



Systemic Indifference

Dangerous & Substandard Medical Care in US Immigration Detention

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Community Initiatives for Visiting Immigrants in Confinement (CIVIC) is the national immigration detention visitation network, which is working to end U.S. immigration detention by monitoring human rights abuses, elevating stories, building community-based alternatives to detention, and advocating for system change. CIVIC currently has over 1,400 volunteers in its network visiting at over 40 immigration detention facilities throughout the United States.

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Systemic Indifference Dangerous & Substandard Medical Care in US Immigration Detention

Summary 1

Recommendations.....8

 To the Department of Homeland Security 8

 To the United States Congress 9

 To State and Local Governments 9

Methodology..... 10

I. Background..... 13

 Overview of the US Immigration Detention System 13

 Lack of Transparency 18

 Medical Care in the Immigration Detention System 20

 Correctional Healthcare in the US24

II. Deaths in Detention, 2012 – 2015 27

 Government Investigations Reveal Substandard Care.....27

 Responses from ICE and Companies Operating Private Facilities 29

 Substandard Care Contributed to Over One-Third of the Deaths.....30

 Misuse of Isolation and Inadequate Treatment of Individuals with Psychosocial Disabilities... 40

 Substandard Care Evident in 16 of 18 Death Investigations.....44

 Questions about the Adequacy of the Death Investigations 48

III. Further Evidence of Deficient Medical Care.....51

 Requests for Care Ignored or Delayed.....56

 Barriers to Care..... 60

 Provision of Healthcare by Unqualified Personnel 61

 Poor Quality Care by Facility Medical Providers65

 Refusals of Care Not Properly Documented..... 68

 Unreasonable Delays in Obtaining Off-Site Care 69

 Inadequate Mental Health Care and Misuse of Isolation 71

 Inadequate Medical Recordkeeping.....77

IV. Inadequate Oversight and Lack of Accountability..... 79

Failure to Take Prompt Corrective Action	80
Failure to Identify Problems	85
Inadequate Grievance Procedures.....	88
Inadequate Data Collection.....	90
Two Examples of Creative Medical Advocacy	92
V. US and International Legal Standards.....	97
Right to Reasonable Medical Care and Health	97
Rights of Persons with Psychosocial Disabilities	101
Limits on the Use of Detention for the Control of Immigration	101
Acknowledgments.....	103
Appendix I.....	105

Summary

On April 6, 2015, Raul Ernesto Morales-Ramos, a 44-year-old citizen of El Salvador, died at Palmdale Regional Medical Center in Palmdale, California, of organ failure, with signs of widespread cancer. He had entered immigration custody four years earlier in March 2011. He was first detained at Theo Lacy Facility, operated by the Orange County Sheriff's Department, and then at Adelanto Detention Facility, operated by the private company Geo Group, both of which had contracts with US Immigration and Customs Enforcement ("ICE") to hold non-citizens for immigration purposes.

An ICE investigation into the death of Morales-Ramos found that the medical care he received at both facilities failed to meet applicable standards of care in numerous ways. Two independent medical experts, analyzing ICE's investigation for Human Rights Watch, agreed that he likely suffered from symptoms of cancer starting in 2013, but that the symptoms essentially went unaddressed for two years, until a month before he died.

Throughout this time, Morales-Ramos repeatedly begged for care. In February 2015, he submitted a grievance in which he wrote, "To who receives this. I am letting you know that I am very sick and they don't want to care for me. The nurse only gave me ibuprofen and that only alleviates me for a few hours. Let me know if you can help me." At the time of ICE's report on its investigation, the final cause of death had not yet been determined, but as detailed below, the facts revealed in the ICE investigation show that systemic indifference to his suffering and systemic failures in the healthcare system spurred his death.

This report examines serious lapses in health care that have led to severe suffering and at times the preventable or premature death of individuals held in immigration detention facilities in the United States. The lapses occur in both publicly and privately run facilities, and have persisted despite some efforts at reform under the Obama administration, indicating that more decisive measures are urgently needed to improve conditions. At time of writing, it was unclear how the Trump administration would address the issue, but its pledge to sharply increase the number of immigrants subject to detention and reports it is

also planning to roll back protections for immigrants in detention, raise serious concerns that the problems fueling the unnecessary suffering could grow even worse.

As with our assessment of the Morales-Ramos case above, this report is based in large part on review by independent medical experts of ICE's own investigations into deaths in custody and, in a range of other cases that did not involve deaths, independent review of detained individuals' medical records as well as interviews with people who have been detained, family members, and those who have worked closely with them.

The number of people held in immigration detention in the United States has grown significantly over the past decade. It hit a record high under President Obama, over 400,000 people per year, and is likely to grow even higher under President Trump, who soon after his inauguration signed executive orders calling for increased detention, both through changes in detention policy and increased construction of or contracts for detention centers along the US-Mexico border. Trump's enforcement priorities, which now encompass people who have no criminal convictions but have committed a "chargeable offense," are also likely to lead to a substantial increase in the number of people detained.

Medical care in the US immigration detention system, and the poor system of oversight that allows substandard care, has long been the target of criticism by investigative journalists and human rights advocates. This is the third report Human Rights Watch has released on medical care in immigration detention since 2007, and one among many reports by civil and human rights organizations on conditions in such facilities nationwide.

Gaining access to immigration detention facilities is difficult and information on conditions there is hard to obtain. ICE took an important, if limited, step forward in June 2016 when it publicly released detailed reports of its investigations into 18 deaths in custody (death reports) that occurred in such facilities between May 2012 and June 2015. (A total of 21 people died in US immigration detention during that period.) To better assess the evidence and gain insight into health care practices and responses to serious illnesses in immigration detention facilities, Human Rights Watch and Community Initiatives for Visiting Immigrants in Confinement (CIVIC) asked independent medical experts to analyze the recently released reports. We also asked experts to review the medical records of a

dozen other individuals, none of whom died in custody, recently held in 10 different facilities across the country.

As detailed here, the experts identified repeated, clear-cut instances of subpar medical care, including inadequate care that contributed to seven deaths in detention. They also found numerous examples of systemic substandard and dangerous medical practices in other cases—such as overreliance on unqualified medical staff, delays in emergency responses, and requests for care unreasonably delayed. The cases examined represent a small but not necessarily representative sample—though many of them point to much larger, systemic failures of healthcare provision and government oversight that have likely put many more thousands of other detained individuals at risk.

Manuel Cota-Domingo, detained at Eloy Detention Center, died of untreated diabetes and pneumonia after numerous delays, including a policy that placed restrictions on which staff could call 911, resulted in eight hours passing between the moment he started to have trouble breathing and his arrival at an emergency room. Tiombe Carlos died by suicide in York County Prison after being detained for two-and-a-half years. The mental health care she received was deemed “woefully inadequate” by an independent expert. Santiago Sierra-Sanchez, detained at Utah County Jail, died of a staph infection and pneumonia. A correctional health expert said of the care he received, “Medical staff essentially abandoned this patient by not properly assessing him or following up.”

Medical experts identified numerous and significant delays in the care “Jose L.” received while detained at Adelanto Detention Facility for three years, including a failure to act quickly to address vision problems that likely led to him becoming legally blind in his right eye. “Carlos H.” tore his ligament while detained at Yuba County Jail in California, but it was not properly diagnosed for three months because he kept seeing licensed vocational nurses who did not refer him to a doctor, and then ICE further delayed his scheduled surgery repeatedly without providing any clinical reason. “Luke R.,” detained at Orange County Jail in New York, had been diagnosed previously with schizophrenia. The facility not only failed to provide adequate mental health care—at one point changing a prescription for an anti-hallucinogen to Benadryl, an anti-histamine—it also disciplined Luke and put him into solitary confinement for actions that were clearly related to his mental health condition.

As noted above, these are not new problems. ICE has been receiving reports of such substandard medical care for years but has failed to take meaningful action. The Obama administration implemented several new programs meant to improve oversight, but these monitoring procedures remain inadequate, and the Trump administration has already announced plans to reverse many of these reforms, including not including the most recent detention standards for contracts with county jails. The Government Accountability Office has faulted ICE for its failure to track and analyze its oversight mechanisms and grievances from detained immigrants. ICE's response to Human Rights Watch's requests under the Freedom of Information Act have been uninformative and in some cases appear to indicate that the agency lacks important baseline information about the provision of healthcare services to people in its custody.

Most disturbingly, there is significant evidence that ICE does know about many of the deficiencies in its medical care system, but that it has failed to take swift and appropriate action. Its own investigations into deaths in detention have shown that it lacks the procedures necessary to take appropriate and timely corrective action. For example, Eloy Detention Center (EDC), run by the private company CoreCivic/CCA¹, has seen 15 deaths in detention since 2003, more than any other detention facility in the US. The ICE death report for Jose de Jesus Deniz-Sahagun, who died by suicide in 2015, flagged the lack of a suicide prevention plan at the facility "despite Deniz Sahagun's suicide being the third at EDC since April 2013 and the fifth since 2005."

Annual reports by the Office of Civil Rights and Civil Liberties at the Department of Homeland Security make clear that recommendations stemming from allegations of abusive conditions in detention facilities are regularly sent to ICE, but ICE often does not respond for years or responds in ways that are deemed completely inadequate to CRCL. In its 2015 report to Congress, CRCL states it sent ICE 49 recommendations regarding an unnamed facility in Arizona that mentions the number of suicides in recent years, making clear it is Eloy Detention Center. It took ICE two years to respond to these recommendations, concurring in 19, but CRCL stated it "[d]oes not believe that ICE responded appropriately to the other 30 recommendations."

¹ Corrections Corporation of America (CCA) changed its name to CoreCivic in October 2016. CIVIC, a co-author of this report, has no connection or relationship with CoreCivic/CCA aside from the fact that CIVIC monitors CoreCivic/CCA facilities and advocates on behalf of immigrants in these facilities. The company is referred to as "CoreCivic/CCA" throughout this report.

Over two-thirds of individuals in immigration detention are held in facilities operated by private prison companies, and these facilities in recent years have come under particular scrutiny by advocates, investigative journalists, and government bodies. The Bureau of Prisons (BOP), the federal prison system, also has private prisons run by the same companies.

In August 2016, a report by the Office of Inspector General at the Department of Justice found, “[I]n most key areas, contract prisons incurred more safety and security incidents per capita than comparable BOP institutions and that the BOP needs to improve how it monitors contract prisons in several areas.” Soon afterward, the Department of Justice announced it would phase-out the use of private prisons in its own federal prison system, “to ensure consistency in safety, security and rehabilitation services.” The US Department of Homeland Security then announced it would review its own use of private facilities.

The report of the Homeland Security Advisory Council, summarizing the results of the review, stated private detention would continue, but in the report’s release, the council voted 17-5 to support one member’s dissenting recommendation of a “measured but deliberate shift away from the private prison model.” At the same time, in October 2016, the Department of Homeland Security decided to reopen Cibola County Correctional Center, a private prison the Department of Justice had closed after a history of numerous citations for deficiencies in medical care, including deaths after inadequate medical care. President Trump’s administration has since reversed the DOJ decision to phase-out the use of private prisons.

In researching this report, Human Rights Watch found significant problems with medical care in facilities operated by private companies, but it also found evidence of subpar care in county jails that contract to hold immigrants for Immigration and Customs Enforcement. It should be noted that in many privately-operated facilities, the medical care is provided by ICE’s Immigrant Health Service Corps (“IHSC”) and not by the private company. Although private facility staff and policy can affect the provision of medical care in IHSC-staffed facilities, including in responses to emergencies, the lack of appropriate medical care in public and private facilities, as well as those staffed by IHSC, underscore that problems with medical care are systemic.

The problem of poor medical care in immigration detention cannot be separated from the enormous and unwieldy nature of the system itself. At present, the US immigration detention system holds an average of 41,000 people on any given day. It holds asylum seekers and long-term residents of the US, including those with lawful permanent resident status. It holds men, women, and children, sometimes for days, and sometimes for months or years. Most are detained without an individualized hearing as to whether their detention is truly necessary.

The United States could meet its legitimate goals of ensuring appearance at removal hearings, protecting public safety, and effectuating removal by releasing many of the people who are currently detained and supervising them through community-based programs that provide case support. Several studies have shown such programs would be considerably less costly. A smaller detention system would also be more in keeping with international human rights principles. The United Nations Working Group on Arbitrary Detention has stated: “If there has to be administrative detention, the principle of proportionality requires it to be a last resort.”

The Trump administration, however, has signaled it will rapidly expand the use of detention. The challenges of adequately monitoring and holding accountable a diffuse and disparate system with numerous operators, including those with a strong incentive to reduce costs, will only be exacerbated in a system that rapidly expands.

The executive branch does not have unfettered power to expand the system: Congress must allocate the funding and thus is in a position to push back and insist on reforms, including increased use of alternatives to detention and measures to ensure effective oversight and adequate provision of health care for those who are detained.

Because ICE relies on contracts with many local governments for detention space, states also have a role to play in improving medical care and detention conditions more generally. In California, which detains more immigrants than any state except Texas, a bill is pending that could improve conditions. At the time of writing, Senate Bill 29, Dignity Not Detention, would end localities’ contracts with private companies to hold immigrants in detention; require localities that hold immigrants in detention for the federal government to adhere to the most recent Performance-Based National Detention Standards; and make these standards enforceable by the California Attorney General and local district and city

attorneys. An earlier version of this bill passed the California legislature in 2016 but was vetoed by Governor Jerry Brown, who cited the then-pending review of private facilities by the US Department of Homeland Security.

Under the US Constitution and international law, anyone who is detained or incarcerated is entitled to adequate medical care. The Trump administration is obligated to ensure that all people in detention are treated humanely and with dignity, including through provision of appropriate medical care, and to provide sufficient funding to meet these obligations. Congress and state governments should work to limit the scope of detention to what is truly necessary and ensure that those who are detained are treated humanely.

Recommendations

To the Department of Homeland Security

- Reserve detention for individuals who pose a danger or flight risk that cannot reasonably be addressed without detention, and increase the use of community-based alternatives to detention for those who are subject to statutory mandatory custody.
- Reform the monitoring system to task a single entity (created for the purpose or existing) with both the responsibility and authority to review and approve corrective action plans, monitor compliance, and impose sanctions for non-compliance, including closure of detention centers.
- Reform the contracting process to ensure meaningful inspections by medical experts before contracts are entered into or renewed, consistent application of the most recent performance-based national detention standards, and clear terms outlining penalties, including cancellation of the contracts, for failure to perform.
- Do not detain people in facilities in which repeat, egregious violations of standards for appropriate medical and mental health care have been documented.
- Increase transparency of detention operations with regularly published statistics on the number of people detained, incidents of violence, and other measures of detention conditions, and publicly and regularly release investigations into deaths in detention, inspections, and contracts. This data should be disaggregated by gender, disability, and age.
- End isolation (also called solitary confinement) for persons with psychosocial² disabilities in immigration detention centers.
- Refrain from detaining families and asylum seekers.
- Refrain from detaining individuals with serious medical and mental health needs that cannot be fully and adequately addressed in detention, and wherever possible release under humanitarian parole individuals with serious medical and mental health needs.

² Psychosocial disability: the preferred term to describe persons with mental health conditions such as depression, bipolar, schizophrenia, and catatonia. This term expresses the interaction between psychological differences and social or cultural limits for behavior, as well as the stigma that the society attaches to persons with mental impairments.

- Expand the use of community-based alternatives to detention.

To the United States Congress

- Deny additional funds for increased immigration detention; or at a minimum:
 - Ensure increased oversight accompanies any increased funds for detention.
- Eliminate the “detention bed mandate” that requires the federal government to maintain 34,000 detention beds at all times.
- End mandatory detention and ensure all non-citizens are eligible for an individualized bond hearing.
- Require increased transparency regarding the immigration detention system, including eliminating exemptions under the Freedom of Information Act that have been applied to private companies operating detention centers.
- Ban all use of isolation for people with psychosocial disabilities.
- Appoint an Independent Medical Oversight Board to be comprised of medical doctors and advocates at the national level and encourage ICE and its contractors to begin implementing local medical oversight boards at individual detention facilities.

To State and Local Governments

- Pass legislation or enact policy reforms banning all use of isolation for people with psychosocial disabilities in local jails.
- Pass legislation or enact policy reforms addressing substandard medical care in local jails.
- Pass legislation to codify ICE’s most recent Performance Based National Detention Standards and allow the state attorney general or any district attorney, city attorney, or private individual to bring a civil action against an immigration detention facility, an agent thereof, or a person acting on its behalf who violates a detained person’s rights.

Methodology

This report is a collaboration between Human Rights Watch and Community Initiatives for Visiting Immigrants in Confinement (CIVIC). Human Right Watch conducted the interviews and wrote the report, with substantial input from CIVIC during the initial stages and through the investigation process. CIVIC consulted on the design, helped identify individuals to interview, and reviewed and provided feedback on the final report and policy recommendations.

This report is based on US government records summarizing investigations into deaths of people in immigration detention from 2012 to 2015, interviews conducted between October 2015 and September 2016, analyses of independent medical experts of the detainee death investigation records and other detained individuals' medical records, and information obtained from Freedom of Information Act (FOIA) requests. It also relies on reports by US government agencies, nongovernmental organizations, and other publicly available sources.

The records summarizing investigations into 18 deaths in detention from 2012 to 2015 were released by US Immigration and Customs Enforcement on its FOIA Library website in June 2016. Human Rights Watch provided these records to two independent medical experts who reviewed and shared their conclusions with us separately. A press release Human Rights Watch released in July 2016 summarized the findings of the experts' analyses.³

The 18 cases relate to a tiny fraction of the hundreds of thousands of people held in detention during the period in question, and do not speak directly to conditions in most of 200-plus different facilities ICE uses to house immigrants. However, the reviews raise serious concerns about ICE's ability to detect, respond appropriately to and successfully correct serious lapses in medical care that arise in any of these facilities—even in cases in which the agency has conducted detailed investigations into deaths in detention.

In addition, Human Rights Watch conducted more than 90 interviews with non-citizens who were or had been in immigration detention at some point in the last 5 years; family

³ "US: Deaths in Detention: Newly Released Records Suggest Dangerous Lapses in Medical Care," Human Rights Watch news release, July 7, 2016, <https://www.hrw.org/news/2016/07/07/us-deaths-immigration-detention>.

members; attorneys representing immigrants in detention; immigration advocates; and correctional health experts. Many of the individuals we interviewed were identified by volunteers with visitation programs in the CIVIC national network, and by CIVIC staff. Others were referred to Human Rights Watch by attorneys, advocacy organizations, or other individuals in detention, or identified by Human Rights Watch during facility tours.

The cases reviewed for this report involve individuals who have been detained in a total of 27 different facilities in 15 different states. Human Rights Watch interviewed individuals who, at the time of the interviews, were detained at seven facilities across the country—Adelanto, Eloy, Etowah, Hudson, Imperial, LaSalle, Santa Ana, and Theo Lacy.

Human Rights Watch provided 12 sets of medical records from 10 different facilities, representing a diversity of facilities across the country to two independent medical experts who reviewed and shared their conclusions with Human Rights Watch separately. Individual medical records were obtained after the individuals consented to Human Rights Watch requesting their records directly from the facilities, ICE, or their attorneys, with the understanding that they might be provided to an independent medical expert for analysis of the medical care they received.

Although the medical records speak directly to the experiences of only 12 detained individuals, they include evidence of inadequate staffing and poor operational systems that are unlikely to have affected only these individuals. The problems documented in these records echo what dozens of individuals, families, and attorneys told Human Rights Watch and CIVIC regarding immigrants' experiences with medical care in these and other facilities. They also echo many of the conclusions independent medical experts reached after examining the death reviews (set forth earlier in this report), and are similar to problems identified by other advocates.

Human Rights Watch and CIVIC also participated in facility tours and group discussions with dozens of individuals detained in the Adelanto, Eloy, Etowah, and Hudson facilities, which were requested under the ICE policy for stakeholder tours.⁴ These group discussions

⁴ In September 2011, ICE announced in response to requests from advocates a policy for organizations and other stakeholders to request tours of immigration detention facilities, including meetings with individuals detained in those facilities. US Immigration and Customs Enforcement, Enforcement and Removal Operations, Office of State, Local, and Tribal Coordination, "Stakeholder Procedures for Requesting a Detention Facility tour and/or Visitation,"

are not included in the overall count of interviews conducted for this report, but the content of these discussions informed our understanding of detention conditions, including medical care.

Interviews were conducted in person or by telephone, and in English, Spanish, and Portuguese by Human Rights Watch staff fluent in these languages. All participants were informed of the purpose of the interview and consented orally. Where medical records were obtained from the detention facilities, consent was provided orally and through signed waivers compliant with Health Insurance Portability and Accountability Act (HIPAA) and ICE requirements. No interviewee received compensation for providing information. Where appropriate, Human Rights Watch provided interviewees with contact information for individuals and organizations providing legal, counseling, or other supportive services at the conclusion of the interview. We have used pseudonyms to protect the privacy of nearly all individuals who were detained at their request and, where we have done so, we have so indicated in the relevant citations.

All of the medical experts who provided their opinions on the death investigations and medical records did so in their personal capacities. The opinions do not represent the official views of their employers or affiliated institutions.

Human Rights Watch sent written questions and requested comments on its findings from private prison company executives and ICE officials. We have included their responses in the report. The companies' full letters are available on the Human Rights Watch website.

<https://www.ice.gov/doclib/ero-outreach/pdf/access-directive-stakeholder.pdf> (accessed April 18, 2017). See also, Women's Refugee Commission, "Immigration and Customs Enforcement Improves Access to Detention Centers," <https://www.womensrefugeecommission.org/immigration-and-customs-enforcement-improves-access-to-detention-centers> (accessed April 18, 2017). On March 15, 2017, CIVIC filed a federal civil rights complaint detailing detention access denials and restrictions at 14 immigration detention facilities across the country. Over 440 organizations, including Human Rights Watch, signed on to a letter calling for continued access to immigration detention facilities. Christina Fialho, "Trump Administration Restricts Access to Immigration Detention Facilities," *Huffington Post*, March 15, 2017, http://www.huffingtonpost.com/entry/trump-administration-restricts-access-to-immigration_us_58c99840e4b0537abd956d68 (accessed April 18, 2017).

