainee went into cardiac arrest at the hospital. Efforts to resuscitate the detainee were unsuccessful. This was the first detainee death to ever occur at DCDF. ODO is currently conducting a Detainee Death Review.

From July 2011 to April 2012, the facility received and processed 355 detainee grievances. Of the 355 grievances, 75 (21%) pertained to complaints against staff, 68 (19%) pertained to medical issues, 57 (16%) pertained to food service, and ten (3%) pertained to complaints related to other detainees. The remaining 145 (41%) grievances were categorized as general grievances. General grievances relate to issues, such as, but not limited to, access to the law library and legal materials, detainee funds and personal property, religious services, the classification system, personal hygiene, recreation, and visitation. ODO reviewed the grievance log at DCDF and confirmed there were no grievances alleging staff misconduct during the period of time under review.

At the time of inspection, there were seven male detainees placed in administrative segregation; there were no male detainees in disciplinary segregation. The seven detainees in administrative segregation were in protective custody at their own request. ODO interviewed all seven detainees, and they stated that they are treated humanely and afforded the same privileges as detainees in the general population. There were no female detainees in administrative or disciplinary segregation during the inspection.

INSPECTION PROCESS

ODO inspections evaluate the welfare, safety, and living conditions of detainees. ODO primarily focuses on areas of noncompliance with the ICE National Detention Standards (NDS) or the ICE PBNDS, as applicable. The PBNDS apply to DCDF. In addition, ODO may focus its inspection based on detention management information provided by ERO Headquarters (HQ) and ERO field offices, and on issues of high priority or interest to ICE executive management.

ODO reviewed the processes employed at DCDF to determine compliance with current policies and detention standards. Prior to the inspection, ODO collected and analyzed relevant allegations and detainee information from multiple ICE databases, including the Joint Integrity Case Management System (JICMS), the ENFORCE Alien Booking Module (EABM), and the ENFORCE Alien Removal Module (EARM). ODO also gathered facility facts and inspection-related information from ERO HQ staff to prepare for the site visit at DCDF.

REPORT ORGANIZATION

This report documents inspection results, serves as an official record, and is intended to provide ICE and detention facility management with a comprehensive evaluation of compliance with policies and detention standards. It summarizes those PBNDS that ODO found deficient in at least one aspect of the standard. ODO reports convey information to best enable prompt corrective actions and to assist in the on-going process of incorporating best practices in nationwide detention facility operations.

OPR classifies program issues into one of two categories: deficiencies and areas of concern. OPR defines a deficiency as a violation of written policy that can be specifically linked to the PBNDS, ICE policy, or operational procedure. OPR defines an area of concern as something that may lead to or risk a violation of the PBNDS, ICE policy, or operational procedure. When possible, the report includes contextual and quantitative information relevant to the cited standard. Deficiencies are highlighted in bold throughout the report and are encoded sequentially according to a detention standard designator.

Comments and questions regarding the report findings should be forwarded to the Deputy Division Director, OPR, ODO.

INSPECTION TEAM MEMBERS

(b)(6), (b)(7)c

Special Agent (Team Leader)
Special Agent
Special Agent
Contract Inspector
Contract Inspector
Contract Inspector

ODO, San Diego
ODO, Phoenix
ODO, Phoenix
Creative Corrections
Creative Corrections
Creative Corrections

OPERATIONAL ENVIRONMENT

INTERNAL RELATIONS

ODO interviewed the Assistant Warden of Operations, the Chief of Security, the AFOD, and an SDDO. During the interviews, all GEO and ERO personnel stated that the working relationship is excellent, and morale is high.

The Assistant Warden of Operations and the Chief of Security stated that GEO is adequately staffed to manage and handle the current detainee population at the facility. The Assistant Warden and the Chief of Security stated that they frequently observe ERO officers visiting the housing units multiple times each week and communicating with detainees to answer their questions or address their concerns.