I. Background

Overview of the US Immigration Detention System

The US immigration detention system is the largest national immigration detention system in the world, holding more than 400,000 people each year, at a cost of \$2 billion per year.⁵ On November 16, 2016, then-Secretary of Homeland Security Jeh Johnson stated the US government was holding more than 41,000 people, more than it had ever held before on any single day.⁶ The *Wall Street Journal* also reported the number was expected to rise to 45,000 soon.⁷

Among the tens of thousands of people detained each day are asylum-seekers who have been found to have a credible claim to protection; women and children fleeing violence and persecution in Central America; and long-term residents, both with and without legal status, many of whom have strong claims to remaining in the US.⁸

Many are held for months or even years while their claims are adjudicated.⁹ Many never receive a bond hearing, which would provide them with a chance at release from detention while their immigration cases are pending with the courts. Some are deemed ineligible for bond because they requested asylum at a port of entry.¹⁰ Others are categorically deemed ineligible for bond for a wide range of convictions—not only for serious crimes but also for

⁵ US Department of Homeland Security, Yearbook of Immigration Statistics, 2001-2013, <https://www.dhs.gov/yearbook-immigration-statistics> (accessed September 6, 2016); Franco Ordonez, “Trump’s tough stand on immigrant detention will cost taxpayers big,” McClatchy, February 13, 2017, <http://www.mcclatchydc.com/news/politics-government/white-house/article132077414.html> (accessed February 16, 2017).

⁶ US Department of Homeland Security, “Statement by Secretary Johnson on Southwest Border Security,” November 10, 2016, <https://www.dhs.gov/news/2016/11/10/statement-secretary-johnson-southwest-border-security> (accessed February 16, 2017).

⁷ Devlin Barrett, “Record Immigrant Numbers Force Homeland Security to Search for New Jail Space,” *The Wall Street Journal*, October 21, 2016, <https://www.wsj.com/articles/record-immigrant-numbers-force-homeland-security-to-search-for-new-jail-space-1477042202> (accessed March 27, 2017).

⁸ American Civil Liberties Union, “Shutting Down the Profiteers: Why and How the Department of Homeland Security Should Stop Using Private Prisons,” September 2016, <https://www.aclu.org/report/shutting-down-profiteers-why-and-how-department-homeland-security-should-stop-using-private> (accessed January 4, 2017).

⁹ American Civil Liberties Union, “Prolonged Detention Fact Sheet,” https://www.aclu.org/sites/default/files/assets/prolonged_detention_fact_sheet.pdf (accessed January 4, 2017); Transactional Records Access Clearinghouse, “Legal Noncitizens Receive Longest ICE Detention,” June 3, 2013, <http://trac.syr.edu/immigration/reports/321/> (accessed January 4, 2017).

¹⁰ US immigration law requires arriving aliens who establish a credible fear of persecution or torture to be detained. Immigration & Nationality Act, Section 235(b)(1)(B)(ii). However, such individuals may be paroled, i.e., released, on a case-by-case basis for “urgent humanitarian reasons” or “significant public benefit,” provided they do not present a security risk nor a risk of absconding. 8 C.F.R. Section 212.5(b).

minor offenses including simple possession of marijuana. A person with a 20-year-old criminal conviction and a long history of rehabilitation is viewed the same way as a person convicted yesterday.¹¹

The US immigration detention system was not always this large. In the past 15 years, the detention population has more than doubled. In 2001, the US detained approximately 209,000 people. In 2013, the most recent year for which the Department of Homeland Security has published official statistics, the US detained 440,557.¹² The recent growth of the US immigration detention system has been fueled, in part, by Congressional efforts since 2004 to fund an increasing number of beds for immigrants in detention. With the 2010 DHS Appropriations Act, Congress began to require the agency to maintain a “detention bed quota,” currently set arbitrarily at 34,000 detention beds, regardless of enforcement needs.¹³

Private prison companies, through millions of dollars spent on lobbying, have sought to influence debate on immigration reform and immigration detention.¹⁴ Between 2004 and 2014, the two largest for-profit companies, CoreCivic/CCA and Geo Group spent \$18 million and \$4 million on lobbying, respectively.¹⁵ CoreCivic/CCA spent more than \$8.7 million and the Geo Group spent \$1.3 million to lobby Congress solely on Homeland Security appropriations between 2006 and 2015.¹⁶ CoreCivic/CCA and Geo Group have doubled their revenues since 2005.¹⁷ During the 2016 presidential campaign, President Trump

¹¹ Human Rights Watch, *Forced Apart: Families Separated and Immigrants Harmed by US Deportation Policy*, July 16, 2007, <https://www.hrw.org/report/2007/07/16/forced-apart/families-separated-and-immigrants-harmed-united-states-deportation>; Human Rights Watch, *A Price Too High: US Families Torn Apart by Drug Deportations*, June 16, 2015, <https://www.hrw.org/report/2015/06/16/price-too-high/us-families-torn-apart-deportations-drug-offenses>.

¹² US Department of Homeland Security, Yearbook of Immigration Statistics 2001, <https://www.dhs.gov/immigration-statistics/yearbook/2001>; “Immigration Enforcement Actions: 2013,” https://www.dhs.gov/sites/default/files/publications/ois_enforcement_ar_2013.pdf (accessed March 29, 2017).

¹³ Department of Homeland Security Appropriations Act, 2010, Public Law 111-83, October 28, 2009, <https://www.gpo.gov/fdsys/pkg/PLAW-111publ83/pdf/PLAW-111publ83.pdf> (accessed March 27, 2017); National Immigrant Justice Center, “Immigration Detention Bed Quota Timeline,” January 13, 2017, <http://www.immigrantjustice.org/immigration-detention-bed-quota-timeline> (accessed March 27, 2017).

¹⁴ Sharita Gruberg, Center for American Progress, “How For-Profit Companies are Driving Immigration Detention Policies,” December 18, 2015, <https://www.americanprogress.org/issues/immigration/reports/2015/12/18/127769/how-for-profit-companies-are-driving-immigration-detention-policies/> (accessed January 4, 2017).

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

spoke approvingly of private prison companies, and in the months after his election, these companies saw their stock prices soar.¹⁸

Much of the recent spike in detention numbers is due to Obama administration enforcement programs and detention policies. The Obama administration deported a record number of people, more than 2.5 million over eight years.¹⁹

The Obama administration also changed its policy on release of asylum-seekers who have been found to have credible fear of persecution in their home countries and greatly expanded the detention of women and children, many of whom are also asylum-seekers. In 2009, the administration announced a revised parole policy for asylum-seekers who pass the first stage of the asylum application process, which resulted in increased numbers of people being released from detention while their cases were pending.²⁰ But at the end of the Obama administration, this policy was no longer being consistently applied throughout the country. In 2010, ICE detained 49 percent of people with positive credible fear determinations; in 2014, ICE detained 84 percent of such people.²¹

In 2009, the administration stopped detaining families at Hutto Family Detention Facility in Texas, effectively limiting family detention to a handful of women and children held at Berks Family Residential Center in Pennsylvania.²² But after an increase in migrants fleeing violence and persecution in Guatemala, Honduras, and El Salvador, the administration reversed course and greatly expanded family detention capacity, from less than 100 beds to almost 3,000 in 2014 and 2015. In June 2015, DHS announced reforms to discontinue long-term detention of families who have passed the first stage of applying for asylum, but some families have continued to be detained for prolonged periods of time.²³

¹⁸ Jeff Somer, "Trump's Win Gives Stocks in Private Prison Companies a Reprieve," *The New York Times*, December 3, 2016, https://www.nytimes.com/2016/12/03/your-money/trumps-win-gives-stocks-in-private-prison-companies-a-reprieve.html?_r=0 (accessed February 14, 2016).

¹⁹ US Department of Homeland Security, "Yearbook of Immigration Statistics, 2008-2015," <https://www.dhs.gov/yearbook-immigration-statistics> (accessed January 4, 2017).

²⁰ US Immigration and Customs Enforcement, "Revised Parole Policy for Arriving Aliens with Credible Fear Claims," December 16, 2009, <https://www.ice.gov/factsheets/credible-fear> (accessed September 8, 2016).

²¹ Human Rights First, "Lifeline on Lockdown: Increased US Detention of Asylum Seekers," July 2016, http://www.humanrightsfirst.org/sites/default/files/Lifeline-on-Lockdown_o.pdf (accessed September 8, 2016).

²² US Immigration and Customs Enforcement, "2009 Immigration Detention Reforms," December 12, 2011, <https://www.ice.gov/factsheets/2009detention-reform> (accessed January 4, 2017).

²³ "US: First Step to End Family Immigration Detention," Human Rights Watch news release, June 24, 2015, <https://www.hrw.org/news/2015/06/24/us-first-step-end-family-immigration-detention>; Michael Matza, "Immigrant mothers detained at Berks center go on hunger strike," *The Philadelphia Inquirer*, August 12, 2016,

Department of Homeland Security Secretary John Kelly's enforcement memorandum on border security states that migrants who are apprehended will be detained while their cases are pending. While it states the 2009 parole directive has not been revoked, it makes clear grants of parole will become less frequent moving forward.²⁴

In order to hold so many people and to sustain the "detention bed quota," the DHS maintains a sprawling network of county jails, privately run facilities, and DHS-run facilities, including facilities for individuals in the custody of US Immigration and Customs Enforcement (ICE) and US Customs and Border Protection (CBP).²⁵ These facilities vary widely in the number of people they hold and the way in which they are run. Some are large facilities holding more than 1,000 people a day; some are county jails that hold a couple of people for ICE each year. Some are only allowed to hold people for less than 72 hours; others are authorized to hold people for more prolonged periods.²⁶ According to ICE, about 70 percent of people in immigration detention are held in privately-run facilities.²⁷

The decentralized, disparate nature of ICE's detention system is apparent in the four different versions of detention standards that apply to these facilities and in ICE's management of the system.

The over-72-hour facilities are subject to one of four different sets of detention standards: the 2000 National Detention Standards (NDS), the 2008 Performance-Based National

http://www.philly.com/philly/news/20160812_Immigrant_mothers_detained_at_Berks_center_go_on_hunger_strike.html (accessed January 4, 2017).

²⁴ US Department of Homeland Security, Memorandum from Secretary John Kelly, February 20, 2017, https://www.dhs.gov/sites/default/files/publications/17_0220_S1_Implementing-the-Presidents-Border-Security-Immigration-Enforcement-Improvement-Policies.pdf (accessed March 3, 2017).

²⁵ This report focuses on ICE facilities, although abuses have been documented in CBP facilities as well. See Fernanda Santos, "Photos Offer Glimpse Inside Arizona Border Detention Centers," *New York Times*, August 18, 2016, <http://www.nytimes.com/2016/08/19/us/photos-show-conditions-in-arizona-border-detention-centers.html> (accessed January 4, 2017).

²⁶ Border Patrol holding cells are intended to hold people for less than 12 hours but Customs and Border Protection data indicate people are regularly held for over 24 hours, and sometimes longer. These facilities have been the subject of a federal lawsuit alleging the conditions in these cells are inhumane. American Immigration Council, "Way Too Long: Prolonged Detention in Border Patrol Holding Cells, Government Records Show," June 10, 2015, <https://www.americanimmigrationcouncil.org/research/way-too-long-prolonged-detention-border-patrol-holding-cells-government-records-show> (accessed March 24, 2017); "Images show miserable conditions at Border Patrol holding cells in Arizona," *Fox News*, August 18, 2016, <http://www.foxnews.com/world/2016/08/18/images-show-miserable-conditions-at-border-patrol-holding-cells-in-arizona.html> (accessed March 24, 2017).

²⁷ Steven Nelson, "Private Prison Companies, Punched in the Gut, Will Keep Most Federal business," *US News & World Report*, August 18, 2016, <https://www.usnews.com/news/articles/2016-08-18/private-prison-companies-punched-in-the-gut-will-keep-most-federal-business> (accessed March 23, 2017).

Detention Standards 2008 (2008 PBNDS), the 2011 Performance-Based National Detention Standards (2011 PBNDS), and the 2007 Family Residential Standards, which apply only to family detention centers.²⁸ According to the GAO, in 2015, 62 percent of the average daily population was in a facility required to adhere to the 2011 PBNDS. Almost 18 percent was still in facilities operating under the NDS, and almost 14 percent was in facilities operating under the 2008 PBNDS.²⁹ Under-72-hour facilities are only subject to self-reporting requirements.³⁰

Details on how these detention standards should apply are set out in the contracts for each facility, and the terms of the contracts can vary widely. In a report analyzing more than 90 contracts obtained through a FOIA lawsuit, the National Immigrant Justice Center concluded, “The immigration detention contracting process ... suffer[s] from a significant lack of uniformity in how contracts are created, executed, and maintained.”³¹ NIJC found 45 of the contracts it received were indefinite and operating under outdated detention standards. Since they have no expiration date, there is no set calendar for negotiating terms and updating the detention standards that apply to a facility. The Trump administration has indicated new jail contracts will no longer include any version of the national detention standards and will instead, be evaluated based on an 18-page checklist used by the US Marshals Service for federal criminal defendants.³²

The use of privately-run facilities by federal agencies has been highly controversial. In August 2016, the US Department of Justice announced it would phase out the use of private prisons by the Bureau of Prisons (which incarcerates persons convicted of federal crimes).³³ Two weeks later, DHS announced it would review the use of private immigration

²⁸ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” February 2016, <http://gao.gov/products/GAO-16-231> (accessed September 8, 2016).

²⁹ Ibid.

³⁰ National Immigrant Justice Center, “Lives in Peril: How Ineffective Inspections Make ICE Complicit in Detention Center Abuse,” <http://immigrantjustice.org/lives-peril-how-ineffective-inspections-make-ice-licit-detention-center-abuse-o> (accessed January 5, 2017).

³¹ National Immigrant Justice Center, “NIJC Freedom of Information Act Litigation Reveals Systemic Lack of Accountability in Immigration Detention Contracting,” August 2015, <http://immigrantjustice.org/immigration-detention-transparency-and-human-rights-project-august-2015-report> (accessed September 9, 2016).

³² Caitlin Dickerson, “Trump Plan Would Curtail Protections for Detained Immigrants,” *New York Times*, April 13, 2017, <https://www.nytimes.com/2017/04/13/us/detained-immigrants-may-face-harsher-conditions-under-trump.html> (accessed April 20, 2017).

³³ US Department of Justice, “Phasing Out Our Use of Private Prisons,” August 18, 2016, <https://www.justice.gov/opa/blog/phasing-out-our-use-private-prisons> (accessed September 6, 2016).

detention centers (which detain persons accused of violating immigration laws).³⁴ On November 30, 2016, the Homeland Security Advisory Council released the results of its review in an unusually contentious public meeting. Its official report concluded that the agency would continue using privately run facilities because of “[f]iscal considerations, combined with the need for realistic capacity to handle sudden increase in detention.”³⁵ However, during the meeting, the council voted 17-5 to recommend “a measured but deliberate shift away from the private prison model.”³⁶ The council’s report also recommended “improved and expanded ICE oversight,” including “reduce[d] reliance on detention in county jails.”³⁷

Since then, the Trump administration has reversed the Department of Justice decision to phase-out the use of private prisons.³⁸

Lack of Transparency

The ICE detention system is shrouded in secrecy, and the lack of transparency is exacerbated by the system’s reliance on private detention centers, which are not subject to public records acts in the same way that publicly run facilities are subject to them.³⁹

There is no publicly available list of all of ICE’s detention facilities. ICE publishes a list of 112 facilities on its website but according to a 2016 report by the Government Accountability Office, 165 facilities are permitted to hold immigrants for more than 72

³⁴ “Statement by Secretary Jeh C. Johnson on Establishing a Review of Privatized Immigration Detention,” US Department of Homeland Security press release, August 29, 2016, <https://www.dhs.gov/news/2016/08/29/statement-secretary-jeh-c-johnson-establishing-review-privatized-immigration> (accessed September 6, 2016).

³⁵ Homeland Security Advisory Council, “Report of the Subcommittee on Privatized Immigration Detention Facilities,” December 1, 2016, <http://www.trbas.com/media/media/acrobat/2016-12/70003382918880-01141658.pdf> (accessed March 3, 2017).

³⁶ Kevin Johnson, “DHS panel raises concerns about privately-run detention centers,” *USA Today*, December 2, 2016, <http://www.usatoday.com/story/news/politics/2016/12/01/dhs-panel-raises-concerns-privately-run-detention-centers/94727944/> (accessed December 6, 2016).

³⁷ Homeland Security Advisory Council, “Report of the Subcommittee on Privatized Immigration Detention Facilities,” <http://www.trbas.com/media/media/acrobat/2016-12/70003382918880-01141658.pdf>.

³⁸ Matt Zaptosky, “Justice Department will again use private prisons,” *Washington Post*, February 23, 2017, https://www.washingtonpost.com/world/national-security/justice-department-will-again-use-private-prisons/2017/02/23/da395d02-fa0e-11e6-be05-1a3817ac21a5_story.html?utm_term=.2bb48dff1606 (accessed April 20, 2017).

³⁹ Joe Watson, “Advocates Want Private Prisons Subject to Open Records Laws,” *Prison Legal News*, August 2, 2016, <https://www.prisonlegalnews.org/news/2016/aug/2/advocates-want-private-prisons-subject-open-records-laws/> (accessed November 17, 2016).

hours.⁴⁰ A database Human Rights Watch received in response to a request under the Freedom of Information Act for information on individuals transferred between detention facilities between 2011 and 2014 listed 867 facilities.⁴¹ CIVIC maintains a map of detention facilities based on its own research.⁴² ICE does not publish a daily population count and the most recent government-released data on detention numbers is from fiscal year 2013. There is no published information on who is being detained, how long they are detained, staffing ratios, incidents of violence, or the number placed in isolation. Even when required by statute to publish the numbers of asylum-seekers who are detained under the Haitian Refugee Immigration Fairness Act, ICE has failed to provide timely reports. The last report was issued in August 2012, for fiscal years 2009 and 2010.⁴³

Private companies have consistently argued they are not subject to open records laws, such as the federal Freedom of Information Act. In one FOIA request made by nonprofit advocacy organizations, ICE withheld staffing plans and per-diem rates for private facilities, citing exemptions for commercial interests.⁴⁴

The Bureau of Prisons, in comparison, provides a list of all federal prisons, and categorizes them by type, including whether they are privately run, on its website.⁴⁵ It provides a weekly population count, including how many inmates are in privately run facilities.⁴⁶ It also provides demographic information on its inmate population, including age, ethnicity,

⁴⁰ US Immigration and Customs Enforcement, Detention Facility Locator, <https://www.ice.gov/detention-facilities> (accessed April 25, 2017); US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://gao.gov/products/GAO-16-231>.

⁴¹ US Immigration and Customs Enforcement response to request by Human Rights Watch under the Freedom of Information Act.

⁴² Community Initiatives for Visiting Immigrants in Confinement, “Immigration Detention Map & Statistics,” <http://www.endisolation.org/resources/immigration-detention/> (accessed January 4, 2017).

⁴³ US Immigration and Customs Enforcement, “Detained Asylum Seekers: Fiscal Year 2009 and 2010 Report to Congress,” August 20, 2012, <https://www.ice.gov/doclib/foia/reports/detained-asylum-seekers2009-2010.pdf> (accessed January 4, 2017).

⁴⁴ *Detention Watch Network v. US Immigration and Customs Enforcement*, Case No. 1:13-cv-00583 (Southern District of New York), Opinion and Order, July 16, 2016, http://ccrjustice.org/sites/default/files/attach/2016/07/2016.7.14.DWN_.v.ICE_.SJ_.opinion.pdf (accessed April 21, 2017). In July 2016, the district court ruled that per diem payments and staffing plans are not exempt under FOIA. Geo and CoreCivic/CCA filed a motion to intervene, granted in September 2016, and the companies are now appealing the lower court’s ruling to the US Court of Appeals for the Second Circuit. Detention Watch Network, “A Toxic Relationship: Private Prisons and US Immigration Detention,” December 2016, http://www.detentionwatchnetwork.org/sites/default/files/reports/A%20Toxic%20Relationship_DWN.pdf (accessed December 5, 2016).

⁴⁵ US Department of Justice, Bureau of Prisons, “Statistics,” <https://www.bop.gov/about/statistics/> and “Facilities,” <https://www.bop.gov/about/facilities/> (accessed January 4, 2017); US Department of Homeland Security, “Yearbook of Immigration Statistics,” <https://www.dhs.gov/yearbook-immigration-statistics> (accessed January 4, 2017).

⁴⁶ Bureau of Prisons, “Population Statistics,” last updated December 29, 2016, https://www.bop.gov/about/statistics/population_statistics.jsp (accessed January 4, 2017).

type of offense, incidence of assault on inmates, the number placed in restrictive housing, and staffing ratios.⁴⁷

Medical Care in the Immigration Detention System

In the late 2000s, in the last years of the Bush administration and the first years of the Obama administration, a number of reports by Human Rights Watch and other organizations, investigations by the *Washington Post* and the *New York Times*, and government reports uncovered evidence of severe medical neglect in immigration detention facilities, including preventable deaths.⁴⁸ These reports led to Congressional investigations and hearings, and the Obama administration in 2011 announced several reforms intended to “overhaul” the immigration detention system and move away from a “decentralized, jail-oriented approach” to one designed for civil detention.⁴⁹

⁴⁷ Bureau of Prisons, “Inmate Statistics,” November 26, 2016, https://www.bop.gov/about/statistics/statistics_inmate_age.jsp (accessed January 4, 2017).

⁴⁸ Human Rights Watch, *Detained and Dismissed: Women’s Struggles to Obtain Health Care in United States Immigration Detention*, March 17, 2009, <https://www.hrw.org/report/2009/03/17/detained-and-dismissed/womens-struggles-obtain-health-care-united-states>; Americans for Immigrant Justice (formerly Florida Immigrant Advocacy Center), “Dying for Decent Care: Bad Medicine in Immigration Custody,” February 2009, http://www.aijustice.org/dying_for_decent_care_bad_medicine_in_immigration_custody (accessed January 5, 2017); Women’s Refugee Commission, “Migrant Women and Children at Risk: In Custody in Arizona,” October 2010, http://www.womensrefugeecommission.org/resources/doc_download/656-migrant-women-andchildren-at-risk-in-custody-in-arizona (accessed January 5, 2017); Nina Bernstein, “Few Details on Immigrants Who Died in Custody,” *New York Times*, May 5, 2008, <http://www.nytimes.com/2008/05/05/nyregion/05detain.html?action=click&contentCollection=N.Y.%20%2F%20Region&module=RelatedCoverage®ion=Marginalia&pgtype=article> (accessed January 5, 2017); Dana Priest and Amy Goldstein, “System of Neglect: As Tighter Immigration Policies Strain Federal Agencies, the Detainees in Their Care Often Pay a Heavy Cost,” *Washington Post*, May 11, 2008, http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d1p1.html (accessed January 5, 2017); US Department of Homeland Security, Office of Inspector General, “Treatment of Immigrant Detainees Housed at Immigration and Customs Enforcement Facilities,” December 2006, https://www.oig.dhs.gov/assets/Mgmt/OIG_07-01_Deco6.pdf (accessed January 5, 2017).