The AFOD and the SDDO stated that ERO is currently understaffed by one (b)(7)e position and (b)(7)e ERA. As a result, ERO is operating under a self-imposed reduced capacity of 432 detainees. The AFOD stated that the FOD/Denver will increase the capacity to 525 detainees once these vacant positions are filled. The AFOD stated that permanent assignment of an Immigration Enforcement Agent (IEA) to DCDF would provide valuable assistance with the current workload. Currently, there are (b)(7)e IEAs assigned to the facility.

DETAINEE RELATIONS

ODO randomly selected and interviewed 30 male ICE detainees (14 Level I male detainees, 12 Level II detainees, and four Level III detainees) and ten female ICE detainees (six Level I female detainees and four Level II detainees) to assess the overall living and detention conditions at DCDF. ODO received no complaints concerning access to the law library and legal materials, issuance and replenishment of basic hygiene items, recreation, religious services, visitation, or the grievance system.

Two (7%) of the 30 male detainees stated they had not received a response for submitted requests; however, ODO verified that staff had provided a response within 72 hours as required by the standard. Two (7%) male detainees complained that the telephone volume is too low, which causes problems hearing the other party during conversations. Both detainees stated they had not reported the issues to DCDF management. ODO randomly tested multiple telephones and verified that housing unit telephones were fully operational with full volume.

Ten (33%) of the 30 male detainees interviewed and all ten (100%) female detainees interviewed complained that food portions served at the facility were too small. ODO verified that meals served at DCDF are compliant with the PBNDS in regards to portion size and nutritional requirements. All menus are certified by a registered dietician, including meals served for medical and religious diets. Three (30%) of the ten female detainees complained they were not receiving proper medical care in a timely manner. ODO reviewed medical files and confirmed that all three female detainees had received proper medical treatment in a timely manner in accordance with the PBNDS.

ICE PERFORMANCE BASED NATIONAL DETENTION STANDARDS

ODO reviewed a total of 16 PBNDS and found DCDF fully compliant with the following eight standards:

- Admission and Release
- Classification System
- Emergency Plans
- Food Service
- Sexual Abuse and Assault Prevention and Intervention
- Telephone Access
- Use of Force and Restraints
- Visitation

As these standards were compliant at the time of the review, a synopsis for these areas was not prepared for this report.

ODO found deficiencies in the following eight areas:

- Disciplinary System
- Environmental Health and Safety
- Grievance System
- Medical Care
- Special Management Units
- Staff-Detainee Communication
- Suicide Prevention and Intervention
- Terminal Illness, Advance Directives, and Death

Findings for each of these standards are presented in the remainder of this report.

DISCIPLINARY SYSTEM (DS)

ODO reviewed the Disciplinary System standard at DCDF to determine if sanctions imposed on detainees who violate facility rules are appropriate, and if the discipline process includes due process requirements, in accordance with the ICE PBNDS. ODO interviewed detainees and staff, and reviewed policies, disciplinary files, and the facility's local detainee handbook.

The disciplinary system at DCDF includes progressive levels of review and appeal procedures. Facility policy and the local detainee handbook adequately define detainee rights and responsibilities.

ODO reviewed 25 randomly selected disciplinary files dated between July 1, 2011, and May 10, 2012. All incidents were investigated by a supervisor within 24 hours of the incident; however, two hearings conducted by the Unit Disciplinary Committee (UDC) were not held within 24 hours after the conclusion of the investigation (**Deficiency DS-1**). Both hearings were conducted one day late, with no documentation explaining the delays. In addition, four of five incidents referred to the Institutional Disciplinary Panel (IDP) were not adjudicated on the first business day after referral by the UDC (**Deficiency DS-2**). All four hearings were conducted two days after referral to the IDP. There was no documentation or explanation justifying the delays. This was a repeated deficiency from the March 2011 QAR.