⁴⁹ US Immigration and Customs Enforcement, “2009 Immigration Detention Reforms,” <https://www.ice.gov/factsheets/2009detention-reform>.

Previous HRW Reports on Medical Care in Immigration Detention

This report follows on previous work by Human Rights Watch on health care in immigration detention. In 2007, Human Rights Watch released *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, documenting the experiences of HIV-positive people in immigration custody whose HIV treatment was denied, delayed, or interrupted, resulting in serious risk and often damage to their health.⁵⁰ The report contributed significantly to revision of the HIV treatment guidelines and to ensuring more comprehensive investigation of AIDS-related deaths.

In 2009, Human Rights Watch issued *Detained and Dismissed: Women's Struggles to Obtain Health Care in United States Immigration Detention*, documenting dozens of cases in which detention center medical staff caused suffering and jeopardized women's health by either failing to respond at all to the medical problems of women in detention or responding only after considerable delays.⁵¹ At the time, the only mention of women's health care in the standards governing immigration detention was a passing reference to pregnancy testing and prenatal care. The 2011 Performance-Based National Detention Standards included for the first time a new standard addressing women's medical care.⁵²

In 2010, in the report *Deportation by Default: Mental Disability, Unfair Hearings, and Indefinite Detention in the US Immigration System*, Human Rights Watch documented how immigrants with mental health conditions are unjustifiably detained for years, during which time they often require emergency medical care, and recommended exercise of prosecutorial discretion in cases involving such persons and the development of alternatives to detention, including supervised release to families and placement in community-based treatment programs.

In 2016, Human Rights Watch released the report, *"Do You See How Much I'm Suffering Here?: Abuse against Transgender Women in US Immigration Detention*, documenting among other abuses, substandard medical and mental health care and misuse of solitary confinement.⁵³

Although the above reports helped prompt some reforms, substandard medical care in immigration detention is a pervasive and continuing problem.

⁵⁰ Human Rights Watch, *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, December 5, 2007, <https://www.hrw.org/report/2007/12/05/chronic-indifference/hiv/aids-services-immigrants-detained-united-states>.

⁵¹ Human Rights Watch, *Detained and Dismissed*, <https://www.hrw.org/report/2009/03/17/detained-and-dismissed/womens-struggles-obtain-health-care-united-states>.

⁵² US Immigration and Customs Enforcement, "2011 Operations Manual ICE Performance-Based National Detention Standards," <https://www.ice.gov/detention-standards/2011> (accessed December 16, 2016).

⁵³ Human Rights Watch, *"Do You See How Much I'm Suffering Here?: Abuse against Transgender Women in US Immigration Detention*," March 23, 2016, <https://www.hrw.org/report/2016/03/23/do-you-see-how-much-im-suffering-here/abuse-against-transgender-women-us>.

Medical care in the detention system, today, however, remains jail-like, decentralized, and dysfunctional. According to a 2016 report by the Government Accountability Office (“GAO”), ICE lacks the tools to track and understand its own system of medical care, from the actual cost of care to trends in off-site medical care.⁵⁴

Medical care providers vary from facility to facility. The Immigrant Health Service Corps (“IHSC”), comprised of US Public Health Service officers, federal civil servants, and contract health professionals, provides medical care in 19 facilities. They also manage some aspects of care at the non-IHSC staffed facilities authorized to hold people for more than 72 hours.⁵⁵ They adjudicate requests for off-site care, address complaints regarding medical care received by other DHS components, such as the Office of Civil Rights and Civil Liberties, and conduct investigations, including into detainee deaths.⁵⁶ The 19 IHSC-staffed facilities include ICE-run detention centers, some private detention centers, some facilities run by local governments but housing only people held for immigration purposes (i.e., not county jails), and some family detention centers.⁵⁷ These facilities hold about 48 percent of the total detained population.⁵⁸ In the remaining facilities, medical care is provided by the private company or local government running the facility or by a third private company providing medical care.

Although facilities that contract with ICE to hold people are generally required to provide medical care, there is little consistency in the terms set forth in the contracts and the specifics of what is required. The 2008 contract for the Joe Corley Detention Facility, for example, requires the facility to ensure on-site medical and health care coverage for at least eight hours per day, seven days per week, and makes specific requirements regarding the qualifications of medical staff: “the Service Provider shall ensure that all health care service providers ... hold current licenses, certifications, and/or registrations with the State and/or City where they are practicing. The Service Provider shall retain a registered nurse to provide health care and sick call coverage unless expressly stated otherwise in this Agreement.”⁵⁹

⁵⁴ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://gao.gov/products/GAO-16-231>.

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Ibid.

⁵⁹ National Immigrant Justice Center, “Immigration Detention Transparency and Human Rights Project,” Intergovernmental Service Agreement Between the US Department of Homeland Security, US Immigration and Customs Enforcement Office of

Adelanto Detention Facility, in contrast, is required to provide “[m]edical coverage at the facility...[for] no less than twenty-four (24) hours per day, seven (7) days per week,” and no specifications are made as to staffing requirements.⁶⁰ When the National Immigrant Justice Center deposed an ICE contracting officer in connection to litigation over its FOIA request for ICE detention center contracts, it found his testimony revealed a “lack of protocol and quality control in detention contracting.”⁶¹

Medical care costs can be generally categorized as on-site costs, usually included in the per-diem rate paid to the facility per person detained, or as off-site costs, requested through the Medical Payment Authorization Request (MedPAR) system. Off-site care must be approved by ICE and is directly paid for by ICE.⁶² At the same time, the facility can incur its own costs for off-site care, as it is often responsible for costs associated with providing transportation and security for individuals taken out of the facility for care.⁶³ For-profit companies and county governments receiving payments from ICE for holding immigrants in detention have a financial incentive to reduce costs related to both on-site and off-site care, with little risk of real penalties for medical care that does not meet the applicable detention standards.⁶⁴

Detention and Removal and Montgomery County, Texas, <http://www.documentcloud.org/documents/2157387-joe-corley-detention-center-montgomery-county-tx.html> (accessed January 5, 2017).

⁶⁰ National Immigrant Justice Center, “Immigration Detention Transparency and Human Rights Project,” Intergovernmental Service Agreement Between the US Department of Homeland Security, US Immigration and Customs Enforcement Office of Detention and Removal Operations and the City of Adelanto, <https://www.documentcloud.org/documents/1633813-adelanto-contract.html> (accessed January 5, 2017).

⁶¹ National Immigrant Justice Center, “NIJC Releases 90 Immigration Detention Contracts, Launches Immigration Detention Transparency and Human Rights Project,” August 13, 2015, http://www.immigrantjustice.org/press-releases/nijc-releases-90-immigration-detention-contracts-launches-immigration-detention?q=press_releases/nijc-publishes-90-immigration-detention-contracts (accessed March 23, 2017).

⁶² US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://gao.gov/products/GAO-16-231>.

⁶³ For example, the contract for Adelanto Detention Facility states transportation and guard services are included in the per-diem rate. National Immigrant Justice Center, “Immigration Detention Transparency and Human Rights Project,” Intergovernmental Service Agreement Between the US Department of Homeland Security, US Immigration and Customs Enforcement Office of Detention and Removal Operations and the City of Adelanto, <https://www.documentcloud.org/documents/1633813-adelanto-contract.html>. Similarly, the contract for Hutto Detention Center states, “The Contractor is responsible for transporting detainees to the hospital and outside medical appointments as needed and/or requested by DIHS personnel, at no additional expense to the Government.” National Immigrant Justice Center, “Immigration Detention Transparency and Human Rights Project,” Detention Services Intergovernmental Agreement, Hutto Detention Center, (Nov. 23, 2009) <http://www.documentcloud.org/documents/1672355-hutto-county-corectional-center-williamson.html> (accessed March 27, 2017).

⁶⁴ For more information on penalties and the lack thereof, see the section on Inadequate Oversight.

According to the Government Accountability Office, ICE is unable to calculate the exact cost of medical care in its detention facilities. Expenditures in its IHSC-staffed facilities totaled \$206 million in fiscal year 2015, but in the other approximately 140 facilities utilized in 2015, the cost of medical care was generally included in each facility's per diem.⁶⁵ Per diem rates, according to documents provided to the National Immigrant Justice Center via a FOIA request, range from \$40 at Etowah County Detention Center to more than \$200 at family detention facilities.⁶⁶ The GAO report also noted ICE is not able to analyze trends in requests for off-site medical care, even though all requests for off-site care come through the MedPAR system. It noted that advocacy organizations have complained of off-site care requests being adjudicated inconsistently, emphasizing that there are “no specific written clinical guidance on which to base approval decisions.”⁶⁷

Human Rights Watch submitted several requests to ICE for information under the Freedom of Information Act for information on aspects of medical care in immigration detention facilities, but the responses we received were incomplete and our appeals were still pending at time of writing.

Correctional Healthcare in the US

The failure of the US immigration detention system to provide appropriate, timely medical care cannot be isolated from the larger problem of abusive and negligent care in many jails and prisons across the country. Although the immigration detention system is supposed to be civil in nature and distinct from the penal, correctional model, ICE facilities are overwhelmingly jails or jail-like institutions.⁶⁸

⁶⁵ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” February 29, 2016, <http://gao.gov/products/GAO-16-231>.

⁶⁶ National Immigrant Justice Center, “Freedom of Information Act Litigation Reveals Systemic Lack of Accountability in Immigration Detention Contracting,” August 2015, <http://immigrantjustice.org/sites/immigrantjustice.org/files/images/NIJC%20Transparency%20and%20Human%20Rights%20Project%20August%202015%20Report%20FINAL2.pdf> (accessed January 5, 2017). The per diem rates were redacted from the contracts NIJC requested and received, as ICE claimed they were exempt as “[t]rade secrets and commercial or financial information obtained from a person and privileged or confidential,” but they were not redacted from the cover pages of the inspection reports.

⁶⁷ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://gao.gov/products/GAO-16-231>.

⁶⁸ US Committee on International Religious Freedom, “Assessing the US Government’s Detention of Asylum Seekers: Further Action Needed to Fully Implement Reforms,” April 2013, <http://www.uscirf.gov/sites/default/files/resources/ERS-detention%20reforms%20report%20April%202013.pdf> (accessed October 27, 2016), concluding, “all detainees, including asylum seekers, continue to be detained under inappropriately penal conditions.” See also, US Commission on Civil Rights, “With Liberty and Justice for All: The State of Civil Rights at Immigration Detention Facilities,” September 2015, http://www.usccr.gov/pubs/Statutory_Enforcement_Report2015.pdf (accessed October 27, 2016).

Many inmates in US prisons fail to get the medical care they need. A 2009 study in the *American Journal of Public Health* found that among inmates with chronic medical problems, 68 percent of local jail inmates, 20 percent of state prison inmates, and 14 percent of federal prison inmates did not receive a medical exam while incarcerated.⁶⁹ Human Rights Watch has documented the particular abuse people with psychosocial disabilities often face in jails and prisons, including severely inadequate medical care.⁷⁰

A recent investigation into medical care at federal prisons run by private companies found overreliance on licensed vocational nurses (LVNs), called licensed practical nurses in some states. The investigators reviewed dozens of medical records of people who died in these prisons, and found “[i]n 19 of the cases reviewed, at least one medical doctor flagged the overextension of LVNs as a factor impeding proper medical care.”⁷¹ It also found that in some facilities, inmates went months without seeing a doctor, while others who required emergency care were not transferred to a hospital, in an apparent attempt to save costs.⁷² One doctor stated, “The pressure of budget is always felt.”⁷³

The private companies who run the federal prisons at issue in the investigation—Geo Group, CoreCivic/CCA, and the Management & Training Corporation—all run immigration detention centers as well, including centers we investigated for this report.

Facilities that are publicly operated often contract with private companies to provide medical care. Some of these companies have been the subject of lawsuits or investigations alleging negligent medical care due to use of undertrained or unqualified medical staff. In 2015, Corizon, one of the country’s largest for-profit prison healthcare providers, and Alameda County in California settled a wrongful death lawsuit involving a jail inmate who died in the midst of alcohol withdrawal. The lawsuit alleged that an LVN put the inmate into the general population without alcohol withdrawal treatment, and that

⁶⁹ Andrew P. Wilper, et al., “The Health and Health Care of US Prisoners: Results of a Nationwide Survey,” *American Journal of Public Health*, April 2009, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661478/pdf/666.pdf> (accessed October 27, 2016).

⁷⁰ Human Rights Watch, *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons*, May 12, 2015, <https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and#44aa12>.

⁷¹ Seth Freed Wessler, “This Man Will Certainly Die,” *The Nation*, February 15, 2016, <https://www.thenation.com/article/privatized-immigrant-prison-deaths/> (accessed October 27, 2016).

⁷² *Ibid.*

⁷³ *Ibid.*

Corizon had hired LVNs instead of registered nurses to cut costs.⁷⁴ In 2014, the New York State Attorney General came to a settlement agreement with Correctional Medical Care, a private prison health care contractor that provided medical services in jails in 13 New York counties, after an investigation in which the attorney general found “the company understaffed facilities and shifted work hours from physicians and dentists to less qualified and lower-wage staff.”⁷⁵

⁷⁴ Henry K. Lee, “\$8.3 million settlement in death of Alameda County inmate,” *San Francisco Chronicle*, February 10, 2015, <http://www.sfgate.com/news/article/8-3-million-settlement-in-death-of-Alameda-6073319.php> (accessed December 5, 2016).

⁷⁵ “A.G. Schneiderman Announces Settlement with Health Care Company That Provided Substandard Service to Jail Inmates in 13 NY Counties,” Attorney General Eric T. Schneiderman news release, September 25, 2014, <https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-health-care-company-provided-substandard-service> (accessed March 27, 2017). See also, R.G. Dunlop, “Lawsuit Over 2013 Montgomery County Jail Death Settled,” Kentucky Center for Investigative Reporting, February 9, 2017, <http://kycir.org/2017/02/09/lawsuits-over-2013-montgomery-county-jail-death-settled/> (accessed March 27, 2017). The lawsuit involved a man who “lay in his cell in his own feces, wracked with pain from severe drug withdrawal, before dying of a seizure.” A separate settlement was reached with Southern Health Partners, Inc., the private health care provider in the jail, which replied on “advance-practice registered nurses” rather than regular visits to the jail by the physician medical director.

II. Deaths in Detention, 2012 – 2015

Government Investigations Reveal Substandard Care

In June 2016, ICE publicly released government investigations into 18 out of 21 cases of people who died in the custody of US Immigration and Customs Enforcement from May 2012 through June 2015. The investigations were conducted by the Office of Detention Oversight (ODO), which conducts inspections at facilities where complaints or deficiencies have been reported, and conducts investigations into all deaths in detention.⁷⁶ Expert analysis of the reports, detailed below, shows that substandard care contributed to the deaths in 7 of the 18 cases.

The 18 death reviews cover deaths at 13 facilities. Those who died included citizens of Mexico, Honduras, El Salvador, Canada, Jamaica, Antigua-Barbuda, Mozambique, and Guatemala, some of them lawful permanent residents and others unauthorized migrants, including at least six who sought protection under refugee law. All of the people who died were between 24 and 50.

Human Rights Watch and CIVIC asked two independent experts to review the circumstances of the deaths, as detailed in the ICE Office of Detention Oversight's reports of its investigations. Dr. Marc Stern is a correctional health expert, assistant affiliate professor of Public Health at the University of Washington, former health services director for Washington State's Department of Corrections, and former subject matter expert for investigations conducted by the Department of Homeland Security Office of Civil Rights and Civil Liberties. Dr. Allen Keller is an expert in access to health care for prisoners, Associate Professor of Medicine at New York University, associate professor at the NYU Gallatin School of Individualized Study, director of the Bellevue/NYU Program for Survivors of Torture, and director of the NYU Center for Health and Human Rights.

⁷⁶ US Department of Homeland Security, "Written Testimony of US Immigration and Customs Enforcement Office of Detention Policy and Planning Assistant Director Kevin Landy for a House Committee on the Judiciary," Subcommittee on Immigration Policy and Enforcement hearing on Performance-Based National Detention Standards (PBNDS) 2011, March 27, 2012, <https://www.dhs.gov/news/2012/03/27/written-testimony-us-immigration-and-customs-enforcement-house-judiciary> (accessed March 3, 2017).

Though Dr. Stern previously investigated medical care in ICE facilities for the Department of Homeland Security, his conclusions communicated to Human Rights Watch are not based upon any confidential information obtained through that work and were drawn exclusively from his review of publicly available ODO death reports and in one case, that of Tiombe Kimana Carlos, a review of her medical records at York County Prison obtained by Human Rights Watch, and on his review of individuals' medical records (analyzed in the following section). Human Rights Watch made these documents available to Dr. Stern for review after he discontinued his work with the Department of Homeland Security.

Our analyses below rely upon the facts and conclusions included in the ODO's report of each investigation. ODO death reviews are based on medical and other records; interviews with relevant medical, custodial, and ICE staff; and in most cases a security and healthcare compliance report by Creative Corrections, a national management and consulting firm contracted by ICE to provide expertise in detention management and compliance with detention standards.

The death reviews include the immigrant's immigration and criminal history, if any, and a timeline of relevant medical and detention events. The reviews conclude with specific findings as to which detention standards were violated, and note further "areas of concern," but most of the 18 reviews also explicitly state that the findings are included "for information purposes only" and "should not be construed as having contributed to the death of the detainee." ICE released these reviews, without attached exhibits such as primary medical records or the Creative Corrections report, if any, in its online FOIA Library.⁷⁷

In their reviews, Dr. Stern and Dr. Keller assessed whether care was adequate considering standard practices in correctional health and the standards applicable to individual ICE facilities. Under international standards, detained individuals are entitled to the same level of medical care as individuals in the community at large and must be treated with humanity and respect for inherent human dignity.⁷⁸

⁷⁷ US Immigration and Customs Enforcement, FOIA Library, <https://www.ice.gov/foia/library> (accessed September 16, 2016).

⁷⁸ For more information, see the section on US and International Legal Standards.

Responses from ICE and Companies Operating Private Facilities

Human Rights Watch provided a summary of our findings to ICE but at time of writing had not received a response from the agency. Human Rights Watch also provided summaries of our analysis of the deaths that occurred at facilities operated by GEO Group, CoreCivic/CCA, and Ahtna Technical Services (ATS) to those companies along with a request for comment. CoreCivic/CCA and GEO Group provided written responses to Human Rights Watch. ATS had not responded at time of writing.

GEO Group operates Brooks County Detention facility, where two people whose deaths are described in this report were detained. At the time of those deaths, Brooks was operated by LCS Corrections, which GEO acquired in 2015. The GEO Group stated that as a matter of company policy, it is unable to comment on any of the individual cases we raised. It emphasized, however, that 2 of the 18 deaths occurred at the Brooks County Detention Facility before GEO Group took over management of that facility, and noted that our medical experts found that another person who died in a GEO Group-operated facility appeared to have received adequate medical care. GEO Group also stated that it employs a robust internal auditing framework to ensure compliance with all “mandated standards and requirements.” It also stated that “Our company takes all recommendations made by ICE very seriously, and for instances in which corrective actions are required, our company has had a long-standing, steadfast commitment to allocating the necessary resources and to working in partnership with ICE to ensure compliance.”

CoreCivic/CCA emphasized in its response that it does not directly provide or oversee the provision of healthcare to immigrants detained in its facilities, and that medical care is provided by ICE’s Immigrant Health Service Corps (“IHSC”). CoreCivic/CCA asserted that “because we are not the healthcare provider, we do not have access to medical-specific information about detainees” and suggested that questions about treatment protocols and the treatment received by individual detainees should be referred instead to ICE. CoreCivic/CCA also stated that the company “adheres strictly” to ICE’s Performance-Based National Detention Standards and that onsite ICE contract monitors have “unfettered, daily access” to CoreCivic/CCA facilities to “provide accountability and oversight and ensure the standards are met.” CoreCivic/CCA also responded to several questions about the individual cases described below; these are incorporated into our findings as appropriate.

Substandard Care Contributed to Over One-Third of the Deaths

Although the 18 death reviews do not make any findings as to whether failures in medical care contributed to the person's death, Dr. Stern and Dr. Keller provided expert opinions, based on the events described in the reviews, that substandard care was likely to have contributed to the deaths of 7 people. Those cases are presented in chronological order below:

Manuel Cota-Domingo: Death from Untreated Diabetes and Pneumonia

ODO's death review for Manuel Cota-Domingo, 34 at his death in December 2012, notes that he entered CoreCivic/CCA's Eloy Detention Center with a plastic bag containing medicine for diabetes but that it was stored with his property and not given to nurses.⁷⁹ Later, a licensed practical nurse doing his intake recorded that he denied having insulin with him or being diabetic. In an interview with ICE, Cota-Domingo's cousin who was also detained at Eloy at the same time, said he encouraged Cota-Domingo to talk to medical personnel about his medical condition but that Cota-Domingo refused because he believed he would "have to pay for medical care he could not afford." CoreCivic/CCA told Human Rights Watch there are no fees for medical care delivered at Eloy.⁸⁰

The review includes interviews with three other detained people. His cellmate said Cota-Domingo began to have problems breathing at about 10 p.m. on the night of December 19, 2012. His cellmate began to bang his cell door and call for help at about 11 p.m.; he stated that correctional officers did not respond until 2 a.m. The review documents further delays, including a decision by a registered nurse to wait two hours to attend to Cota-Domingo's complaint of chest pain, failure to call 911 because of an Eloy Detention Center policy that only certain medical staff could call 911, and a decision by facility staff to send Cota-Domingo to the emergency room in a van rather than an ambulance.⁸¹

Taken together these delays meant that Cota-Domingo did not arrive at the emergency room until at least eight hours after he first began to have trouble breathing. He was pronounced

⁷⁹ US Department of Homeland Security, Immigration and Customs Enforcement, "Report of Investigation: Cota-Domingo, Manuel/Unknown/0109 Detainee/Alien – Death (Known Cause – Terminal Illness)/Eloy, Pinal, AZ," June 10, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-cotadomingo.pdf> (accessed September 19, 2016).

⁸⁰ Ibid.

⁸¹ Ibid.

dead at the hospital days later of hypertrophic and atherosclerotic cardiovascular disease with diabetic ketoacidosis, or untreated diabetes, and pneumonia.⁸²

Expert comments: The medical experts found that this death was very likely preventable. “If diagnosed properly and treated, diabetic ketoacidosis and pneumonia are treatable,” Dr. Keller said. “But both of these life-threatening diagnoses were missed at the detention facility.”⁸³ Both experts further agreed that the inappropriate delays in responding to Cota-Domingo’s condition on the night and morning before he was transported to the hospital likely contributed to his death. “Each delay—getting out of the cell, getting an initial medical assessment, and going to the hospital by van—all added to overall delay which made a probably reversible condition fatal,” said Dr. Stern.⁸⁴

Lelis Rodriguez: Death from Stroke and Hypertension

Lelis Rodriguez, 50 at the time of his death, entered Border Patrol custody on July 16, 2013, and died on July 31 in ICE custody.⁸⁵ ODO’s review notes that the cause of his death was an intracranial hemorrhage—a stroke—and hypertension. The review says he was first screened for health issues two days after his initial arrest. ODO’s review documented that at this screening, on July 18, a Border Patrol officer “checked ‘no’ after the question, ‘Does alien have health problems/issues?’” but “‘yes’ after the question, ‘Was the alien prescribed medication?’” The agent did not provide any more information on the medication, despite a specific direction on the form to do so.

Border Patrol agents later told ODO investigators that Rodriguez did not possess medication while in Border Patrol custody. However, when he entered ICE custody at the Brooks County Detention Center (BCDC) six days after his initial arrest he was screened by a correctional officer who documented that Rodriguez said he had been taking medication for high blood pressure. This screening form was never sent to the BCDC medical unit. BCDC also “failed to verify and inventory medication” in Rodriguez’s property. On July 24, a BCDC Certified Medical Assistant (CMA) generated a record of an

⁸² Ibid.

⁸³ Human Rights Watch telephone interviews with Dr. Allen Keller, July 1-6, 2017.

⁸⁴ Human Rights Watch email and telephone correspondence with Dr. Marc Stern, June 8, 26, 30, and July 1-6, 2017.

⁸⁵ US Department of Homeland Security, Immigration and Customs Enforcement, “Report of Investigation: Rodriguez, Lelis/Unknown/0109 Detainee/Alien – Death (Known Cause – Terminal Illness)/Harlingen, Cameron, TX,” February 11, 2014, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-rodriguez.pdf> (accessed September 19, 2016).

intake medical screening for Rodriguez, stating that he had no history of hypertension and no current medication.

On the evening of July 29, ICE transferred Rodriguez to Rio Grande Valley Staging (RGVS), an ICE facility operated by Ahtna Technical Services, which holds immigrants for periods under 12 hours immediately prior to their removal to their country of citizenship, in Rodriguez's case, Honduras. Several hours after his arrival, a licensed vocational nurse documented that he had a headache and blood pressure of 172/90. She said he also told her that he had high blood pressure and he had informed BCDC staff about the hypertension medication in his property bag.

The nurse searched the property bag, and found the tablets for hypertension, but left them in the bag. She told him she would recheck his blood pressure in an hour but took no other action. Three hours later, a nurse checked Rodriguez's blood pressure again and found it to be 200/110. The ICE review fails to note what the nurse did at this point. Then, at a time unspecified in the ICE report, Rodriguez collapsed, complaining of right shoulder pain and a headache. A nurse noted that his right arm and right leg were twitching. The nurse called emergency medical services and he was transported to a hospital emergency department. He quickly fell into a coma and was pronounced brain dead the next day.

Expert comments: "This was an avoidable death," Dr. Stern said after his review of the ICE investigation. Medical staff "failed to react immediately when [they] learned that Mr. Rodriguez had a blood pressure of 172/90, was on blood pressure medication and had a headache. These were symptoms that required immediate contact with a practitioner for further action that may very well have saved his life."⁸⁶ Dr. Keller made similar comments. "Hypertension is sometimes referred to as a 'silent killer' given that there often no symptoms. However, in its severe manifestation it can cause symptoms including headaches." Dr. Keller said. "In this case, Mr. Rodriguez' symptoms were by no means silent. Unfortunately, it appears that medical staff did not connect these symptoms with his hypertension and delayed responding. This delay might have cost him his life."⁸⁷

⁸⁶ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

⁸⁷ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

Both experts noted that decisions made by Border Patrol agents also contributed to the mismanagement of Rodriguez’s care. Though the death review indicates that Rodriguez reported taking medication, this information was not passed along. “Had someone identified that the patient was taking—and needed—medications for high blood pressure and gotten those medications restarted at some point in the two weeks he was held by US authorities, the death may have been averted,” Dr. Stern said.⁸⁸ Dr. Keller added, “This death review showed one mistake after another with regard to missing and then mismanaging his symptoms, with fatal consequences.”⁸⁹

Tiombe Carlos: Death by Suicide

Tiombe Kimana Carlos, 34, died in October 2013, after committing suicide while detained at the York County Prison (YCP).⁹⁰ She showed symptoms of an acute mental health condition from the start of her two-and-a-half-year detention at York. ODO’s review states that before she died, she was placed on suicide watch five times and attempted suicide once. ODO found that the facility violated ICE’s standards for detention conditions, by having no “overall treatment plan with measurable goals and objectives,” and by failing to communicate with ICE regarding her treatment until shortly before her death.

Carlos was held in isolation while at YCP for at least nine months over 12 separate instances because of her “behavioral issues and associated mental health concerns.” ODO found that “Carlos’s records show the rationale for placing her in segregation was valid on all occasions.” The ODO notes a licensed professional counselor (LPC) decided more than once that Carlos was not suicidal. After her first suicide attempt by hanging on August 13, 2013, the LPC told ODO that “he considered her action ... a suicidal gesture, not a suicide attempt, because she waited for officers to enter her cell before dropping from the stool.” Another correctional officer told ODO her August 2013 attempt was “done for attention.”

On August 20, 2013, a contract psychiatrist saw Carlos, documented that she declined any medication changes or increases, described her as “animated” and “angry,” and “ordered no change in her treatment with follow up in eight weeks.” The review cites Creative Corrections, which “highlights that Dr. [redacted]’s [August 20, 2013] note about Carlos’s

⁸⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

⁸⁹ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

⁹⁰ US Immigration and Customs Enforcement, “Detainee Death Review of Tiome Kimana Carlos, JICMS number 201400713,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-carlos.pdf> (accessed September 19, 2016).

medication is the first reference in her medical record to a possible change or increase in her medication,” over two years after she entered the facility and after she had repeatedly refused her medication and attempted suicide once. After her August 2013 suicide attempt, Carlos remained in isolation.

The death review states that Carlos’ record contains “no documentation [YCP mental health staff pursued alternative placement with ICE Enforcement and Removal Operations].” The only effort made, according to an ICE official, was shortly before Carlos’ death in October 2013, when the YCP warden requested that ICE “look into placing Carlos in a long-term mental health facility.” ICE’s response was that “an appropriate alternative facility was not available at that time.” Carlos hanged herself on October 23, 2013.

Expert Comments: Both experts found that subpar mental health care likely contributed to Carlos’ death. Dr. Keller called the mental health evaluation and treatment Carlos received while at YCP “woefully inadequate” and raised concerns about the apparent failure to develop, document, and implement a mental health treatment plan for Carlos.⁹¹ Dr. Stern had similar comments. “Staff were aware that this patient suffered from an acute and serious mental illness and was a) not getting treatment for it, and b) was not transferred to a facility that could provide that treatment,” said Dr. Stern. “Instead, medical staff kept giving her [anti-psychotic medication] and no other therapy, and she kept trying to kill herself. In other words, the medical staff kept doing the same thing, expecting a different outcome. That she finally killed herself should not have come as a surprise.”⁹² He also questioned the psychiatrist’s decision to schedule a follow-up session eight weeks after seeing Carlos, saying it appeared “too long for such an unstable person, seven days after a suicide attempt and three days after being taken off of constant observation.”⁹³

Dr. Keller particularly called attention to the substantial amount of time Carlos was held in isolation. “This is counter to accepted norms for treating mental illness whereby segregation and use of restraints are temporizing measures for use in emergencies and as a last resort-rather than a routine response,” Dr. Keller said. “If viewed separately, each of the many episodes of segregation Carlos was subjected to might seem justified, but when

⁹¹ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

⁹² Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

⁹³ Ibid.

viewed in their totality this overuse of segregation was inappropriate and likely harmful to Carlos' mental health.”⁹⁴

Dr. Stern also noted the ODO review team failed to include a psychiatrist or psychologist who would be qualified to evaluate with more specificity the quality of mental health care she received.⁹⁵

Marjorie Annmarie Bell: Death from Heart Attack and Coronary Disease

ODO's death review for Marjorie Annmarie Bell records that she died on February 13, 2014, due to sudden cardiac death, acute coronary syndrome and multivessel coronary artery disease.⁹⁶ She was 48. She came into US custody on December 24, 2013 when she crossed the US-Mexico border at the San Ysidro port of entry. The death review says that she told Customs and Border Protection officers that she did not feel well and had diabetes, and that she was transported to Sharp Chula Vista Medical Center (SCVMC) where she was admitted. There, ODO notes, she reported she had a history of heart disease and had at least three stents in her heart. SCVMC placed one additional stent.

Bell was admitted to the CoreCivic/CCA-operated San Diego County Detention Facility on January 2. There, medical staff responded to her requests for care and at one point in late January sent her to the emergency room for chest pain. The discharge summary from the hospital stated, “treatment of her congestive heart failure should be done,” but the nurse practitioner who saw Bell at the detention facility did not include congestive heart failure in her assessment. The facility did not seek expert assistance from a cardiologist. Bell repeatedly requested nitroglycerin tablets to take as needed for her chest pain and medical staff became concerned she was overusing nitroglycerin. In early February, Bell told a psychologist that she was dissatisfied with the medical care she was receiving at the facility and that “medical staff did not listen to her.”

On February 13, 2014, Bell saw a doctor for chest pain who decided to send her to the emergency room, but waited 15 minutes to instruct a medical officer to call 911. The ODO noted, “the apparent 15-minute delay remains unexplained.” It was another six minutes

⁹⁴ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

⁹⁵ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

⁹⁶ US Immigration and Customs Enforcement, “Detainee Death Review of Marjorie Annmarie Bell, JICMS Number 201404156,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-bell.pdf> (accessed September 19, 2016).

before emergency responders received a call from the facility. Bell died later that day of a heart attack.

Expert Comments: Both experts found that substandard medical care contributed to Bell's death. "On multiple occasions medical staff did not adequately address and evaluate her chest pain," Dr. Keller said. "Given the severity of her heart disease and the fact she had just recently undergone a cardiac procedure, there should have been a very low threshold for sending her back to the hospital. It took her being near death for them to finally do that but it was too late," Dr. Keller said.⁹⁷ "This is a woman with a known history of heart attacks," said Dr. Stern. "On six separate occasions she informed nurses that she was having chest pain, and on none of those occasions did a nurse contact a physician or call an ambulance. She ultimately died of another heart attack."⁹⁸ Both doctors agreed that if a stent needed to be placed on December 25, 2013, it should have been clear that Bell required close observation and monitoring by a heart expert, which she did not receive.

Peter George Carlisle Rockwell: Death by Hemorrhagic Stroke

ODO's death review for Peter George Carlisle Rockwell, 46 when he died in February 2014, notes that he was admitted to CoreCivic/CCA's Houston Contract Detention Facility with a history of hypertension for which he took medication.⁹⁹ At a physical examination on intake, a nurse practitioner developed a treatment plan that included daily blood pressure monitoring. However, according to the ODO review, this monitoring did not occur. An electrocardiogram ordered to be performed two weeks after Rockwell's physical exam was not completed. When he complained of blurred vision five days after intake, a physician's assistant determined he should be seen by a health care provider within one day but "[m]edical records staff did not schedule the vision appointment, and [Rockwell] was never seen by a provider for the blurry vision."

When Rockwell collapsed in full view of a correctional officer 10 days after first complaining of blurry vision, the review found that staff took eight minutes to call 911, that three more minutes elapsed before CPR was started and that two minutes after that staff applied an automated external defibrillator (AED). The ODO notes that according to the

⁹⁷ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

⁹⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

⁹⁹ US Immigration and Customs Enforcement, "Detainee Death Review of Peter George Carlisle Rockwell, JICMS Number 201404529," <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-rockwell.pdf> (accessed September 19, 2016).

American Heart Association’s Adult Basic Life Support guidelines, “as soon as [Rockwell] was determined to have ineffective or agonal breathing (abnormal breathing characterized by gasping, labored breaths), 911 should have been called, an AED should have been used, and CPR should have been initiated.”

ODO said that the delays occurred due to the failure of medical staff to recognize the emergency and bring emergency equipment to the scene as required by facility policy, and to malfunctioning medical equipment. Rockwell was transported to the hospital while nonresponsive, and placed on a ventilator in the intensive care unit until his death seven days later which was determined to have been due to a hemorrhagic stroke.

Expert Comments: Both medical experts found that substandard care contributed to Rockwell’s death. “The facility knew about his blurred vision and other systemic symptoms and did not manage them,” said Dr. Stern.¹⁰⁰ “The providers missed what may have been a telltale sign of an intracranial bleed when he reported the blurry vision,” said Dr. Keller. “It could have been something else but it merited investigation.”¹⁰¹ Both experts also pointed to the delayed emergency response as inadequate. Dr. Keller raised concerns about whether the facility appropriately addressed the inadequate emergency response after it occurred. “The review notes there was no debriefing of the emergency response with corrections staff. Such debriefings are crucial to identifying errors and correcting future problems.”¹⁰²

Santiago Sierra-Sanchez: Death from Staph Infection and Pneumonia

ODO’s death review for Santiago Sierra-Sanchez, 38 at his death in July 2014, records that he told an intake nurse at the Utah County Jail that he had a six- to-seven-month history of lower back pain that had been worsening in the preceding few days.¹⁰³ ODO reviewed video showing that he was unable to stand without assistance in the jail intake area. ODO reports that Sierra-Sanchez told ICE officers that he was “‘dying’ from the pain in his back.”

The review says that nursing staff at the jail suspected Sierra-Sanchez “might be playing games to get narcotic pain medication” and did not thoroughly assess him—including by

¹⁰⁰ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

¹⁰¹ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

¹⁰² Ibid.

¹⁰³ US Immigration and Customs Enforcement, “Detainee Death Review – Santiago Sierra-Sanchez, JICMS #201409551,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-sierra.pdf> (accessed September 19, 2016).

taking his temperature—or follow standard protocols regarding back pain. The ODO review notes that Sierra-Sanchez’s medical history included a prior history of drug use. The review also states his pulse and blood pressure increased between his intake and his evaluation by an RN, “which warranted a consultation with a provider,” but this did not occur. His temperature was not taken; Creative Corrections noted, “an elevated temperature can signal an infection.” On the night he died, Sierra-Sanchez told a nurse he was “spitting blood” around 8 p.m. but the nurse told ICE that there was no evidence of this.

Around 3:30 a.m., a correctional officer (CO) saw he was unresponsive. Six minutes elapsed before staff entered his cell, where they found him in a pool of bloody vomit. The CO called for medical assessment, not an emergency, so the RN arrived without emergency equipment, which the ODO found delayed CPR and the call for emergency medical services. Sierra-Sanchez died that morning of disseminated *Staphylococcus aureus* and pneumonia.

Expert comments: “Medical staff essentially abandoned this patient by not properly assessing him or following up. If they had, there is a chance the patient’s emerging infection would have been noted and treated, avoiding death or at least greatly increasing the odds of survival,” Dr. Stern said.¹⁰⁴ Dr. Keller had similar comments. “When someone has a fulminant bacterial infection as was the case with Mr. Sierra-Sanchez, rapid treatment including intravenous antibiotics can make all the difference between life and death,” said Dr. Keller. “But it appears they even missed some of the basics like monitoring his temperature.”¹⁰⁵

Raul Ernesto Morales-Ramos: Death after Delayed Surgery to Remove Abdominal Mass

ODO’s death review for Raul Ernesto Morales-Ramos, 44 when he died in April 2015, notes that he was first referred for a follow-up with a doctor for gastrointestinal symptoms in April 2013, while detained at the Theo Lacy Facility.¹⁰⁶ But more than a year later, this consultation had not occurred, which the ODO review called a “critical lapse in care.” In May 2014, he was transferred to the GEO Group-operated Adelanto Detention Facility with no documentation of his gastrointestinal symptoms. There, he was seen several times over

¹⁰⁴ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

¹⁰⁵ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

¹⁰⁶ US Immigration and Customs Enforcement, “Detainee Death Review – Raul Ernesto Morales-Ramos, JICMS #20505282,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-morales.pdf> (accessed September 19, 2016).

the next nine months by registered nurses after submitting sick call requests for body aches, weight loss, pain in his joints, knees, and back, and diarrhea.

In February 2015, Morales-Ramos submitted a grievance in which he wrote, “To who receives this. I am letting you know that I am very sick and they don’t want to care for me. The nurse only gave me ibuprofen and that only alleviates me for a few hours. Let me know if you can help me. I only need medical attention.” Four days later, he was seen by a nurse practitioner who documented that his symptoms were resolved and “instructed him to increase his water intake and exercise to promote bowel regularity.”

In early March 2015, a registered nurse seeing Morales-Ramos after a sick call request documented that he was complaining of abdominal pain and asking again to see a doctor. The nurse who saw Morales-Ramos on March 2, 2015 told ODO that she noted Morales-Ramos had a distended abdomen but that she “did not detect a mass or protrusion.” A consultation with a doctor occurred on March 6, 2015. The doctor, who held a certification in medical oncology, told ODO that at that visit Morales-Ramos had “the largest [abdominal mass] she had ever seen in her practice,” which was “notably visible through the abdominal wall.”

Based on the doctor’s findings and referrals Morales-Ramos was scheduled for a colonoscopy, which did not occur until about one month later. During the colonoscopy, he began to experience abdominal bleeding after the doctor attempted to remove “a huge rectal mass.” Morales-Ramos was transferred to the hospital and died three days later after a surgical attempt to stop his bleeding.

Expert comments: Both medical experts noted that it appears Morales-Ramos suffered from symptoms of cancer starting in 2013, at least two years before he died, but the symptoms went unaddressed until a month before he died. “Had Mr. Morales’ gastrointestinal symptoms been evaluated much sooner as was clinically indicated, it is possible that the malignancy from which Mr. Morales died, might have been caught at a time when it was still treatable,” Dr. Keller said.¹⁰⁷ Dr. Stern similarly noted that Mr.

¹⁰⁷ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

Morales “was not appropriately referred for specialist care” until a month before his death, when it was too late.¹⁰⁸

Misuse of Isolation and Inadequate Treatment of Individuals with Psychosocial Disabilities

Prolonged solitary confinement may amount to torture or cruel, inhuman, or degrading treatment, which is prohibited under international human rights law. Because solitary confinement may severely exacerbate previously existing mental health conditions, the United Nations special rapporteur on torture believes that solitary confinement of any duration for those with psychosocial disabilities is cruel, inhuman, or degrading treatment.¹⁰⁹

Tiombe Carlos: Death by Suicide After Prolonged Solitary Confinement

The death review for Tiombe Kimana Carlos, summarized above, states she was in isolation for a significant period of time, including two stints in 2013, one for four-and-a-half months and another for two-and-a-half months immediately before her death. The dangers of isolation for people with mental health conditions are well-documented, yet the ODO review indicates that the safeguards set by national detention standards were not followed.¹¹⁰ It says that the facility did not record isolation orders, in violation of the applicable detention standards. The ODO also noted that for six of the months Carlos spent in isolation, the facility only reviewed its necessity monthly. Weekly checks started in June 2013, but documentation was inconsistent and there was no evidence they were adequate to evaluate whether Carlos should have remained in isolation.

¹⁰⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

¹⁰⁹ UN Human Rights Council, Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez, A/66/268, August 5, 2011, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N11/445/70/PDF/N1144570.pdf?OpenElement> (accessed September 19, 2016), para.78. See also, Human Rights Watch, *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons*, May 12, 2015, <https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and>; Maureen L.O’Keefe, et al., “One Year Longitudinal Study of the Psychological Effects of Administrative Segregation,” submitted to the National Institute of Justice, October 31, 2010, <https://www.ncjrs.gov/pdffiles1/nij/gr> (accessed September 19, 2016).

¹¹⁰ US Immigration and Customs Enforcement, “Detainee Death Review of Tiome Kimana Carlos, JICMS number 201400713,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-carlos.pdf>.

Clemente Mponda: Death by Suicide After Repeated Use of Isolation

In another case involving a migrant who committed suicide in ICE detention, that of Clemente Mponda, 27, the medical experts noted that repeated placement in isolation may well have exacerbated his mental health condition.¹¹¹ For eight months of his 15-month detention at CoreCivic/CCA-operated Houston Contract Detention Facility (HCDF), Mponda was in isolation, including administrative segregation, disciplinary segregation, and three days on suicide watch.

The ODO found numerous violations of standards for placing someone in isolation or for reviewing whether continued isolation was justified, including failure to medically clear him for isolation, a violation of the 2008 PBNDS and of the Immigrant Health Service Corps policy that “a qualified healthcare professional ... review the detainee’s health record to determine whether existing mental health needs contraindicate placement in segregation.” When Mponda was returned to the general population from isolation in January 2013, the death review says, he “functioned well,” with one stint in disciplinary isolation, followed by another five months without incident.

Shortly before his death, the ODO says, Mponda physically attacked another detained individual and he was cleared by medical staff “to be moved to ‘Special Housing Unit (Segregation).’” During his transfer to isolation, the ODO states, correctional staff did not search him as required by facility policy. During the investigation, another detained individual told ODO he had seen Mponda place medication in one of his socks prior to the altercation. The ODO also noted a bottle of pills, medication Mponda had been prescribed, had been found in his cell, but this did not trigger facility staff to search Mponda and ensure he was not secreting medication. Two days later, he was found unresponsive in his cell. The autopsy found he died from toxicity after consuming a large amount of the medication he had been prescribed.

In addition to the facts described above, the ODO states that Mponda was identified as having significant mental health needs early in his detention at HCDF when facility medical staff diagnosed him with depression or schizophrenia. However, the ODO concluded that staff delays in evaluating Mponda’s mental health after two suicide attempts in July 2012

¹¹¹ US Immigration and Customs Enforcement, “Detainee Death Review - Clemente Mponda, JICMS #201312347,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-mponda.pdf> (accessed September 19, 2016).

violated detention standards. After the first attempt, no mental health professional assessed him until five days later. The second time, although Mponda was found hanging and had to be cut down and taken to the hospital, where he stayed for two weeks, staff placed him in isolation upon his return and did not create a mental health treatment or management plan despite the clear risk of suicide.

Expert comments: Dr. Stern, upon reviewing Mponda’s death review, stated: “This case might be the poster child for misuse of isolation for mental health patients.”¹¹² Although the death review identified many problems with Mponda’s care and custody, he noted the ODO team failed to include a mental health care expert and did not fully examine how segregation could have adversely impacted Mponda’s mental health.