STANDARD/POLICY REQUIREMENTS FOR DEFICIENT FINDINGS

DEFICIENCY DS-1

In accordance with the ICE PBNDS, Disciplinary System, section (V)(F)(2), the FOD must ensure the detainee in UDC proceedings shall have the right to due process, which includes: attending the entire hearing (excluding committee deliberations); waiving the right to appear; or having a UDC hearing within 24 hours after the conclusion of the investigation. If security considerations prevent detainee attendance, the committee must document the security considerations and, to the extent possible, facilitate the detainee's participation in the process via telephonic testimony, the submission of documents, written statements, or questions to be asked of witnesses.

DEFICIENCY DS-2

In accordance with the ICE PBNDS, Disciplinary System, section (V)(H)(4), the FOD must ensure that the IDP shall conduct the hearing on the first business day after receiving the UDC referral, unless the detainee waives the 24-hour notification provision and requests an immediate hearing. In cases where a hearing is delayed, the reason(s) must be documented (for example, a continuing investigation of facts, unavailability of one or more essential witnesses, etc.) and approved by the facility administrator. If the detainee is being held in segregation, the delay shall not exceed 72 hours, barring an emergency.

ENVIRONMENTAL HEALTH AND SAFETY (EH&S)

ODO reviewed the Environmental Health and Safety standard at DCDF to determine if the facility maintains high standards of cleanliness and sanitation, safe work practices and control of hazardous materials and substances, in accordance with the ICE PBNDS. ODO toured the facility, interviewed staff, and reviewed procedures and documentation of inspections, hazardous chemical management, and fire drills.

While touring the facility, ODO observed prominently posted evacuation diagrams, which included locations of emergency equipment and directional arrows for traffic flow. The diagrams were displayed in both English and Spanish. The facility's Environmental Specialist/Fire Safety Manager provided documentation of extensive weekly and monthly fire and safety inspections. ODO verified the facility maintains a master index of hazardous substances with locations, and a master file of Material Safety Data Sheets.

Documentation was reviewed confirming the emergency power generator is tested bi-weekly by facility staff and quarterly by an external generator service company. A local pest control company is under contract to provide monthly and on-call service to the facility. Certification of the water supply by the City of Aurora was verified by ODO. Barber services are provided to the detainee population in a designated barber shop.

ODO observed that hazardous substances in the laundry area were properly stored; however, these substances had not been inventoried for more than seven months. Two small propane cylinders and a gallon of paint thinner stored in the maintenance department's flammables cabinet were not listed on the inventory (**Deficiency EH&S-1**). Maintaining physical control and accurate inventories of all chemicals protects the safety and well-being of detainees, visitors, and staff. During the inspection, the propane cylinders and the paint thinner were added to the inventory in the maintenance department.

STANDARD/POLICY REQUIREMENTS FOR DEFICIENT FINDINGS

DEFICIENCY EH&S-1

In accordance with ICE PBNDS, Environmental Health and Safety, section (VI)(C), the FOD must ensure that every area shall maintain a current inventory of the hazardous substances (flammable, toxic, or caustic) used and stored there. Inventory records shall be maintained separately for each substance. Entries for each shall be logged on a separate card (or equivalent) filed alphabetically by substance. The entries shall contain relevant data, including purchase dates and quantities, use dates and quantities, and quantities on hand.

GRIEVANCE SYSTEM (GS)

ODO reviewed the Grievance System standard at DCDF to determine if a process to submit formal or emergency grievances exists, and responses are provided in a timely manner, without fear of reprisal. In addition, the review was conducted to determine if detainees have an opportunity to appeal responses, and if accurate records are maintained in accordance with the ICE PBNDS. ODO interviewed staff and reviewed policies, grievance logs, detention files, and the facility's local detainee handbook.

Detainees at DCDF are encouraged to resolve grievances informally. The facility does not utilize an informal grievance form. All informal grievances are handled and resolved verbally by staff. Detainees may file formal written grievances for any issues or concerns by completing and submitting a detainee grievance form. Grievance forms are available in each housing unit and can be obtained by requesting them from the Housing Unit Officer. Grievances are collected daily, except for weekends and holidays, and are forwarded to the Grievance Coordinator for review. After a grievance is reviewed, the Grievance Coordinator assigns a grievance number and records it in an electronic database to document the grievance and track its progress. The Grievance Coordinator then forwards the grievance to the appropriate department head for handling and response based on the nature of the complaint.

Detainees can appeal any grievance decision to the Detainee Grievance Committee (DGC) within five working days. The DGC conducts an investigation and provides its decision to the Assistant Warden of Operations for review. The Assistant Warden of Operations then forwards the decision of the DGC to the Warden. The DGC's decision may be further appealed to the Warden for final response. If a detainee is dissatisfied with the Warden's response, the detainee may contact ERO directly.

The local detainee handbook states that a drop box specifically labeled "Medical Requests/Grievances" is located in each housing unit and in the SMUs. However, ODO observed that the drop boxes are not labeled in the manner described in the local detainee handbook. Specifically, there are two types of drop boxes in the housing units. One drop box is designated for submitting "grievances" and a second is designated for the submission of "medical requests." As a result of the mislabeling of these boxes, detainees have placed medical grievances inside the general grievance box, which has commingled medical grievances with non-medical grievances. This has caused medical grievances to be screened by the Grievance Coordinator, who is non-medical personnel, prior to being forwarded to medical staff for processing (**Deficiency GS-1**). The PBNDS requires that medical grievances be delivered directly to medical staff for response.

ODO confirmed that medical grievances are not maintained in detainee medical files. Instead, medical grievances are filed in a three-ring binder (**Deficiency GS-2**).

STANDARD/POLICY REQUIREMENTS FOR DEFICIENT FINDINGS

DEFICIENCY GS-1

In accordance with the ICE PBNDS, Grievance System, section (V)(C)(3)(2)(c), the FOD must ensure that grievance forms concerning medical care shall be delivered directly to medical staff designated to receive and respond to medical grievances at the facility. Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale. This record should be maintained per Section E "Record-Keeping and File Maintenance."

DEFICIENCY GS-2

In accordance with the ICE PBNDS, Grievance System, section (V)(E), the FOD must ensure that medical grievances are maintained in the detainee's medical file.

MEDICAL CARE (MC)

ODO reviewed the Medical Care standard at DCDF to determine if detainees have access to healthcare and emergency services to meet health needs in a timely manner, in accordance with the ICE PBNDS. ODO toured the clinic, reviewed policies, procedures, and medical staff credentials, and interviewed health care and administrative staff. ODO examined 30 medical records of detainees falling into the following categories: ten chronic care, one opioid withdrawal, six suicide watches, ten random healthy, and three detainee complaints (summarized in the detainee interview section of this report). Seven of the detainees whose records were reviewed were females.

All detainees are screened by nursing staff within the required 12-hour timeframe. Receiving Screening Form 168, dated January 2007, is currently utilized by DCDF medical personnel; however, the GEO Quality Control Specialist provided ODO with a much more thorough and complete form dated January 2012, which has not yet been implemented. ODO recommends implementation of the new form to enhance the screening process. In addition to the standard screening form, a Nurses Incoming Screen Progress Notes form is also completed, focusing on chronic care issues and medication needs. Review of medical records confirmed all detainees with acute or chronic care issues were appropriately addressed in a timely manner.

DCDF utilizes color-coded Progress Notes to easily identify documentation generated while a detainee is housed in the medical unit. All mental health documentation is recorded on blue Progress Notes. This system efficiently organizes medical records and provides immediate access to medical information. ODO cites this as a best practice.

A chest x-ray (CXR) is performed upon arrival to rule out the presence TB. A physical examination (PE) is performed on each detainee within nine days of admission. This was confirmed in all 30 medical records reviewed. Detainees access health care services by completing sick call request slips, which are available in English and Spanish. ODO verified requests are triaged within 48 hours to determine priority for care. Detainees are seen for sick call in a timely manner. Nursing staff conducts sick call on a daily basis using GEO medical protocols. Follow-up appointments and referrals are completed as indicated. If a language barrier exists, bilingual staff assists or a translation service is used. Detainees who require a higher level of medical care are sent to the Medical Center of Aurora, or the University of Colorado Hospital (UCH). UCH also treats psychiatric illnesses.