Dr. Keller emphasized that isolation is a stressful and highly disruptive and traumatizing event. “Standard psychiatric care is to utilize segregation and restraints as temporizing measures for short-term use in only urgent situations, rather than as a routine means of addressing psychiatric illness,” Dr. Keller said. “While Mr. Mponda may have benefited from psychiatric hospitalization or from close follow up and care in a community-based mental health program, these were never considered as options. Instead, repeated segregation was the preferred punishment and treatment of choice.”¹¹³

“The repeated overuse of segregation without considering other options may well have contributed to an unstable individual becoming even more unstable and ultimately contributed to his death,” Dr. Keller said.¹¹⁴

Both experts noted that Mponda’s ability to hoard potentially lethal medications he was taking without detection represented a dangerous failure of the facility’s security system.

Jose de Jesus Deniz-Sahagun: Death by Suicide After Being Moved Off of Suicide Watch

Jose de Jesus Deniz-Sahagun, 31 at death, committed suicide on May 20, 2015 in CoreCivic/CCA-operated Eloy Detention Center less than 12 hours after a doctor moved him from suicide watch to mental health observation status with 15-minute checks and no

¹¹² Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

¹¹³ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

¹¹⁴ Ibid.

restrictions on his property.¹¹⁵ According to the review, Deniz-Sahagun ultimately used an item from his property—a sock—to end his life. Before arriving at Eloy, while in Border Patrol custody, ODO documented that Deniz-Sahagun exhibited self-harming behavior. He jumped twice from a bench and landed on his head. Border Patrol agents transported him to the hospital on May 17, 2015, where he “told the emergency room physician he was attempting to break his own neck because he feared his life was in danger by both Mexican coyotes and USBP [US Border Patrol].”

On May 18, 2015, when Deniz-Sahagun was transferred to Eloy, ODO noted that Border Patrol agents informed a nurse in Eloy’s booking area that Deniz-Sahagun had been taken to the hospital the day before for his suicide attempt and that he had since been “observed banging his head against a wall at the Border Patrol Station and behaved erratically during transport.” ODO noted however that “the Medical Alert section of his [Border Patrol] Alien Booking Record was blank, and no medical or mental health documentation accompanied him to [Eloy].” The pre-screening and intake nurses at Eloy determined that Deniz-Sahagun was not suicidal and referred him for a routine, rather than urgent, mental health follow-up. Deniz-Sahagun was cleared for placement in general population in the early afternoon. Around 10 p.m. that evening, Deniz-Sahagun requested to be placed in protective custody “because he believed his cellmate [redacted] was going to kill him.”

On the morning of May 19, 2015, ODO discussed four separate use of force incidents “used to control Deniz-Sahagun” over the course of approximately three hours. The ODO reviewed video of each of these events, including “a video recording shows Deniz-Sahagun struggling on the floor as four officers hold him in place. He screams in English and Spanish, ‘Help me,’ ‘Call my lawyer,’ ‘This is brutality,’ and ‘They want to kill me.’” A facility doctor determined that Deniz-Sahagun suffered from delusional disorder and placed him on suicide watch from May 19 to 26, 2015. The order required nursing checks every eight hours, mental health checks every 24 hours and one-on-one observation by an officer. The doctor also ordered anti-psychotic and anti-anxiety medications assuming that “involuntary administration would be necessary.” These medications were not

¹¹⁵ US Immigration and Customs Enforcement, “Detainee Death Review – Jose De Jesus Deniz-Sahagun, JICMS #201506640,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-denizshagun.pdf> (accessed September 19, 2016).

administered by medical staff, but no documentation of this was made in Deniz-Sahagun's medical record and the doctor was not informed.

On the morning of May 20, 2015, a doctor removed Deniz-Sahagun from suicide watch "because he believed the detainee was no longer a danger to himself." The doctor told ODO that it was "not clear to him what prompted Deniz-Sahagun's change, but he assumed the detainee had been administered a sedative." Around 5:30 p.m. that day, Deniz-Sahagun was discovered unresponsive in his cell. His airway was blocked by an orange sock which caused him to asphyxiate.

Expert comments: Dr. Keller emphasized that medical staff failed to adequately elevate the level of Deniz-Sahagun's treatment as his symptoms worsened. "This patient was severely unstable. He had been taken to the hospital after a suicide attempt days before and was placed on suicide watch at Eloy," said Dr. Keller. "Based on one report of him claiming he was not suicidal he was downgraded [from constant watch] ... to 15-minute checks." Dr. Keller believes he instead should have been thoroughly evaluated by a psychiatrist and strongly considered for hospitalization.¹¹⁶

Dr. Keller further noted that detention itself could have exacerbated Deniz-Sahagun's mental health condition.¹¹⁷

Dr. Stern also raised serious concerns about the appropriateness of Deniz-Sahagun's mental health care, in particular the doctor's decision to downgrade Deniz-Sahagun from suicide watch. He faulted the ODO's death review for not adequately analyzing that decision and not including an appropriate subject matter expert in psychiatric health.¹¹⁸

Substandard Care Evident in 16 of 18 Death Investigations

In 16 of the death reviews, the medical experts found evidence of substandard medical practices that, if typical of the facilities, would put many other people detained in these facilities in question at risk. These included the seven cases in which subpar care contributed the patient's death, as well as nine additional cases in which death was not

¹¹⁶ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

¹¹⁷ Ibid.

¹¹⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

necessarily preventable, but in which they saw evidence of faulty systems whose operation would create danger for others in detention.

Delays in Care and Emergency Responses

Several of the individuals who died experienced delays in care, including delays in emergency responses.

In Eloy Detention Center, the death reviews for three of the four people who died during this time period noted delays in the emergency responses. The ODO found in its review of Cota-Domingo's death that Eloy Detention Center medical staff believed they could not call 911 without first receiving a "provider's order" per Eloy Detention Center's Local Operating Procedure on Emergency Medical Services. The ODO did not cite this policy as a violation in this case. Four months later, Jorge Garcia-Maldonado and Elsa Guadalupe-Gonzalez hanged themselves within days of each other.¹¹⁹ In reviews of these deaths, ODO found that "confusion as to who has the authority to call for local emergency medical assistance" led to three-minute and five-minute delays in calling 911, respectively. The ODO reviews of their deaths indicate that Eloy Detention Center policy did then allow security personnel to call 911 under CoreCivic/CCA Policy 8-1A on medical emergencies, but not before alerting others within the facility, and that security staff believed they had no authority to call 911 without an assessment from medical staff. In these latter cases, the ODO found the facility violated the 2011 PBNDS requirement of "access to specified 24-hour emergency medical, dental, and mental health services" due to the confusion over who could call 911. CoreCivic/CCA, the company that operates the Eloy Detention Center, told Human Rights Watch that "there has never been a CCA policy that specifically indicates who can or cannot contact 911 for emergency services."

¹¹⁹ US Department of Homeland Security, Immigration and Customs Enforcement, "Report of Investigation: Garcia-Mejia, Jorge/Unknown/0617 Detainee/Alien – Death (Suicide) / Eloy, Pinal, AZ," October 7, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-garciamaldonado.pdf> (accessed September 19, 2016); US Department of Homeland Security, Immigration and Customs Enforcement, "Report of Investigation: Guadalupe-Gonzales, Elsa/Unknown/0617 Detainee/Alien – Death (Suicide) / Phoenix, Maricopa, AZ," September 25, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-guadalupegonzales.pdf> (accessed September 19, 2016).

“While it is unclear whether their lives could have been saved in the absence of this delay, waiting five minutes to call 911 can be a matter of life or death,” said Dr. Keller.¹²⁰ “Any staff member should be able to call 911 in an emergency,” said Dr. Stern.¹²¹

System-Wide Failures with Staffing and Training

In some facilities, the ODO found medical staffing was inadequate or the staff was insufficiently experienced. In Brooks County Detention Center, the ODO found “[m]ost medical care is provided by low level medical professionals such as LVNs [licensed vocational nurses] and certified medical assistants.” The one doctor was at the facility for only two hours each week, for 652 people held for ICE and other inmates.

A dearth of qualified staff was apparent during ODO’s investigation of the death of Federico Mendez-Hernandez.¹²² During the two weeks that he showed symptoms of a serious medical condition, which turned out to be rabies, he did not see a physician. The ODO stated in its review of Mendez-Hernandez’s death that at one point, when he was found unconscious, nursing staff roused him by sprinkling water on his face, which the review noted was an “inappropriate nursing practice.” Dr. Stern also noted other important indicators of substandard care, notably staff’s recording of vital signs four weeks after the fact “from memory.”

Similarly, in Adelanto, the ODO noted many Adelanto medical staff cited “a high turnover rate among nurses [as] a great concern,” and that “approximately 50 percent of ADF’s medical staff hires are new graduates” with a “definite difference between their skills and those of more experienced nurses.” The ODO’s investigation found that an RN who saw Morales-Ramos on March 2, 2015 noted that his abdomen was distended but “did not detect a mass or protrusion.” The doctor who saw Morales-Ramos four days later described his abdominal mass as “the largest she has ever seen in her practice.”

Dr. Stern told Human Rights Watch he believed seven other reviews pointed to the conclusion that licensed vocational nurses (also called licensed practical nurses in some

¹²⁰ Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

¹²¹ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

¹²² US Department of Homeland Security, Immigration and Customs Enforcement, “Report of Investigation: Mendez-Hernandez, Federico / Unknown / 0109 Detainee / Alien – Death (Known Cause – Terminal Illness) / Kingsville, Kleberg, TX,” January 6, 2014, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-mendezhernandez.pdf> (accessed January 5, 2017).

states), certified medical assistants, and registered nurses were providing medical care and making critical decisions they were not qualified to make in a way that was dangerous. He further noted that such routine use of staff outside the scope of their license should have been discoverable during inspections before contracting or during routine follow-up inspections.¹²³

In one of these cases, that of Pablo Ortiz-Matamoros, 25, both experts concluded there was probably nothing that could have been done to prevent his death from metastatic cancer in February 2013.¹²⁴ He first reported symptoms indicating a larger problem—loss of appetite, dark yellow urine and weight loss—in mid-January 2013. However, the ODO review of his death contains evidence that licensed vocational nurses at GEO Group’s Joe Corley Detention Facility (JCDF) were regularly conducting clinic visits and clinically assessing patients for any danger that might follow from placing them in isolation, outside of their scope of practice as defined by their license to practice nursing. The ODO, however, did not flag this as a problem requiring resolution. The ODO review notes that a registered nurse employed in the Joe Corley Detention Facility clinic during this time “resigned her position with GEO at JCDF ... over her concerns with the JCDF medical clinic.”

In the case of Marjorie Annmarie Bell, whose death by heart attack Dr. Stern and Dr. Keller considered preventable, the ODO noted, “several nurses indicated that they were unsure whether San Diego Contract Detention Facility had chest pain guidelines, or were unsure of the guidelines’ contents.” Creative Corrections, a contractor hired by ICE to assess medical care at the facility, said that training and adherence by nurses to established guidelines on chest pain, however, “is critical.”

In two of the 18 cases, that of Jorge Umana-Martinez and Jose Javier Hernandez-Valencia, both Dr. Stern and Dr. Keller found based on the evidence in the death reviews that the patient received appropriate care.¹²⁵

¹²³ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

¹²⁴ US Department of Homeland Security, Immigration and Customs Enforcement, “Report of Investigation: Ortiz-Matamoros, Pablo/Unknown/0109 Detainee/Alien – Death (Known Cause – Terminal Illness)/Conroe, Montgomery, TX,” September 3, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-ortizmatamoros.pdf> (accessed January 5, 2017).

¹²⁵ US Immigration and Customs Enforcement, “Detainee Death Review – Jorge Umana-Martinez, JICMS Case #201501038,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-umanamartinez.pdf> and “Detainee Death Review – Jose Javier Hernandez-Valencia, JICMS Number 201406153,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-hernandezvalencia.pdf> (accessed January 5, 2017).

The 18 cases relate to a tiny fraction of the hundreds of thousands of people held in immigration detention during the period in question, and do not speak directly to conditions in most of the 200-plus different facilities ICE uses to house immigrants. However, the reviews raise serious concerns about ICE’s ability to detect, respond appropriately to and successfully correct serious lapses in medical care that arise in any of these facilities—even in cases in which the agency has conducted detailed investigations into individuals’ deaths.

Questions about the Adequacy of the Death Investigations

While the detainee death reviews reveal serious problems with the medical care provided to the individuals who died, they also indicate weaknesses within the investigative and monitoring process.

In each review, the Office of Detention Oversight explicitly and consistently refused to draw conclusions as to whether the identified deficiencies contributed to the individual’s death. The death investigations also appear to stop far short of analyzing the incidents in a way that would improve medical care in facilities and prevent future harm, illness, and death. In one review of a death in 2014, ODO stated, “ODO does not review quality of care during a DDR, makes no determinations regarding the quality of care provided [.]..to Umana, and recognizes that any thoughts regarding whether changes to its quality of care would have affected the ultimate outcome are purely speculative.” The failure to draw conclusions and effectively analyze incidents is a primary reason Human Rights Watch chose to work with independent medical experts to review the ODO’s work.

In releasing these investigations, ICE did not provide any information as to the purpose of these investigations, nor as to their outcome. ICE has not answered repeated requests for information on what action was taken to remedy problems identified in these reviews.

Dr. Stern, who has experience investigating medical care in correctional facilities, including immigration detention centers, also noted several ways in which the reviews were deficient.

Failure to Properly Identify Deficient Care Decisions

In numerous cases, Dr. Stern identified events that constituted deficient care in the ODO’s timeline of events that were not identified or emphasized adequately in the ODO’s

findings. The ODO's focus on technical violations and its failure to recognize major errors is in keeping with what critics contend is the "checklist culture" of ICE oversight, as described in a 2015 report from the National Immigrant Justice Center, which reviewed hundreds of inspection reports for the 105 largest detention facilities from 2007 to 2012.¹²⁶ It may also be due to a lack of expertise in the ODO's investigation team.

In some cases, the ODO highlighted technical violations of the applicable detention standards as "deficiencies" but described more serious errors as mere "areas of concern." Dr. Stern noted that in the review of the death of Welmer Alberto Garcia-Huezo, ODO investigators focused on relatively unimportant omissions, like the failure to have Garcia-Huezo sign a consent form before a tuberculosis skin test, yet seemed to miss the importance of much larger failings. The latter includes their conclusion that the emergency response when Garcia-Huezo was found unconscious was "appropriate and timely" despite the fact that there was a four-minute delay in calling 911 and that staff loaded the patient and moved him to the medical area while awaiting the ambulance, during which time they could not monitor his condition nor continue CPR.¹²⁷ The ODO also noted that when Garcia-Huezo was given oxygen, medical staff found the oxygen level in the bottle was very low and alternative oxygen bottles were all empty. Dr. Stern further stated there may have been legitimate reasons to move Garcia-Huezo, such as security concerns, but the failure of the ODO to consider these issues renders their analysis incomplete.¹²⁸

In another case, the ODO deemed Rockwell's care at Houston only violated one detention standard and relegated other decisions that fall short of the standard of care, like the failure to respond to the emergency call with all necessary emergency medical equipment, to an "area of concern." The applicable 2011 Performance-Based National Detention Standards, Dr. Stern noted, "has a lot of holes, is poorly organized, and poorly written," but he said that many errors in Rockwell's care should have been considered a violation of the general standard, to "ensure detainees have access to appropriate and necessary medical, dental and mental health care, including emergency services."¹²⁹

¹²⁶ National Immigrant Justice Center and Detention Watch Network, "Lives in Peril: How Ineffective Inspections Make ICE Complicit in Detention Center Abuse," <http://immigrantjustice.org/lives-peril-how-ineffective-inspections-make-ice-complicit-detention-center-abuse-o>.

¹²⁷ US Immigration and Customs Enforcement, "Detainee Death Review – Welmer Alberto Garcia-Huezo, JICMS #201410359," <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-garciahuezo.pdf> (accessed January 5, 2017).

¹²⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

¹²⁹ *Ibid.*

In many cases, Dr. Stern believed the failure of the ODO to identify key medical errors was likely due to the absence of necessary medical expertise on the investigation team. In nearly all of these 18 reviews, ODO contracted with Creative Corrections to provide a subject matter expert. In the review of the 2012 death of Juan Flores Segura, no medical subject matter expert was involved in the investigation. When specified, the review stated the investigative team included a registered nurse or, in one case, a physician's assistant. "An RN does not have the requisite skill to evaluate all aspects of clinical care above the level of an RN," said Dr. Stern. "That some of the death investigations were not conducted with a physician's input ... suggests that the underlying process for conducting death investigations is fundamentally flawed."¹³⁰ In the case of Deniz-Sahagun, where the critical decision for analysis was the psychiatrist's decision to remove the patient from suicide watch, the death review could not have been done appropriately by a registered nurse or even a non-psychiatrist physician.

¹³⁰ Ibid.

III. Further Evidence of Deficient Medical Care

The ICE death reports are not the only recent evidence of substandard care in US immigration detention facilities. Serious allegations of substandard and inappropriate medical care recently have been made regarding facilities around the country:

- In February 2017, New York Lawyers for the Public Interest released a report identifying serious and sometimes life-threatening deficiencies in medical care experienced by people detained in three New York City-area county facilities.¹³¹
- In May 2016, CIVIC filed a multi-party complaint with the Office of Civil Rights and Civil Liberties summarizing complaints from 61 men and women detained at Hudson County Correctional Facility, which include allegations of long delays in receiving care and repeated failures by medical staff to use interpretation services for non-English speaking patients, among others.¹³²
- A November 2016 report by the Southern Poverty Law Center included numerous reports by detained people of inadequate medical care, including a man who stated he broke his collar bone in detention but was denied treatment for five months.¹³³
- In May 2015, a coalition of nongovernmental organizations, including CIVIC and the American Civil Liberties Union, sent a letter alleging similarly substandard medical care at Adelanto Detention Center.¹³⁴
- Many of the hundreds of people who have engaged in hunger strikes in immigration detention centers in recent years have cited poor medical care as one of the reasons for their strike.¹³⁵

¹³¹ New York Lawyers for the Public Interest, “Health in Immigration Detention,” February 2016, http://www.nylpi.org/wp-content/uploads/2017/02/HJ-Health-in-Immigration-Detention-Report_2017.pdf (accessed February 16, 2017).

¹³² Complaint filed by CIVIC, May 10, 2016, <https://assets.documentcloud.org/documents/2829608/CIVIC-Medical-Complaint-Final.pdf> (accessed January 5, 2017).

¹³³ Southern Poverty Law Center, “Shadow Prisons: Immigrant Detention in the South,” November 2016, <https://www.splcenter.org/news/2016/11/21/new-splc-report-uncovers-abuse-and-neglect-immigrant-detention-centers-south> (accessed December 5, 2016).

¹³⁴ Letter from American Civil Liberties Union of Southern California, et al., to US Department of Homeland Security, May 15, 2016, <https://www.aclusocal.org/wp-content/uploads/2015/05/NGO-letter-re-Adelanto-medical-care.pdf> (accessed January 5, 2017).

¹³⁵ Samantha Michaels, “Here’s Why Hundreds of Immigrants in Detention Have Gone on Hunger Strike,” *Mother Jones*, December 3, 2015, <http://www.motherjones.com/politics/2015/11/why-are-hundreds-detained-immigrants-going-hunger-strike> (accessed January 5, 2017).

In this chapter, we present additional evidence obtained from our own interviews with more than 90 people who have experienced detention, family members, and attorneys, and from expert medical analyses of the medical records of 12 individuals held by ICE in 2015 and 2016. The cases come from 10 different immigration detention facilities in different parts of the country, including facilities operated by both private companies and local county governments.

Expert analysis of the medical records identified numerous instances where patients experienced:

- Requests for care refused, ignored, or unreasonably delayed;
- Provision of care by unqualified medical staff or professionals;
- Poor quality care by facility nurse practitioners, physician assistants, and doctors;
- Lack of informed refusals of care;
- Delays in receiving off-site medical care;
- Severely inadequate mental health care; and
- Inadequate medical recordkeeping.

Our own investigations also identified serious logistical and linguistic barriers to care.

Although the medical records excerpted and analyzed below pertain to the experiences of only 12 detained individuals, they include evidence of inadequate staffing and poor operational systems that are unlikely to have affected only these individuals. The problems documented in these records echo what dozens of individuals, families, and attorneys told Human Rights Watch and CIVIC regarding the experiences of immigrants detained in these and other facilities. They also echo many of the conclusions independent medical experts reached after examining the death reviews (set forth earlier in this report), and are similar to problems identified in a recent investigation of medical care in private federal prisons operated by the same companies, a study which attributed many of the failings to a “culture of austerity” reflecting constant pressure to cut costs.¹³⁶

¹³⁶ Seth Freed Wessler, “This Man Will Certainly Die,” *The Nation*, <https://www.thenation.com/article/privatized-immigrant-prison-deaths/>.

Human Rights Watch requested or obtained medical records for dozens of individuals who said they had not received adequate or appropriate medical care while detained by ICE. All individuals consented to having their medical records reviewed by medical experts for analysis in this report. The 12 records analyzed by the experts were primarily chosen to reflect individuals' experiences with medical care in a diversity of facilities, and to reflect a diversity of cases. The cases include people with preexisting chronic conditions, injuries incurred while detained, and diagnoses of serious conditions, like cancer, while detained. Three of the records come from facilities that were also investigated for a detainee death from 2012 to 2015.

The medical records were reviewed independently by Dr. Marc Stern, who also reviewed the detainee death investigations analyzed earlier in this report, and by Dr. Palav Babaria. Dr. Babaria is the Chief Administrative Officer of Ambulatory Services at Alameda Health System in Oakland, California, and Assistant Clinical Professor in Internal Medicine at the University of California, San Francisco. She has over a decade of health-system improvement and global health experience working in urban underserved areas of the United States, South Africa, India and Haiti. She regularly provides expert opinions on medical records for lawsuits involving medical care in correctional settings.

The experts assessed whether care was adequate, as reflected in the medical records, considering standard practices in correctional health. Some of the people whose records we obtained were still detained at the time we obtained their records, and for some of the people who had been released, we were only able to obtain incomplete records. Therefore, unlike the detainee death reviews, the experts were not asked to opine on whether substandard medical care contributed to a particular outcome, but rather to identify instances in which the care provided did not meet appropriate standards.

The experiences of the individuals below, as reflected in their medical records, do not speak directly to the conditions in all of ICE's detention facilities. But these medical records add new evidence that substandard medical care is an ongoing and systemic problem in the US immigration detention system.

Human Rights Watch provided summaries of the findings in this section to the private companies that operate the facilities in question: Geo Group, CoreCivic/CCA, and Management and Training Corporation. We did not request that these companies directly

address the complaints in specific cases, as we had withheld the individuals' real names to protect their privacy. But where companies responded to specific cases, those responses are included in our analysis.

CoreCivic/CCA stated that in all of the facilities named in this report, other than Laredo Processing Center, IHSC provides medical care and is “solely responsible for contracting, staffing and oversight of all medical and mental health services.”¹³⁷

We have provided the companies' full responses on our website.

After Three Years of Immigration Detention, 54-Year-Old with Serious Disabilities Deported

“Jose L.,” a 54-year-old former green card holder who had lived in the US for 32 years, was arrested by immigration officials in February 2013 and detained at Adelanto Detention Facility, run by Geo Group, in Adelanto, California. According to his medical records, he had a history of lower back pain and diabetes. Both independent medical experts who reviewed his medical records for this report identified several instances in which initial or follow-up care was unreasonably delayed. By the time he was deported in 2016, he was in a wheelchair, only able to walk short distances with a walker, and had lost vision in his right eye.¹³⁸

Jose told Human Rights Watch he was a lawful permanent resident and had lived in the US for 32 years. His entire family—brothers, sisters, and extended family—are US citizens and permanent residents. His wife passed away several years ago. He told Human Rights Watch that he was convicted in 2012 for transporting drugs and had served 240 days of a three-year sentence. At the completion of that sentence, immigration authorities took him to Adelanto.

In mid-2013, Jose was working in the facility kitchen when he slipped and fell, hitting his hip and back. He did not feel a need to see a doctor at that time, but about a month later, he began to feel worsening pain and asked to see a doctor. According to his records, he waited four months after a referral by the facility doctor to an orthopedist to actually see the specialist. The orthopedist recommended a referral to a spine surgeon. Jose had to wait another 18 months to see a surgeon.

Dr. Stern, upon analyzing the records, concluded that the first four months of the delay were reasonable because the patient was responding to treatment of his pain. But once his pain could no longer be controlled and he could not stand up for more than five minutes, the remaining 18 months of delay were

¹³⁷ Letter from CoreCivic/CCA to Human Rights Watch, January 20, 2017.

¹³⁸ Human Rights Watch interview with “Jose L.” (pseudonym), Adelanto, California, 2015 (exact date withheld).

not reasonable. He pointed out the records do not indicate what recommendations the spine surgeon made nor if any treatment plan was followed. Dr. Babaria noted there was some disagreement between outside specialists as to the appropriate care, but concluded, “Ultimately [the facility] is responsible for his care.” Dr. Stern similarly concluded, “Patient suffered a long time without proper care to his back pain.” By the point the records end, “No specific treatment has been rendered and the patient remains in pain with decreased function.”¹³⁹

Jose told Human Rights Watch he was eventually scheduled for surgery but was deported before he could have the surgery.¹⁴⁰

In July 2014, Jose began to complain about losing vision in his right eye and severe pain, which was eventually diagnosed as proliferative diabetic retinopathy, a common complication of diabetes. Both experts pointed out problems with the steps the facility took in response. From the time he first complained, it took five days for Jose to receive an initial evaluation by a physician, who thought he might have a retinal detachment, which Dr. Stern deemed an emergency. Forty-eight hours later, the optometrist found he had a hemorrhage within the eyeball and recommended that Jose see a retinal specialist as soon as possible. It then took the facility doctor four days to submit a request for authorization stating, “needs retinal specialist ASAP.” Over a month later, Jose was seen by a retinal specialist. Both experts concurred with the need for a referral to a retinal specialist as soon as possible and stated the facility failed to accomplish this. Afterward, numerous recommendations for follow-up appointments with a retinal specialist were delayed. For example, a follow-up scheduled for one week later would occur four weeks later. At one point, the retinal specialist cancelled the appointment due to non-payment, presumably by ICE.

Both experts noted that proliferative diabetic retinopathy does not develop overnight, and they questioned the competency of the facility eye doctor, who did his annual exam in February 2014—just five months earlier—but failed to note any retinopathy. Dr. Babaria stated the facility in general did not manage his diabetes well, and although his sugar level was high, the doctors did not make changes to his insulin dosages. By the end of the records, Jose had become legally blind in his right eye.

Both doctors highlighted yet another significant delay. As Dr. Stern noted: “It took nine months after discovering anemia and blood in the stool—a strong indication of the possibility of colon cancer in a 54-year-old—for the patient to finally receive a colonoscopy [in January 2015]...”¹⁴¹ Dr. Babaria noted that a

¹³⁹ Human Rights Watch email and telephone correspondence with Dr. Marc Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁴⁰ Human Rights Watch telephone interview with “Jose L.” (pseudonym), June 2, 2016.

¹⁴¹ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

new doctor in October 2014 noticed he had not had the colonoscopy and requested approval for the procedure from ICE. ICE's response was to cancel the colonoscopy, claiming it was not needed. Dr. Babaria concluded, "This is completely inappropriate and not the standard of care."¹⁴² Fortunately, when he did eventually receive the colonoscopy, it was negative.¹⁴³

In response to a summary of the problems identified above which we sent to the company without identifying the patient, Geo Group wrote in a letter to Human Rights Watch that it did not have enough information on this particular case to determine whether referrals to specialists occurred within an appropriate time-frame, but noted that Geo policy requires detainees to be seen within seven days of the original request for medical care, and that Jose's first visit with a physician for his eyesight fell within that time frame. Geo further noted with regard to delays in follow-up care: "The record is needed to determine his condition upon return to the facility, specialist consultation notes, appointment availability, and time-frame of TAR approval for follow-up appointment."¹⁴⁴

Geo also said it could not evaluate the delays Jose faced in seeing a specialist for back pain without a thorough review of the medical record, but noted pain management is provided "based on the clinical judgment of the qualified health care professional founded on objective findings and assessment of the current medical condition."¹⁴⁵ With regard to the delay in Jose's colonoscopy, Geo did not address the initial delay in ordering a colonoscopy after discovering anemia and blood in the stool but pointed out he did get one three months after a doctor ordered one in October 2014.

Requests for Care Ignored or Delayed

In some of the medical records we examined, the patients requested medical care citing a specific complaint, but were never seen for that complaint or were seen weeks later. The records of "Henry P." from his one-and-a-half year stay at Etowah County Detention Center revealed spotty access to care. Although Henry—who experienced a range of ailments from blurriness in vision to fever after being diagnosed with stomach cancer—sometimes was seen quickly, on several occasions he received a written response, sometimes with a prescription, without being seen at all. Both doctors flagged this as a serious problem. Dr. Babaria expressed concern that the facility appears to "make a lot of medical decisions

¹⁴² Human Rights Watch email and telephone correspondence with Dr. Palav Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁴³ Another detainee at Adelanto, Raul Ernesto Morales-Ramos, died in May 2015 after similar delays in following up with symptoms of colon cancer. See Section, "Deaths in Detention, 2012-2015, Raul Ernesto Morales-Ramos."

¹⁴⁴ Email from Geo Group to Human Rights Watch, January 17, 2017.

¹⁴⁵ Ibid.

without seeing the patient.”¹⁴⁶ Dr. Stern described such “care by correspondence” as “dangerous.”¹⁴⁷ Dr. Stern detailed how in some cases Henry P. waited three weeks or more to get treatment, including after a request for care describing “lower abdominal pain.” When a nurse practitioner finally saw him, the encounter, as described by Dr. Stern, was “severely deficient,” as the NP failed to do a full examination and assessment given his age-related risk for colon cancer.¹⁴⁸

Both experts flagged delays faced by a man in Imperial Regional Detention Facility in California who requested emergency help because of a severe tooth pain that he rated as pain level 10 on a scale of 1-10. He saw a nurse who gave him some pain medication and was initially told he would see a dentist later that day, but the patient did not actually see a dentist until four days later.¹⁴⁹ Dr. Babaria further noted that the dentist eventually diagnosed him with a periodontal abscess, which, left untreated, could have spread to the rest of the body and developed into sepsis. She believes given the severity of his pain, he should have been seen by a dentist that same day.¹⁵⁰

The medical records for “Martin P.,” held in York County Prison in Pennsylvania, seem to indicate the patient requested care for pain and loss of vision in his right eye on May 2, 2015, but the records indicate he was not actually seen by a nurse practitioner until three weeks later. Both experts flagged this as a serious problem. Dr. Stern noted it was possible the records were missing pages, but in one of the requests for care, Martin states, “This is my 10th slip,” suggesting he had repeatedly sought care without success.¹⁵¹ “Sudden loss of vision is an eye emergency,” Dr. Babaria stated. “The sooner you get treatment the better your chances of full recovery. Patients with delays are at risk of permanent vision loss.”¹⁵²

¹⁴⁶ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁴⁷ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁴⁸ Ibid.

¹⁴⁹ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017; and with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁵⁰ Ibid.

¹⁵¹ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁵² Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

Almost four months after his first request for care about his vision, Martin P. was seen by an eye doctor who found he was legally blind after toxoplasmosis, a parasitic infection. Records from people held in Orange County Jail in New York, Hudson County Correctional Facility in New Jersey and Adelanto Detention Facility in California also reveal instances in which requests for care were ignored or were addressed only after unreasonable delay.¹⁵³ According to Dr. Stern, the records of a man held in Hudson County Correctional Facility directly contradicted the claims of facility staff who told Human Rights Watch and CIVIC volunteers during a tour that requests are triaged by registered nurses and everyone is seen within 24 hours.¹⁵⁴ The records, in fact, indicate that the facility responded to his requests for care with written notes saying he had already been seen earlier, but those earlier visits were for other ailments: he eventually was seen in connection with his specific complaint, described by the patient as “strong pain in my glublodder [sic], I cannot walk with the pain,” only one month after his initial request.¹⁵⁵

The kind of delays and failures to provide care evidenced by these records are similar to the problems reported by individuals and attorneys in other cases to Human Rights Watch. A woman detained in Eloy Detention Center told Human Rights Watch she had benefited from meeting with the psychiatrist there, but when she had a crisis with her depression and asked to meet with him, she was told the doctor was not there and she could not see him. Soon thereafter, she cut herself. Even after her self-harm she was only able to see a psychiatrist four days later. She told us: “I feel impotent. It’s like talking to a wall because they don’t listen to us.”¹⁵⁶

Angel Rosa told Human Rights Watch that while he was held in Utah County Jail, he felt pain in his groin for months and repeatedly sought care, but was denied access to a doctor. When he was finally seen in November 2014, he was sent to the local hospital where he was diagnosed with Fournier’s gangrene, a potentially life-threatening infection

¹⁵³ Ibid.; Human Rights Watch email and telephone correspondence with Dr. Stern, March 27, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁵⁴ Human Rights Watch stakeholder tour of Hudson County Correctional Facility, Kearny, New Jersey, March 22, 2016.

¹⁵⁵ Human Rights Watch email and telephone correspondence with Dr. Stern, March 27 and May 10, 2016. For months afterward, this patient continued to complain of abdominal pain and was eventually diagnosed with gallstones and recommended for surgery, which was scheduled but did not occur. Shortly after his release in December, six months after he had first complained of severe abdominal pain, he received emergency gallbladder surgery. Human Rights Watch interview (name withheld), New York, New York, February 21, 2016; medical records from emergency gallbladder surgery post-release provided to Human Rights Watch by the patient.

¹⁵⁶ Human Rights Watch interview (name withheld), Eloy, Arizona, 2016 (exact date withheld).

in his testicles.¹⁵⁷ As noted in the previous section, our medical experts concluded that a preventable death had occurred in that same facility in July 2014.¹⁵⁸

Attorney Brian Hoffman reported that he believed his client, a three-year-old boy held in the South Texas Family Residential Center in Dilley, Texas, was seriously sick but the illness was not being taken seriously by the facility medical staff, who gave him Tylenol. After consulting the Texas Department of Family and Protective Services, Hoffman called 911, which led to an ambulance taking the child to a hospital where he was diagnosed with pneumonia.¹⁵⁹

Eduardo Beckett, an attorney in Texas, described how his client, a Mexican man with a strong claim for asylum, was experiencing severe pain in his testicles and back, but was told, “It’s in your head, you’re fine, you’re fine.” Soon after, he lost consciousness and was taken to the hospital, where they prescribed several medications, but he reported to his attorney that five days later, he was only getting one of the medications. He told his attorney, “This medical pain is so bad, I’d rather just go back and be killed.”¹⁶⁰ In another case, Beckett described a client who was throwing up repeatedly and suspected she was pregnant, but the facility continued to say she was not pregnant until she was sent to the emergency room where a test quickly revealed she was, in fact, pregnant.¹⁶¹

A former correctional officer at a Geo Group immigration detention facility told Human Rights Watch of an incident where a man who had seizures told her he had not gotten his medicine and that he was in the top bunk. She said she called medical three times, but found out later that they never came, he never got his medicine, and he then fell off his bed.¹⁶² Geo Group stated in response to this allegation that it has specific “Clinical Practice Guidelines” that follow national guidelines governing treatment of seizures and medication management, and that physical location of bed assignments are considered for detainees under treatment for seizure disorders.

¹⁵⁷ Human Rights Watch interview with Angel Rosa, Spanish Fork, Utah, January 23, 2016.

¹⁵⁸ US Immigration and Customs Enforcement, “Detainee Death Review – Santiago Sierra-Sanchez, JICMS #201409551,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-sierra.pdf>.

¹⁵⁹ Human Rights Watch telephone interview with Brian Hoffman, December 17, 2015.

¹⁶⁰ Human Rights Watch telephone interview with Eduardo Beckett, November 13, 2015.

¹⁶¹ *Ibid.*

¹⁶² Human Rights Watch telephone interview with former Geo Group correctional officer, October 29, 2015.

Barriers to Care

Many people who have experienced detention, attorneys, and other persons with knowledge of detention facilities interviewed by Human Rights Watch noted there are often significant barriers to accessing any care at all.

A woman held in Eloy Detention Center told Human Rights Watch that to request medical care, you had to go to sick call at 5 am and wait outside in the cold, and that it could take three days to a week to get what you need.¹⁶³ Individuals in other facilities, as well as a former correctional officer with experience in immigration detention facilities, told Human Rights Watch of sick call procedures that also required early morning wake-up, and that people who were sick but asleep were unable to request help.¹⁶⁴

All versions of the detention standards applicable in US immigration detention facilities require health care providers to obtain translation assistance, through a telephone translation service if necessary, but lack of language access continues to be an issue for immigrants seeking medical care in detention.¹⁶⁵ Laura Redman, director of the Health Justice Program at New York Lawyers for the Public Interest, told Human Rights Watch that several of the organization's clients never received the detainee handbook telling them how to make a sick call request, and that many, particularly those who did not read or write English, were dependent on acquaintances to make sick call requests.¹⁶⁶ She noted that although facilities have a telephonic "language line" available facility staff can call for interpretation assistance, their clients told them staff rarely called the line.¹⁶⁷

A former correctional officer employed by Geo Group described linguistic challenges to medical care at one Geo facility. "It starts from when they arrive," she said. "The nurse gets on the bus. They say in English, does anybody have any immediate medical needs? Nobody responds and they get off the bus."¹⁶⁸ As one man detained at Etowah

¹⁶³ Human Rights Watch interview (name withheld), Eloy Detention Center, Eloy, Arizona, 2016 (exact date withheld).

¹⁶⁴ Human Rights Watch telephone interview with former Geo Group correctional officer, December 14, 2015.

¹⁶⁵ The standards vary in that the 2000 National Detention Standards allow for another detainee to be used for translation assistance "if they are proficient and reliable, and the detainee being medically screened consents," whereas the 2011 Performance-Based National Detention Standards explicitly states detainees shall not be used for interpretation service, unless in an emergency medical situation. US Immigration and Customs Enforcement, "2000 Detention Operations Manual," <https://www.ice.gov/detention-standards/2000>, and "2011 Operations Manual ICE Performance-Based National Detention Standards," <https://www.ice.gov/detention-standards/2011> (accessed December 16, 2016).

¹⁶⁶ Human Rights Watch telephone interview with Laura Redman, Reena Aurora, and Sola Stamm, September 20, 2016.

¹⁶⁷ *Ibid.*

¹⁶⁸ Human Rights Watch telephone interview with former Geo Group correctional officer, December 14, 2015.

Detention Center stated, “The nurses don’t speak Spanish, so if you don’t speak English, you can’t complain.”¹⁶⁹

According to Geo Group, its policies state: “At the time of intake, Detainees will be advised both verbally and in writing of the site-specific procedure to access medical, dental, and mental health care. This information is also provided in the Detainee Handbook in English and Spanish.” It further noted its policies require all healthcare providers to ensure detainees receive care and services in a manner compatible with their preferred language and level of education.¹⁷⁰

Provision of Healthcare by Unqualified Personnel

One of the recurring problems identified in the detainee death investigations described in the previous chapter is provision of healthcare by unlicensed or under-licensed personnel. In records for several of the non-death cases, our experts identified evidence of similar practices, where licensed vocational or practical nurses and registered nurses appeared not to have consulted with a medical provider and made medical decisions outside the scope of their license.

Both medical experts flagged the case of Carlos H., held in Yuba County Jail in California, as particularly egregious. His torn ligament and severe knee pain went unaddressed for months while he repeatedly saw a licensed vocational nurse (see inset below for more detail on his story).¹⁷¹

They also highlighted the cases of Maribel Z, a woman detained in Laredo Processing Center, and Ali F., a man detained at Imperial Regional Detention Facility, as cases in which licensed vocational or practical nurses and registered nurses seemed to be providing care without sufficient input from a nurse practitioner, physician’s assistant, or physician.

Maribel Z.’s records show that she requested medical care because she was throwing up blood. As Dr. Stern notes, the record suggests that the symptom was “not explored at all” by the licensed practical nurse on duty. The LPN also described the patient’s neck as

¹⁶⁹ Human Rights Watch interview (name withheld), Etowah Detention Center, Gadsden, Alabama, 2016 (exact date withheld).

¹⁷⁰ Letter from Geo Group to Human Rights Watch, January 17, 2017.

¹⁷¹ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017; and with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

visibly swollen, but no further examination was done. Dr. Stern stated this was an emergency until proven otherwise: “If the LPN really consulted with the nurse practitioner, then this swelling was either not communicated, or the nurse practitioner failed to pursue it. Either way it was very dangerous.”¹⁷²

In response to our inquiry about this case, CoreCivic/CCA, which operates Laredo Processing Center, stated that the case summary we provided in our letter did not set forth sufficient information to identify the patient, and that it could not comment without the patient’s permission even if it had been able to identify the patient. It further stated, “Nursing staff are trained to operate first within their scope of practice, and to follow specific nursing protocols related to patient care.”¹⁷³

In reviewing the records of “Ali F.,” detained at Imperial Regional Detention Facility, the medical experts noted that the RN did not conduct a thorough examination of Ali despite seeing him several times. Ali’s principal complaint was with pain in his right leg, which he believed stemmed from a fracture from a gunshot wound in 2006. A nurse’s entry in his records from December 2015 notes that he had felt pain in his right leg for three months. His records include the report of an X-ray eight days later, but it is of his left ankle, not his right. Both experts noted there was no documentation a medical professional authorized to order an X-ray had seen the patient before the X-ray was taken.¹⁷⁴ No one noticed the wrong leg was X-rayed.

Management and Training Corporation, which operates Imperial Regional Detention Facility, stated in a letter to Human Rights Watch: “We only hire RN3- and LVN3-level nurses who receive advanced medical training.” They further stated, “We have a rigid internal checks and balances system overseen by a quality improvement committee which reviews charts daily and creates monthly reports,” and noted they are audited multiple

¹⁷² Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁷³ Letter from CoreCivic/CCA to Human Rights Watch, January 20, 2017.

¹⁷⁴ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017, and with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017. In general, only physicians are authorized to order X-rays. Under California law, a nurse practitioner may order an X-ray if there is a standardized procedure in place. California Code of Regulations, Title 16, Division 14, Article 7, Section 1474; see also State of California Department of Consumer Affairs, “An Explanation of Standardized Procedure Requirements for Nurse Practitioner Practice,” <http://www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf> (accessed March 23, 2017). There is no indication in the records or in the response from the company operating the facility that such a standardized procedure was in place.

times a year.¹⁷⁵ They did not directly address why there was no record of a physician ordering the X-ray.

Poor Care and Delays by ICE Lead to Untreated ACL Tear and Severe Knee Pain for Months

On February 2015, “Carlos H.,” fell in the shower at Yuba County Jail where he was being held for immigration authorities. His medical records confirm what Carlos told Human Rights Watch: long delays at each stage of the process, from seeing a doctor, to being diagnosed with a torn anterior cruciate ligament (ACL), to being scheduled for surgery, to receiving physical therapy.¹⁷⁶ He essentially endured pain that could have been treated or ameliorated for almost a year.

Both medical experts agreed that his records revealed dangerous substandard medical practices. Dr. Babaria stated, “It is evident from reading the first 10 pages of his records the system is providing substandard care.”¹⁷⁷ Dr. Stern concurred, “It is clear that the health care is delivered mostly by LVNs practicing independently. They call the MD when they think it’s necessary, but unfortunately, they do not have sufficient training and licensure to know when that is.”¹⁷⁸

Both medical experts noted that the records indicate Carlos requested medical care for his knee five times over three months, and made two other requests for other medical issues without seeing a doctor or a registered nurse. Instead, he was seen by a licensed vocational nurse who did not refer him to a doctor until the fifth visit. Both experts agreed this constituted practice outside the scope of an LVN’s license. Dr. Babaria explained LVNs are allowed to assess patients, but they are not allowed to make diagnoses or to make treatment plan recommendations independently.¹⁷⁹

Once he was seen by a doctor, his knee was appropriately examined and he was sent for an X-ray and MRI, which revealed a torn ACL and possibly a meniscus tear. Dr. Babaria stated the MRI report also noted some inflammation deep in the bone, indicating possible fracture as well. “The damage was more than you would have seen just in a tear,” she said.¹⁸⁰ Carlos was referred to an orthopedist who recommended surgery and the facility submitted a request to ICE for approval at the end of July. Dr. Babaria was not troubled by the two months it took from seeing a doctor to submitting a request for surgery since the injury

¹⁷⁵ Email communication from Management and Training Corporation to Human Rights Watch, January 10, 2017.

¹⁷⁶ Human Rights Watch interview with “Carlos H.” (pseudonym), (location withheld), March 7, 2016.