ODO reviewed the medical records of seven female detainees and noted that one of the medical records did not contain documentation of a pregnancy test. Specifically, a female detainee was admitted to DCDF on July 26, 2011, but had not received a pregnancy test during her entire stay at the facility (**Deficiency MC-1**). During the inspection, the facility attempted to correct this deficiency by offering a pregnancy test to the female detainee; however, the detainee declined to take the test and signed a refusal form to acknowledge her declination. ODO is citing this as a deficiency because the language of the PBNDS specifically requires pregnancy tests be given and the standard does not address this type of situation where the detainee refuses the pregnancy test. This was a repeated deficiency from the March 2011 QAR. ODO recommends that the

standard be amended to account for this type of scenario when a detainee refuses a pregnancy test.

Copies of all professional licenses were present; however, the licenses had not been primary source verified with the issuing agency for their authenticity (**Deficiency MC-2**). ODO observed there was no documentation to confirm that clinical privileges had been granted in writing to the dentist and the PA. Although this is not a deficiency, ODO notes this observation as an area of concern. During the inspection, all licenses were primary source verified and the GEO corporate office Medical Director granted the dentist clinical privileges.

ODO also noted that the cardiopulmonary (CPR) certification for the CD expired in April 2012. A deficiency is not cited because the contract physician is not considered a member of the GEO staff. However, the ERO Contracting Officer's Technical Representative stated the CD is contractually obligated to maintain current CPR certification. As a result, the GEO corporate office stated that the CD will be required to obtain CPR certification immediately following the CI.

STANDARD/POLICY REQUIREMENTS FOR DEFICIENT FINDINGS

DEFICIENCY MC-1

In accordance with ICE PBNDS, Medical Care, section (II)(12), the FOD must ensure that female detainees will undergo pregnancy testing and pregnancy management services.

DEFICIENCY MC-2

In accordance with ICE PBNDS, Medical Care, section (II)(29), the FOD must ensure that health care services will be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are verifiable licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements.

NOTE: ICE PBNDS, Medical Care, section (V)(B), states that Health care personnel perform duties for which they are credentialed by training, licensure, certification, job descriptions, and/or written standing or direct orders by personnel authorized by law to give such orders

For the purpose of this inspection, ODO will only cite under section (II)(29) due to the similarity between the sections under the same standard.

SPECIAL MANAGEMENT UNITS (SMU)

ODO reviewed the Special Management Units (SMU) standard at DCDF to determine if the facility has procedures in place to temporarily segregate detainees for disciplinary and administrative reasons, in accordance with the ICE PBNDS. ODO toured each SMU, reviewed policies and documentation, and interviewed staff and detainees.

The facility has written procedures in place to temporarily segregate detainees for disciplinary and administrative reasons. Each SMU (Administrative; Disciplinary) is well ventilated, adequately lit, temperature appropriate, and maintained in a sanitary condition. Review of SMU housing records confirmed that detainee health and living conditions are regularly monitored by medical, custody, and administrative staff.

ODO reviewed SMU logs and verified that activities, privileges, and staff observations were properly recorded; however, a review of four randomly selected detention files confirmed that facility staff is not conducting regular status reviews of detainees placed in administrative segregation to determine if segregation is still warranted. Two of the four files did not contain a 72-hour review or a seven-day review by the Security Supervisor. One file was missing three weekly reviews. The fourth file was lacking a 72-hour review and two weekly reviews (**Deficiency SMU-1**). It is important that these status reviews are consistently conducted in a timely manner, so detainees can be quickly returned to the general population when segregation is no longer warranted.

STANDARD/POLICY REQUIREMENTS FOR DEFICIENT FINDINGS

DEFICIENCY SMU-1

In accordance with the ICE PBNDS, Special Management Units, sections (V)(C)(3)(a)(b)(c), the FOD must ensure that all facilities shall implement written procedures for the regular review of all detainees held in Administrative Segregation, consistent with the procedures specified below.