¹⁷⁷ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁷⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁷⁹ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁸⁰ *Ibid.*

did not require emergent surgery, but stated, “The consultation would have happened 3 months earlier if he hadn’t seen only LVNs.”¹⁸¹

What followed then was unexplained delays by ICE in scheduling the surgery. Both experts flagged notes in the record indicating that ICE twice requested delays, first from mid-August to the end of August, and then again until the first week of October. Dr. Stern questioned the ICE delay. He did not find the delay “clinically significant” because ACL surgery is not emergent, but stated, “I can’t imagine any good reason for [the delay].”¹⁸² Dr. Babaria concurred, “It’s not clear to me this was run by a physician, if any clinical decision making went into this.”¹⁸³ A 2016 GAO report states IHSC does not have specific written clinical guidance on which to base decisions for off-site care.¹⁸⁴ The record did not contain notes from the surgery, but Dr. Babaria noted there were indications the surgeon had found a fracture, due to the presence of hardware in a later X-ray, although without an operative report, she cannot definitively state a fracture was found. “If he did have a fracture, that is even more concerning,” she said. “The patient may have had a broken bone and was walking around on it with a five-month delay not explained anywhere.”¹⁸⁵

Even after his surgery, Carlos’s ordeal was not over. Dr. Stern noted that the surgeon had ordered narcotic pain medications, but the facility doctor changed the order to a non-narcotic without explanation and without setting up a mechanism to monitor post-operation pain. Two days after surgery, Carlos collapsed with shortness of breath. The LVN who managed the emergency response measured his pulse and oxygen, but not his respiration or blood pressure, and did not get the facility physician involved. Dr. Stern stated, “This episode is particularly worrisome and dangerous because of the risk of blood clot and pulmonary embolism. The failure to get the physician involved presented a major threat to the patient’s life.” He further noted the episode may have resulted from not having adequate pain control, which would have been prevented by the medications ordered by the surgeon.¹⁸⁶

Both doctors emphasized the substandard care Carlos received indicates systemic problems at the facility. “For five months, [Carlos] had this really severe pain and damage that just went untreated,” Dr. Babaria said. “If there’s anyone at facility who’s unfortunate enough to develop cancer, a five-month delay is a death sentence.”

¹⁸¹ Ibid.

¹⁸² Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁸³ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁸⁴ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://www.gao.gov/assets/680/675484.pdf>.

¹⁸⁵ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁸⁶ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

Poor Quality Care by Facility Medical Providers

The quality of care is another concern. In their review of the medical records, the experts identified situations in which potentially dangerous symptoms were not addressed quickly; repeat visits regarding the same symptoms were treated in the same manner, often with over-the-counter medication, rather than examined further; or symptoms were too quickly ascribed to “anxiety.”

Both experts highlighted the poor care received by “Maria C.” at Eloy Detention Center—whose symptoms of dizziness and headaches could have been a sign of a serious and dangerous condition, but were too quickly ascribed to anxiety by nurses (her story is set forth in more detail below).

Both experts also noted numerous instances of poor care for Henry P., a case already mentioned above. In October 2014, Henry complained of pain in his lower abdomen when he had a bowel movement. After waiting three weeks, he saw a nurse practitioner whom both experts faulted for failing to examine his rectum. The NP prescribed antibiotics, which both experts questioned. Dr. Babaria noted there was no diagnosis or testing, so “I don’t know what [the NP] is treating.”¹⁸⁷ Dr. Stern pointed out that if the NP thought Henry had a bacterial infection, he should have received much closer follow-up monitoring.¹⁸⁸ At other points during his detention, Henry had abnormal lab results which were not addressed, such as evidence of possible hypertension and liver malfunction.

A year later, soon after Henry P. was diagnosed with stomach cancer, he requested care for a sore throat, cough, and fever in December 2015. He was seen by a nurse, who talked to a doctor, and then gave him Tylenol and amoxicillin, an antibiotic, for seven days. Both doctors noted that given his cancer diagnosis, he could have had a serious infection. Dr. Babaria stated, “He should absolutely have been seen by a physician.”¹⁸⁹ Dr. Stern noted he was immunocompromised and that the safest course of action would have been to

¹⁸⁷ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁸⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁸⁹ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

keep him in the infirmary and monitor every four to eight hours to ensure he was getting better, not worse, and the failure to schedule a follow-up was “wrong and dangerous.”¹⁹⁰

Other examples of poor quality care the experts flagged included poor management of a severe seizure disorder suffered by an individual detained at Adelanto Detention Center, prescribing an antidepressant without any documented explanation to a woman at Hutto Detention Center, spotty and poor administration of antibiotics at Imperial Regional Detention Facility, and inadequate and dangerous monitoring and treatment of detoxification from alcohol or drugs in two separate cases in Hudson County and York County Prison.¹⁹¹

In the case of “Julio P.,” an HIV-positive man, the records indicate that in November 2015 a nurse practitioner visually examined his rectum and concluded that he had a hemorrhoid. In February 2016, he was referred to an outside specialist because a rectal mass was found and he was diagnosed with anal cancer. Both doctors noted the lack of documentation between November 2015 and February 2016, which should have explained who identified the rectal mass and determined he needed an outside referral. Dr. Babaria further concluded that Hudson County Correctional Facility, where he was held, was not following appropriate HIV screening guidelines. She explained people who are HIV positive have a higher risk of anal and cervical cancer, and should be given annual screenings, which were not done in Julio’s case; the failure could have resulted in a meaningful delay in diagnosing his cancer.¹⁹²

¹⁹⁰ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁹¹ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017, and with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁹² Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017. See also, US Department of Veteran Affairs, “Anal Dysplasia and HIV,” October 28, 2011, <http://www.hiv.va.gov/provider/manual-primary-care/anal-dysplasia.asp> (accessed November 30, 2016).

Poor Care by Nurses Indicates Ongoing Problems at Eloy Detention Center

The medical records for “Maria C.,” a woman who reported a history of hypertension or high blood pressure, indicate recent poor care by nurses at Eloy Detention Center, a facility that has been under scrutiny because of four deaths from 2012 to 2015.

When Maria first entered Eloy, she was prescribed medication for her reported high blood pressure. From October 2015 through March 2016, the records indicate Maria made repeated requests for care, complaining of dizziness and headaches. In most instances, Maria saw a nurse who recorded low blood pressure readings. In February 2016, she lost consciousness, which both experts noted could have been due to low blood pressure. Dr. Stern stated, “This required [another] measurement of blood pressure and pulse lying and standing,” which was not done.¹⁹³ Dr. Babaria agreed more should have been done but instead “[t]hey made her rest, drink water, and sent her back out.”¹⁹⁴ Both experts questioned whether she ever had high blood pressure and whether the medication prescribed for hypertension might have lowered her blood pressure, causing these symptoms. Yet, throughout this time, no change was made to her blood pressure medication.

Both doctors noted her repeat complaints of headache should not have been addressed simply with ibuprofen. Dr. Stern found such care “dangerous,” stating: “There are a number of serious conditions that can ... manifest as eye/head/dental pain that at least needed to be considered.”¹⁹⁵ Dr. Babaria agreed, “Someone who has recurrent headaches needs to be evaluated by a nurse-practitioner or MD.... [But] she keeps seeing a nurse, the nurse keeps treating her the same way, and no one evaluates her.”¹⁹⁶

Dr. Stern pointed out other instances of dangerous practice, such as a urinalysis in April 2016 that was abnormal and probably indicative of an acute urinary tract infection, but for which no action was taken.¹⁹⁷ Dr. Babaria noted on February 22, 2016, Maria complained of menstrual cramps one year after she had her last period. “Postmenopausal bleeding could potentially be endometrial cancer, and it should be

¹⁹³ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁹⁴ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁹⁵ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

¹⁹⁶ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁹⁷ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

automatically evaluated by gynecologist to rule out cancer.”¹⁹⁸ By the time the records end in April, this issue had not been addressed.

In the records, nurses repeatedly ascribe Maria’s complaints to anxiety. Dr. Stern pointed out that on November 25, 2015 a nurse who saw Maria for chest pain diagnosed her with difficulty coping without doing a complete examination and without discussing the case with a practitioner, which he found to be dangerous.¹⁹⁹ Dr. Babaria was concerned by notes that indicate the nurses are “attributing all of these symptoms to her anxiety, which may or may not be true, but until you rule out more concerning diseases (like cardiac issues), it’s not appropriate.”²⁰⁰

“There was a repeat pattern of nurses making decisions they’re not qualified to make and little to no oversight by nurse-practitioners or physicians, which is dangerous,” concluded Dr. Babaria.²⁰¹

Refusals of Care Not Properly Documented

Several of the records include instances in which the patient seems to have refused medication or treatment without any indication that the patient was adequately informed of the risks. Under international human rights law and US law, individuals have the right to refuse medication or treatment, but the experts raised concerns about the way the refusals were documented and whether they were truly informed refusals. Dr. Stern explained, “A patient contemplating consenting to—or refusing—a complex and dangerous surgical procedure should receive a detailed explanation of the risks, benefits, and alternatives, have an opportunity to have all his/her questions answered, and the event should be memorialized in a written document.”²⁰²

Dr. Stern pointed out that in the case of “Martin P.” at York County Prison, the records indicate he refused medication that was likely prescribed for withdrawal from alcohol, which can be extremely dangerous. The refusals were obtained by a licensed practical

¹⁹⁸ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

¹⁹⁹ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

²⁰⁰ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

²⁰¹ Ibid.

²⁰² Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

nurse without documented explanation of the risks.²⁰³ In Henry P.’s case, after major surgery for his stomach cancer, he refused to be housed in the infirmary. Dr. Stern pointed out that, given the importance of post-surgical monitoring, “This demanded a one-to-one conversation by the MD with the patient to be sure he understood the reason for the refusal and made every effort to change the patient’s mind or find an accommodation.... You don’t just throw up your hands and say, ‘Oh well, I tried.’”²⁰⁴ Henry’s medical records give no indication that this consultation took place.

Unreasonable Delays in Obtaining Off-Site Care

Long delays in receiving off-site care recommended by detention facility medical providers was a common complaint among formerly detained people and attorneys who represent them, as already illustrated in the multiple delays experienced by Carlos H, whose case is detailed in an inset above.

When an individual requires medical care that the facility clinic cannot provide, the facility is required to take the following steps: identify an off-site provider, schedule an appointment, and submit a request through the MedPAR (Medical Payment Authorization Request) system, which request is then reviewed by the Immigrant Health Service Corps (“IHSC”).²⁰⁵ A nurse at Etowah County Detention Center stated that some requests, such as for a urinalysis, are approved right away but some requests can remain pending for months.²⁰⁶

The medical records of Carlos H. indicate the delays in his care (described in more detail above) were not only due to failures by facility nurses to refer him to a physician, but also by ICE’s decision to repeatedly delay surgery for his torn ligament after the problem was diagnosed. As both experts found, the notes indicated no clinical reason—such as pain being effectively controlled by medication—for these delays. The delay may have been due to budgetary considerations, as the last request for a delay pushed his surgery into the next fiscal year.

²⁰³ Ibid.

²⁰⁴ Ibid.

²⁰⁵ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://gao.gov/products/GAO-16-231>.

²⁰⁶ Human Rights Watch stakeholder tour of Etowah County Detention Center, Gadsden, Alabama, January 20, 2016.

During a tour of Adelanto Detention Facility, the assistant field office director, Gabe Valdez, told Human Rights Watch that decisions on outside treatment can be affected by whether deportation is imminent. He stated, “Timelines for approval exist,” explaining that a man who wants dentures but who will be deported in three days will not get dentures. He further stated decisions are made in consultation with ICE and with IHSC.²⁰⁷ In many immigration cases, however, it is not easy to predict when a person will be deported or released. Delays in referring a patient to a gastrointestinal specialist were noted in the case of Raul Ernesto Morales Ramos, detailed in the previous chapter.²⁰⁸ Dr. Stern observed that the case also reveals an underlying flaw in the process for requesting off-site care—the facility is supposed to make an appointment with an off-site provider before receiving approval from IHSC. He explained this process risks cancellation of the appointment if IHSC does not approve the request, which he criticized as wasting staff resources and risking specialists being annoyed and unwilling to take future referrals. “It’s hard enough to find specialists who are willing to see detainees in their community offices,” he said. “When annoyed, they have a low threshold for severing their relationship with the detention facility.”²⁰⁹

In its letter to Human Rights Watch responding to our findings on off-site care, Geo Group stated: “Community specialist appointments are based on availability and, on occasion, can be beyond the scheduled time-frame requested by the facility provider.... If a detainee is unable to be seen within the time-frame ordered, the request is returned to the provider for an alternative treatment plan, extension, or referral to a hospital if appropriate.”²¹⁰ Human Rights Watch and other organizations have long-criticized ICE for contracting with facilities in remote locations far from the cities and towns where most immigrants are apprehended, which are also far removed from legal service providers and other services. A 2009 report by a corrections expert, commissioned by ICE, included a recommendation to locate facilities nearby consulates, pro bono counsel, and 24-hour emergency care.²¹¹ The challenge of scheduling appointments with medical specialists, as acknowledged by Geo Group, underscores another important reason for ensuring that facilities are not

²⁰⁷ Multi-organizational stakeholder tour of Adelanto Detention Facility, Adelanto, California, September 4, 2015.

²⁰⁸ US Immigration and Customs Enforcement, “Detainee Death Review – Raul Ernesto Morales-Ramos, JICMS #20505282,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-morales.pdf>.

²⁰⁹ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

²¹⁰ Letter from Geo Group to Human Rights Watch, January 17, 2017.

²¹¹ Dora Schriro, US Department of Homeland Security, US Immigration and Customs Enforcement, “Immigration Detention Overview and Recommendations,” October 6, 2009, <https://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf> (accessed February 14, 2017).

located far from needed services. A recent DHS enforcement memorandum states most migrants apprehended at the border will be detained until their proceedings are concluded, and calls for increased detention capacity along the southern border, policies that can be expected to exacerbate the problem.²¹²

“Ali F.” told Human Rights Watch that facility staff had told him they could not provide care for his leg injury because it stemmed from a shooting that occurred in his home country years earlier.²¹³ Such a statement would be incorrect—ICE is required to provide adequate medical care for all medical issues, whether stemming from preexisting conditions or from conditions that first appear in the facility. As noted above, many of the publicly available contracts indicate that even when ICE pays for off-site care, the facilities are responsible for transportation and security costs associated with off-site care, and therefore have a financial incentive for limiting or denying off-site care.²¹⁴

Inadequate Mental Health Care and Misuse of Isolation

Mental health care in US correctional facilities is often poor, and people with mental health conditions frequently suffer appalling abuses, including isolation that amounts to cruel, inhuman, and degrading treatment under international human rights law. Individuals detained in some facilities suffer from both poor mental health care and misuse of isolation. A recent investigation by *The Verge* found more than 160 cases of individuals with mental health conditions placed in isolation in logs maintained through 2016 from three privately run ICE facilities.²¹⁵ Another study found regular use of isolation in multiple immigration detention centers as a form of control for people with psychosocial disabilities.²¹⁶ The Department of Homeland Security Office of Inspector General issued a

²¹² US Department of Homeland Security, Memorandum from Secretary John Kelly, February 20, 2017, https://www.dhs.gov/sites/default/files/publications/17_0220_S1_Implementing-the-Presidents-Border-Security-Immigration-Enforcement-Improvement-Policies.pdf.

²¹³ Human Rights Watch interview with “Ali F.” (pseudonym), Calexico, California, 2016 (exact date withheld).

²¹⁴ National Immigrant Justice Center, “Immigration Detention Transparency and Human Rights Project,” Intergovernmental Service Agreement Between the US Department of Homeland Security, US Immigration and Customs Enforcement Office of Detention and Removal Operations and the City of Adelanto, <https://www.documentcloud.org/documents/1633813-adelanto-contract.html>; Detention Services Intergovernmental Agreement, Hutto Detention Center, <http://www.documentcloud.org/documents/1672355-hutto-county-corectional-center-williamson.html>.

²¹⁵ Spencer Woodman, “ICE detainees are asking to be put in solitary confinement for their own safety,” *The Verge*, March 10, 2017, <http://www.theverge.com/2017/3/10/14873244/ice-immigrant-detention-solitary-trump-corecivic-geo> (accessed March 23, 2017).

²¹⁶ National Immigrant Justice Center and Physicians for Human Rights, “Invisible in Isolation: The Use of Segregation and Solitary Confinement in Immigration Detention,” September 2012, <http://www.immigrantjustice.org/research-items/report->

short report in 2016, following up on a 2011 investigation into mental health care in immigration detention, that found that ICE continues to struggle to attract and retain mental health providers, particularly in rural and remote areas.²¹⁷

Dr. John Rubel, a clinical psychologist with decades of experience in the federal Bureau of Prisons, spent two years providing mental health services at Hutto Detention Center in Texas, and found a tremendous need for mental health care, but trying to provide it at Hutto eventually posed a “ethical and moral dilemma” that led him to leave. Dr. Rubel described the prevalence of trauma in the facility, which housed more than 500 women, as “extremely high,” saying, “It’s not just a single event [for these women], but multiple episodes of trauma.”²¹⁸ Despite the great need, mental health staff at the facility consisted of one to two full-time staff members and one half-time staff member. Without more mental health staff, he said, it was impossible to provide the comprehensive mental health services required under IHSC policy.

Dr. Rubel noted that many people he saw were diagnosed with post-traumatic stress disorder or major depressive disorder, “pretty severe diagnoses.” For such cases, he said, “The treatment is not a 15-minute ‘How are you feeling, how are you sleeping, are you taking your medication?’ That’s not treatment.” Dr. Rubel created a group therapy program, similar to ones he had run successfully in other institutions for years, and felt like that was one way of working with limited resources, but he said in his second year, the administration stopped supporting group therapy, and he felt he could no longer offer a real option of treatment to the traumatized women he evaluated. In talking to mental health providers at other facilities, he heard they faced similar challenges with limited resources.²¹⁹

invisible-isolation-use-segregation-and-solitary-confinement-immigration?q=publications/report-invisible-isolation-use-segregation-and-solitary-confinement-immigration-detenti (accessed November 30, 2016).

²¹⁷ US Department of Homeland Security, Office of Inspector General, “ICE Still Struggles to Hire and Retain Staff for Mental Health Cases in Immigration Detention,” July 2016, <https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-Jul16.pdf> (accessed January 5, 2017); see also, US Department of Homeland Security, Office of Inspector General, “Management of Mental Health Cases in Immigration Detention,” March 2011, https://www.oig.dhs.gov/assets/Mgmt/OIG_11-62_Mar11.pdf (accessed January 5, 2017).

²¹⁸ Human Rights Watch telephone interview with Dr. John Rubel, February 17, 2017.

²¹⁹ Ibid.

“A Sad Excuse of a Detention System for Individuals with Mental Illness”

“Luke R.,” a 39-year-old lawful permanent resident from Guyana diagnosed with schizophrenia, was detained in Orange County Jail in New York from November 2015 through March 2016. Our experts reviewed his medical and disciplinary records from this time, and agreed his care was abysmal. Dr. Stern stated, “The events of early March describe a sad excuse for a detention system for individuals with mental illness.”²²⁰

At the time of his intake, the facility learned of Luke’s history of schizophrenia, which was diagnosed in 2001, and the medications he had been taking. The records seem to indicate he refused to continue taking those medications. In December, a doctor noted he wanted something “stronger” and prescribed 100 milligrams of trazodone at bedtime. Dr. Babaria noted that trazodone is an anti-depressant, not an anti-psychotic, and as an internist, she would prescribe the dose Luke was given for people with insomnia.²²¹

Dr. John Rubel, a clinical psychologist, also noted the records provided no indication Luke was given any therapy. Although there are visits with social workers that are described as “supportive therapy,” he described the notes as “sparse” and “totally unacceptable,” as they provided no information on his mental state, what the social worker did, and what plan there was for follow up.²²²

Both experts agreed the most serious problems began in early March. On March 4, Luke met with the facility’s psychiatrist and complained of hearing voices and people shouting. The doctor at first decided to prescribe Haldol, an anti-psychotic, but because of an allergy, he changed the order to Benadryl, which both doctors noted is an antihistamine. Dr. Stern described in detail why this was a poor decision. He noted that while the doctor confirmed Luke did not have suicidal or homicidal ideation, he failed to explore the nature of the voices further to find out what they were saying and to determine to what extent the voices were causing dysfunction. “It may not be urgent to treat auditory hallucinations if they are benign and not interfering with function or bothering the patient,” he stated. “However, if they are, they need to be treated.... Based on the treatment given, we have no reason to believe they would stop.”²²³

On March 7, Luke was written up for inmate misbehavior (not moving a grey bin back to his cell after cleaning) and moved to “Delta 1,” which according to Luke’s attorney constituted solitary confinement while awaiting disciplinary hearings. While in this unit the next day, according to an “Emergency Response Team Incident Response Report,” Luke banged his head against the glass window, causing a large laceration on his forehead and breaking the cell window. Seven minutes later, he was examined by a nurse, who sent him to the emergency room at an outside hospital. There he received 11 stitches and was seen by a nurse-practitioner who also works at the facility. Upon his return, this nurse-practitioner saw Luke, described him as “psychotic & paranoid & delusional,” and prescribed Geodon and Cogentin. Luke was then placed in disciplinary segregation.

Dr. Babaria expressed serious concern about the initial response of the correctional officers. His 11 stitches indicate his injury was severe, but “the officers’ first response was not to stop the bleeding or assess the patient,” but to put him in restraints and videotape what was happening. “From previous experience, facilities where officers don’t respond to medical emergencies appropriately using basic life support measures are facilities where patients are placed at increased risk. That to me is a red flag,” she said. Medical professionals saw Luke six minutes after the Emergency Response Team was notified. Dr. Babaria stated, “Depending on how severe the injury, that five- to seven-minute delay could be life or death for someone.”²²⁴

From March 10 onward, when he had returned from the hospital, a nurse “cleared” him for placement in isolation pending a disciplinary hearing. Dr. Babaria noted there were a number of refusals for medication, but the recordkeeping was poor: they do not list which medications or why he refused. Although Luke had a right to refuse, a facility is still required to take steps to ensure refusal is informed. The records did not contain medicine administration records, so it was not clear to Dr. Babaria whether he was getting any psychiatric medications upon his return from the hospital.

On March 11, the facility held a disciplinary hearing for Luke, which he refused to attend. He was found guilty of all charges and sentenced to seven days in disciplinary segregation with six days’ credit for the time he had already spent in segregation.

On March 14, Luke had a psychiatric consultation with a licensed clinical social worker, who recommended that he be hospitalized. Dr. Babaria noted this was the first psychiatric evaluation he had had at the facility since his self-harm attempt on March 8.

Dr. Stern, Dr. Babaria, and Dr. Rubel all expressed grave concerns about the way his self-harm attempt was treated. “Clearly the behaviors of March 7 and 8 were psychiatrically induced,” stated Dr. Stern. “He should not have been cleared to be placed in segregation and this should have been addressed at the hearing.... Instead he was essentially punished for being mentally ill.”²²⁵ Dr. Babaria concurred: “They

²²⁰ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

²²¹ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

²²² Human Rights Watch telephone interview with Dr. John Rubel, March 3, 2017.