- a. A security supervisor shall conduct a review within 72 hours of the detainee's placement in Administrative Segregation to determine whether segregation is still warranted. The review shall include an interview with the detainee. A written record shall be made of the decision and the justification. The Administrative Segregation Review (Form I-885) shall be used for the review. If the detainee has been segregated for his or her own protection, but not at the detainee's request, the signature of the facility administrator or assistant facility administrator is required on the Form I-885 to authorize the alien's continued detention.

- b. A security supervisor shall conduct the same type of review after the detainee has spent seven days in Administrative Segregation, and every week thereafter, for the first 60 days and (at least) every 30 days thereafter.

- c. The review shall include an interview with the detainee, and a written record shall be made of the decision and its justification.

STAFF-DETAINEE COMMUNICATION (SDC)

ODO reviewed the Staff-Detainee Communication standard at DCDF to determine if procedures are in place to allow formal and informal contact between detainees and key ICE and facility staff, and if ICE detainees are able to submit written requests to ICE staff and receive responses in a timely manner, in accordance with the ICE PBNDS. ODO interviewed staff and detainees, toured and observed housing units, and reviewed ERO visitation records, Facility Liaison Visit Checklists, and Telephone Serviceability Worksheets.

The facility allows detainees to have formal and informal access and interaction with facility and ERO staff. Detainees can submit written questions, requests, or concerns to facility and ERO staff by completing a request form. Request forms are available upon request in each housing unit. Secure drop boxes for submitting the request forms are located throughout the facility.

While touring DCDF, ODO observed Department of Homeland Security, Office of the Inspector General, Hotline Information Posters are conspicuously posted throughout the facility.

ODO reviewed a sample of randomly selected Facility Liaison Visit Checklists from March 2012 to the present and noted that multiple fields on the forms were left blank. Three of the forms had notations stating that ERO officers had visited the SMU; however, the block titled "ICE Detainees in SMU Admin Seg" reflected that zero detainees were in administrative segregation. ODO confirmed there were detainees housed in administrative segregation during the dates listed on the forms. All forms had notations indicating that ERO officers had visited the SMU, but ODO reviewed seven randomly selected detention files and noted that four (57%) of the seven files were missing status reviews to determine if administrative segregation was still warranted. The Model Protocol requires segregation status reviews. There were no notations made by ERO officers on the Facility Liaison Visit Checklist stating that segregation status reviews were missing (**Deficiency SDC-1**).

The accuracy and completion of the Facility Liaison Visit Checklist and completion of required segregation status reviews are essential for ERO assessment of detainee treatment at DCDF. Incomplete or missing information on forms may prevent ERO from fully and accurately assessing detainee living conditions at DCDF.

STANDARD/POLICY REQUIREMENTS FOR DEFICIENT FINDINGS

DEFICIENCY SDC-1

In accordance with the ICE PBNDS, Staff-Detainee Communication, section (V)(E), the FOD must ensure that a Model Protocol for DRO Officer Facility Liaison Visits, along with associated documentation forms, are accessible via the website of the Headquarters Detention Standards Compliance Unit. The Model Protocol is designed to standardize an approach to conducting and documenting facility liaison visits, observing living and working conditions, and engaging in staff-detainee communications.

In accordance with the required frequency of liaison visits described above in the section on Scheduled Contact with Detainees, Model Program forms shall be:

- Completed weekly for SPCs, CDFs, and regularly used IGSA facilities, and for each visit to intermittently used IGSA facilities.
- Submitted annually with the required Annual Detention Reviews.

SUICIDE PREVENTION AND INTERVENTION (SP&I)

ODO reviewed the Suicide Prevention and Intervention standard at DCDF to determine if the health and well-being of detainees are protected by training staff in effective methods of suicide prevention, in accordance with the ICE PBNDS. ODO inspected the suicide watch cell, interviewed medical staff and the training manager, reviewed six suicide watch records, DCDF suicide prevention policies, the DCDF suicide prevention training curriculum, and ten staff training records.

ODO verified detainees are screened for suicide potential during the intake process. Review of ten training files and the GEO corporate training curriculum confirmed facility staff has completed initial and ongoing suicide prevention training covering all elements required by the PBNDS. The training is presented by certified instructors.

There have been six documented suicide watches since July 2011. Review of detainee medical records confirmed four (67%) of the six suicide watches were not re-evaluated by medical staff on a daily basis to assess suicide watch status. In two (50%) of the four cases, the detainees were not re-evaluated on the second day after the suicide watch was initiated. One was not re-evaluated for five days, and the second was not re-evaluated for 13 days. Suicide watch was discontinued by the HSA in one case. In another case, the HSA downgraded the suicide watch from constant observation to close observation. Removal from constant observation status terminated the suicide watch as defined by the PBNDS. The HSA is not qualified or authorized to terminate suicide watch status, and there was no documentation verifying consultation with a psychiatrist or psychologist (**Deficiency SP&I-1**). The psychologist stated that the HSA has been counseled regarding the importance of strict adherence to the requirement that restricts the authority to discontinue a suicide watch to qualified mental health professionals and physicians.

STANDARD/POLICY REQUIREMENTS FOR DEFICIENT FINDINGS

DEFICIENCY SP&I-1

In accordance with ICE PBNDS, Suicide Prevention and Intervention, section (V)(D), the FOD must ensure that detainees who are placed on suicide watch are to be re-evaluated by appropriately trained and qualified medical staff on a daily basis and this re-evaluation is documented in the detainee's medical record.

Only the mental health professional, clinical medical authority, or designee may terminate a suicide watch after a current suicide risk assessment is completed. A detainee may not be returned to the general population until this assessment has been completed.

TERMINAL ILLNESS, ADVANCE DIRECTIVES, AND DEATH (TIADD)

ODO reviewed the Terminal Illness, Advance Directives, and Death standard, to include Do Not Resuscitate orders and organ donations, at DCDF to determine if the facility's policies and practices are in accordance with the ICE PBNDS. ODO interviewed medical staff and reviewed policies and procedures.

There was a detainee death within the last year. The death occurred on April 12, 2012. On that day, a male detainee complained of chest pains. Medical staff evaluated the detainee in the DCDF clinic. Vital signs were normal, but emergency medical services (EMS) were requested and dispatched via a 911 call. EMS staff transported the detainee from DCDF to the ER. After evaluation in the ER, the detainee was moved to the cardiac catheterization room (CCR). While in the CCR, the detainee suffered a cardiac arrest. CPR was unsuccessful, and the detainee was pronounced dead. ODO is conducting a detainee death review to determine if PBNDS requirements were met, and procedures were followed.

ODO reviewed GEO policies "Advance Directives, Terminal Illness, and End of Life Decision Making" and "Death, Inmate/Detainee" and noted that these policies do not address procedures related to autopsies (Deficiency TIADD-1). It should be noted that this was a repeated deficiency from the March 2011 QAR.

STANDARD/POLICY REQUIREMENT FOR DEFICIENT FINDINGS

DEFICIENCY TIADD-1

In accordance with ICE PBNDS, Terminal Illness, Advance Directives, and Death, section (V)(J), the FOD must ensure that each facility shall have written policy and procedures to implement the provisions detailed below in this section.

- The facility Chaplain should also be involved in the formulation of the facility's procedures.
- Because state laws vary greatly, including when to contact the coroner or medical examiner, the respective Chief Counsel will be consulted.
- A copy of the written procedures shall be forwarded to the Chief Counsel.

The written procedures shall address, at a minimum:

- Contacting the local coroner or medical examiner, in accordance with established guidelines and applicable laws;
- Scheduling the autopsy;
- Identifying the person who will perform the autopsy;
- Obtaining the official death certificate, and
- Transporting the body to the coroner or medical examiner's office.