²²³ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

²²⁴ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

²²⁵ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

[treated] him as a criminal when he has a mental illness and it's completely uncontrolled.”²²⁶ Dr. Rubel pointed out it was highly unlikely Luke was mentally competent to participate in the disciplinary hearing. He also questioned why the mental health professional who recognized Luke had a serious mental health condition did not advocate for him by requesting a competency hearing or speak on his behalf at the disciplinary hearing. Dr. Rubel concluded, “The whole system failed.”²²⁷

Luke's attorney, Luis Mancheno, told Human Rights Watch that when he met with his client two days after the self-harming attempt, Luke told him that it was a suicide attempt, that he wanted to “finish it all.” According to Mancheno, Luke was transferred in mid-March to the Columbia Regional Care Center in South Carolina, far from his attorney and family. ICE told Mancheno that was the closest mental health facility with which it had a contract. While in South Carolina, Mancheno reported Luke received appropriate care, that he was able to communicate with him easily and he was taking his medication, which he stated, “speaks volumes of the horrible care he was receiving at Orange.”

Mancheno also stated Luke was criminally charged with destruction of property and now has a pending case in Orange County. He wrote, “I can't believe ICE punished him after not giving him the appropriate care for so long.”²²⁸

Luke's experience is similar to those reported by other individuals and attorneys.

Reena Aurora, an attorney with New York Lawyers for Public Interest, told Human Rights Watch one of her clients had attempted suicide at Orange County Jail (the same facility in which Luke R. was held), and he was placed in isolation and never had a psychiatrist do an evaluation or assessment.²²⁹

Diane Devore, a therapist in San Diego, regularly consults with attorneys to assess the credibility of asylum applicants, and expressed serious concern about the impact of detention on already traumatized people. In one particular case, her client had done well in a psychiatric facility, but when she was returned to the detention center, she did not receive the same medication she had received in the hospital. “[S]he became unstable and suicidal,” Devore said. “Typically, she would get isolated, which is probably the very

²²⁶ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

²²⁷ Human Rights Watch telephone interview with Dr. John Rubel, March 3, 2017.

²²⁸ Email from Luis Mancheno to Human Rights Watch, April 25, 2016.

²²⁹ Human Rights Watch telephone interview with Laura Redman, Reena Aurora, and Sola Stamm, September 20, 2016.

worst thing to do with someone who is suicidal.”²³⁰ Florence Weinberg, an attorney who has worked with Devore, concurred, stating, “I’ve had clients, very mentally ill clients ... who’ve suffered from schizophrenia and various psychotic episodes, and the way [CoreCivic/CCA] responds to that is to put people in solitary.”²³¹

Two attorneys of clients with mental health conditions detained in Adelanto Detention Center told us their clients were regularly put into isolation because adequate mental health care was unavailable.²³² Kelsey Provo, a legal services attorney, said she had encouraged one client to reach out to a staff psychologist when he told her he had suicidal thoughts, but the response was to put him in isolation on suicide watch, unable to see or speak to anyone for a long period of time.²³³ Geo Group stated in its response to our inquiry on this issue that its policy on suicide watch requires the detainee to have access to staff within sight or sound 24 hours a day, seven days a week, with regular observation depending on the detainee’s level, and scheduled mental health rounds conducted on a daily basis by qualified mental health providers.²³⁴

In September 2013, ICE issued a segregation directive creating more requirements for facilities to notify ICE when a person is placed in segregation. In particular, facilities are to notify the local ICE Field Office Director (“FOD”) immediately and no later than 72 hours after placement if a person placed in segregation “has a serious mental illness or a serious medical illness or serious physical disability.”²³⁵ The FOD is then supposed to notify IHSC, who then shall, “For detainees with a medical or mental illness, or identified as being a suicide risk or on a hunger strike, evaluate the appropriateness of the placement and ensure appropriate health care is provided. Such detainees shall be removed from segregation if the IHSC determines that the segregation placement has resulted in deterioration of the detainee’s medical or mental health, and an appropriate alternative is available.”²³⁶

Even the limited prescriptions of the ICE segregation directive may not be fully understood by some facility officials. During a tour of Hudson County Correctional Facility, Human

²³⁰ Human Rights Watch telephone interview with Diane Devore, March 10, 2016.

²³¹ Human Rights Watch telephone interview with Florence Weinberg, March 2, 2016.

²³² Human Rights Watch telephone interview with Alisa Whitfield, November 18, 2015

²³³ Human Rights Watch telephone interview with Kelsey Provo, October 26, 2016.

²³⁴ Letter from Geo Group to Human Rights Watch, January 17, 2017.

²³⁵ US Immigration and Customs Enforcement, “ICE Segregation Directive,” September 4, 2013, https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf (accessed November 30, 2016).

²³⁶ *Ibid.*

Rights Watch asked if anyone had ever been removed from isolation because of deterioration of their mental health or other health condition. A facility official at HCCF responded that such removals did not occur because, “We clear them before we put them in here,” and that a nurse does “welfare checks” three times a day. When asked what the nurse should do during such a check, he responded, “Asking ‘how are you?’”²³⁷

Dr. Stern, who accompanied Human Rights Watch on the tour, disputed that assessment, stating that during such checks, the nurse should be trying to have a normal interaction and check that there are no unmet needs, not just check that the person is still alive.²³⁸ Florence Weinberg, an attorney who practiced mainly in southern California, found such perfunctory mental health checks to be common in her clients’ cases. “Let’s say a client is in administrative segregation,” she said. “The therapist will stick their head in and say, ‘how are you feeling today?’ That’s the therapist checking in.”²³⁹

Inadequate Medical Recordkeeping

Several of the records examined for this report are missing crucial documentation of medical care; sometimes there are gaps of several months. Both experts highlighted two cases in which both patients were eventually diagnosed with cancer, but where documentation was severely inadequate. Dr. Babaria explained, “In any facility where multiple providers are seeing a given patient, if you’re not documenting why you’re treating people, it leads to a lot of confusion.”²⁴⁰ With regard to the records for Henry P., Dr. Stern noted it was possible the missing records could show a “failure to address this problem in a timely manner leading to delay of diagnosis of what is most likely going to be a fatal problem.”²⁴¹

Some records indicate crucial medical information was not provided when the individual was transferred from one detention facility to another. The records of a man with a history of seizures indicates when he was transferred from South Texas Detention Center in Texas to Etowah Detention Center in Alabama, no transfer summary was sent with him.²⁴²

²³⁷ Human Rights Watch and CIVIC stakeholder tour of Hudson County Correctional Facility, March 22, 2016.

²³⁸ Human Rights Watch email and telephone correspondence with Dr. Stern, March 27 and May 10, 2016.

²³⁹ Human Rights Watch telephone interview with Florence Weinberg, March 2, 2016.

²⁴⁰ Human Rights Watch email and telephone correspondence with Dr. Babaria, October 3, 7, and 21, and November 10, 2016; April 18, 2017.

²⁴¹ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017.

²⁴² *Ibid.*

Mayra Gamez, a legal services attorney who represents individuals who qualify for court-appointed representation due to mental health conditions under the settlement in *Franco v. Gonzalez*, described a case in which her client was transferred, without notice to her, from Adelanto Detention Center to Northwest Detention Center while she was in discussions with ICE about releasing him on his own recognizance. In a complaint she filed with DHS Office of Civil Rights and Civil Liberties, she wrote her client “suffers from chronic mental illness ... [and] is epileptic, paraplegic, has hypertension and gastrointestinal bleeding.” Her client informed her that since his transfer two weeks earlier, he had not met with a psychiatrist, nor been given his psychiatric medication, though he had received his epilepsy medication.²⁴³

Geo Group stated in its response to our inquiry about these cases that medical care at South Texas Detention Center is provided by IHSC, and further stated, “A detainee cannot leave the Adelanto Detention Facility without a Medical Transfer Summary, as they will not be accepted by ICE officials for transport.... The detainee was transferred to a facility where medical care is provided by [IHSC].”²⁴⁴

Some of the medical records we requested we never received; others were so incomplete they were not reviewable. While some attorneys told Human Rights Watch it was not difficult to obtain copies of medical records, others reported they faced long delays or were never able to obtain the records.

²⁴³ Human Rights Watch interview with Mayra Gamez, Los Angeles, California, April 25, 2016; CRCL complaint provided to Human Rights Watch.

²⁴⁴ Letter from Geo Group to Human Rights Watch, January 17, 2017.

IV. Inadequate Oversight and Lack of Accountability

In recent years, numerous reports by both US government and outside monitors have identified serious failures of oversight in the US immigration detention system.²⁴⁵ Reforms implemented by the Obama administration created numerous monitoring bodies, some of which have identified problems, but these initiatives have had a mixed record and typically have no authority to hold facilities accountable for even severe failures to meet standards, even after deaths occur. Notably, in March 2016, the Office of Inspector General at DHS announced it would start ongoing, unannounced inspections of ICE and CBP detention centers.²⁴⁶ A March 2017 report from one of these unannounced inspections of Theo Lacy Facility in California found detained individuals being served meat that appeared to be spoiled, moldy showers, mixing of low- and high-risk individuals, violations of ICE detention standards regarding the use of isolation; and failure to properly document and ensure follow through on grievances.²⁴⁷ Although this is a welcome step, it is too soon to tell whether deficiencies found in these unannounced inspections will be treated any differently than deficiencies found through other oversight mechanisms.

The expert opinions Human Rights Watch obtained from medical professionals for this report, our own investigations and those of numerous governmental bodies and other NGOs, and the reports of investigative journalists all point to a seriously inadequate system of oversight of medical care in detention facilities, in particular:

- Failure to take corrective actions after problems are identified;
- Failure of investigations to identify problems;

²⁴⁵ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://www.gao.gov/assets/680/675484.pdf>; US Government Accountability Office, “Additional Actions Needed to Strengthen Management and Oversight of Facility Costs and Standards,” October 2014, <http://www.gao.gov/assets/670/666467.pdf> (accessed March 29, 2017); American Civil Liberties Union, Detention Watch Network, and National Immigrant Justice Center, “Fatal Neglect: How ICE Ignores Deaths in Detention,” February 2016, <https://www.aclu.org/report/fatal-neglect-how-ice-ignores-death-detention> (accessed January 5, 2017); National Immigrant Justice Center, “Lives in Peril: How Ineffective Inspections Make ICE Complicit in Detention Center Abuse,” <http://immigrantjustice.org/research-items/report-lives-peril-how-ineffective-inspections-make-ice-licit-detention-center>.

²⁴⁶ US Department of Homeland Security, Office of Inspector General, “DHS OIG to Periodically Inspect CBP and ICE Detention Facilities,” March 15, 2016, <https://www.oig.dhs.gov/assets/pr/2016/oigpr-031516b.pdf> (accessed January 5, 2017).

²⁴⁷ US Department of Homeland Security, Office of Inspector General, “Management Alert on Issues Requiring Immediate Action on Theo Lacy Facility in Orange, California,” March 6, 2017, <https://www.oig.dhs.gov/assets/Mga/OIG-mga-030617.pdf> (accessed March 24, 2017).

- Inadequate grievance procedures; and
- Inadequate data collection.

Failure to Take Prompt Corrective Action

Since ICE released its reviews of 18 of the 21 deaths in detention that occurred between 2012 and 2015, it has not publicly announced any corrective action plans for the deficiencies the investigations uncovered and has not provided evidence of any such corrective action plans in response to requests from Human Rights Watch. Analysis of more recent medical records indicate that in at least three of the facilities in the death reviews—Eloy Detention Center, Adelanto Detention Center, and York County Prison—there have been ongoing failures to provide appropriate care.

The detainee death reviews themselves indicate that problems are not addressed quickly, even when reform is urgently needed. In the Eloy Detention Center, for example, one of the contributing factors to Cota-Domingo’s death on December 23, 2012 was confusion over who had the authority to call 911, due to facility policies. Four months later, Garcia-Maldonado and Guadalupe-Gonzalez died within days of each other and in both of those cases confusion over 911 authority again played a role. “A timely review of Mr. Cota-Domingo’s death should have remedied the 911 confusion before Ms. Guadalupe-Gonzales’s and Mr. Garcia-Maldonado’s deaths,” Dr. Stern told us.²⁴⁸

The reviews of the deaths at Eloy identify other oversight failures. In the death reviews for Guadalupe-Gonzales and Garcia-Maldonado, who both committed suicide, the Office of Detention Oversight (ODO) states: “All [Eloy Detention Center] staff members interviewed by ODO stated [Eloy Detention Center] did not hold a multidisciplinary debriefing to review critical elements surrounding” the suicides.²⁴⁹ In its reply to Human Rights Watch, CoreCivic/CCA contested this point, saying that “on April 29, 2013, CCA, ICE and IHSC

²⁴⁸ Human Rights Watch email and telephone correspondence with Dr. Marc Stern, June 8, 26, 30, and July 1-6, 2017.

²⁴⁹ US Department of Homeland Security, Immigration and Customs Enforcement, “Report of Investigation: Garcia-Mejia, Jorge/Unknown/0617 Detainee/Alien – Death (Suicide) / Eloy, Pinal, AZ,” October 7, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-garciamaldonado.pdf>; US Department of Homeland Security, Immigration and Customs Enforcement, “Report of Investigation: Guadalupe-Gonzales, Elsa/Unknown/0617 Detainee/Alien – Death (Suicide) / Phoenix, Maricopa, AZ,” September 25, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-guadalupegonzales.pdf>.

conducted several debriefings to discuss the [Guadalupe-Gonzales] incident.”²⁵⁰ (Though asked, it did not give an answer as to whether there had been debriefings for the Garcia-Maldonado suicide.)

In any case, two years later, in the death review of Jose de Jesus Deniz-Sahagun, who also committed suicide at Eloy, the ODO noted that Eloy Detention Center “did not convene a multi-disciplinary debriefing in contravention of IHSC Local Operating Procedure 1501, Suicide Prevention and Intervention which requires, ‘A formal debriefing with ... multidisciplinary team members to convene the next business day for a formal debriefing to review critical elements that contributed to the death and measures to prevent future deaths.’”²⁵¹

“It’s quite alarming to me ... based on these death reviews how often it appears that debriefings are not done by medical and security staff at the facility following deaths to determine whether mistakes were made,” Dr. Keller told us. “A basic tenet of medical care is that we do our best to learn from mistakes when they are made.”²⁵²

The ICE review of both the Guadalupe-Gonzales and the Garcia-Maldonado deaths point to Eloy Detention Center’s failure to have a local suicide prevention plan, “in contravention of the [Performance Based National Detention Standards] and CCA Policy 9-19 ... which require the facility to develop a local Suicide Prevention Plan, to be reviewed annually, addressing ‘specific facility initiatives and the facility's plan for compliance’ with the policy.” Both reviews indicated that the facility was “currently in the process of developing a Suicide Prevention Plan.”²⁵³

²⁵⁰ Letter from CoreCivic/CCA to Human Rights Watch, July 6, 2016. Human Rights Watch asked about debriefings after both suicides. The Guadalupe-Gonzales suicide occurred on April 28, 2013 and the Garcia-Maldonado suicide occurred on April 30, 2013.

²⁵¹ US Immigration and Customs Enforcement, “Detainee Death Review – Jose De Jesus Deniz-Sahagun, JICMS #201506640,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-denizshagun.pdf>.

²⁵² Human Rights Watch telephone interviews with Dr. Keller, July 1-6, 2017.

²⁵³ US Department of Homeland Security, Immigration and Customs Enforcement, “Report of Investigation: Garcia-Mejia, Jorge/Unknown/0617 Detainee/Alien – Death (Suicide) / Eloy, Pinal, AZ,” October 7, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-garciamaldonado.pdf>; US Department of Homeland Security, Immigration and Customs Enforcement, “Report of Investigation: Guadalupe-Gonzales, Elsa/Unknown/0617 Detainee/Alien – Death (Suicide) / Phoenix, Maricopa, AZ,” September 25, 2013, <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-guadalupegonzales.pdf>.

Two years later, in the death review of Jose de Jesus Deniz-Sahagun, the ODO again noted the requirement that the facility develop a “Suicide Prevention Plan which is reviewed annually and addresses specific facility initiatives for suicide prevention.” The ODO review found “no evidence [Eloy Detention Center] has developed such a plan, despite detainee Deniz-Sahagun’s suicide being the third at EDC since April 2013 and the fifth since 2005.”²⁵⁴ CoreCivic/CCA told Human Rights Watch that the facility has been engaged in a process of reviewing and revising the facility’s suicide prevention plan since 2013.

Notably, the Office of Civil Rights and Civil Liberties (“CRCL”) at the Department of Homeland Security, which conducts investigations of detention conditions at ICE facilities, stated in its 2015 annual report to Congress that CRCL sent ICE 49 recommendations to improve conditions at an unnamed facility in Arizona in which three deaths, including two suicides, occurred between October 2012 and April 2013.²⁵⁵ Although the facility is not named, these details make clear it is Eloy Detention Center. According to this report, it took ICE two years to respond to these recommendations, concurring with 19 of the recommendations. CRCL concluded, however, that it “[d]oes not believe that ICE responded appropriately to the other 30 recommendations.”²⁵⁶

ICE investigations into the death of Federico Mendez-Hernandez at Brooks County Detention Center also indicate a failure to act promptly to address a dangerous situation. As described previously, the ODO report found most medical care was provided by LVNs and certified medical assistants, and that one LVN recorded vital signs months after the fact “from memory.” The ODO report stated the ODO team was at the facility in September 2013, and that IHSC’s investigatory team was there in June 2013. Dr. Stern pointed out that meant an LVN who was interviewed and identified by the ODO team as making serious mistakes was still employed three months after IHSC had visited the facility. Dr. Stern emphasized the seriousness of the situation:

[T]he conditions extant at Brooks at the time of this patient’s death constituted a clear, present, and ongoing danger to the health of detainees

²⁵⁴ US Immigration and Customs Enforcement, “Detainee Death Review – Jose De Jesus Deniz-Sahagun, JICMS #201506640,” <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-denizshagun.pdf>.

²⁵⁵ US Department of Homeland Security, Office for Civil Rights and Civil Liberties, “Fiscal Year 2015 Annual Report to Congress,” June 10, 2016, <https://www.dhs.gov/sites/default/files/publications/crcl-fy-2015-annual-report.pdf> (accessed January 5, 2017).

²⁵⁶ *Ibid.*

housed at Brooks. At both these points in time—the IHSC visit in June 2013, and the ODO visit in September 2013—the teams had a responsibility to take immediate steps to take detainees out of harm’s way.²⁵⁷

ICE may have recognized the seriousness of conditions at Brooks County, even if it did not act quickly. According to a spreadsheet released on ICE’s online FOIA Library for one day, ICE detained 190 people in FY 2013 at Brooks County, 43 in FY 2014, one in FY 2015, and zero in FY 2016. The contract between ICE and Brooks County Detention Center was signed three months before Mendez-Hernandez died. Dr. Stern stated the substandard practices found in the investigation into his death would have been apparent if a thorough inspection had been done prior to entering into the contract.²⁵⁸

CRCL’s own reports make clear that it has investigated and made recommendations regarding other facilities that similarly have resulted in an inadequate or seriously delayed response from ICE. The 2015 report states that CRCL conducted site visits to an unnamed detention facility in Alabama in 2006, 2008, and 2012 “[a]s a result of numerous complaints” and made numerous recommendations for changes at the facility.²⁵⁹ ICE responded to the recommendations in 2015, concurring with most of the recommendations, but since the 2012 visit, CRCL wrote,

CRCL has opened more than 50 additional complaints related to conditions at this facility. As a result, in May 2015 CRCL sent a “super-recommendations” memorandum to ICE formally notifying them of our long-standing and continuing concerns. This memorandum also recommended that ICE develop a comprehensive plan to address the deficiencies at the facility, address the issues raised in complaints opened since the 2012 site visit, and either transition the facility to the 2011 Performance Based National Detention Standards or cease use of the facility. CRCL intends to close the complaint associated with the 2012 site

²⁵⁷ Human Rights Watch email and telephone correspondence with Dr. Marc Stern, June 8, 26, 30, and July 1-6, 2017.

²⁵⁸ Ibid.

²⁵⁹ US Department of Homeland Security, Office for Civil Rights and Civil Liberties, “Fiscal Year 2015 Annual Report to Congress,” <https://www.dhs.gov/sites/default/files/publications/crcl-fy-2015-annual-report.pdf>.

visit, and has asked ICE to address the facility’s ongoing deficiencies in its response to the 2015 memorandum.²⁶⁰

ICE’s failure to promptly address CRCL’s recommendations to fix identified problems is apparent in CRCL’s descriptions of several other facilities, including an unnamed facility in New Jersey to which CRCL makes repeat visits due to continuing complaints, and an unnamed facility in Louisiana, which CRCL investigated and sent recommendations about in 2012. ICE responded to the recommendations two-and-a-half years later, but “a large number of the responses were deemed to be either incomplete or unresponsive by CRCL.”²⁶¹

Regarding an unnamed facility in Massachusetts, CRCL states that during a follow-up visit in 2012 after a 2009 investigation, “CRCL discovered that its recommendations from December 2009 had never been provided to the facility by ICE and multiple earlier recommendations had not been addressed.”²⁶² After CRCL issued new recommendations in January 2013, ICE took another two years to respond, and 23 of the 29 responses, including recommendations involving medical care, mental health care, dental care, and suicide risk, were deemed to be either incomplete or insufficient.²⁶³

In several other investigations, CRCL reported it had made recommendations regarding other facilities, including one with “a grievance system [that] violates the 2011 Performance-based National Detention Standards,” but that ICE’s response was inadequate. In one case, CRCL wrote, “Two of the responses are inadequate and CRCL strongly disagrees with them.” CRCL reported it was continuing to work with ICE in fiscal year 2016 to address ongoing concerns identified three to four years earlier.²⁶⁴

CRCL does conclude that ICE has “adequately addressed its recommendations” and closed its complaints with regard to several facilities. However, even in some of those cases, ICE did not respond to CRCL’s recommendations for months or even years. For example, regarding the unnamed facility in New Jersey, CRCL reported it made nine recommendations to ICE in May 2012 regarding conditions of detention, including medical

²⁶⁰ Ibid.

²⁶¹ Ibid.

²⁶² Ibid.

²⁶³ Ibid.

²⁶⁴ Ibid.

care. ICE did not respond until April 2015.²⁶⁵ The CRCL also indicates ICE stopped housing people in a couple of the facilities it was investigating, but that in many cases where problems were identified, ICE responded slowly or inadequately. And as the analyses of ICE death investigations and medical records indicate, delays in fixing dangerously substandard medical practices can have severe and sometimes deadly results.

As described in the February 2016 report by the Government Accountability Office, there are multiple systems of oversight over most immigration detention facilities. The vast majority of inspection reports, CRCL recommendations to ICE, and other reports are not publicly available. But even the little that has been made public makes clear ICE often fails to act quickly or effectively to fix serious problems with medical care and other conditions of detention. As long as these facilities remain open, thousands of people, perhaps more, remain at risk.

Failure to Identify Problems

One of the principal ways ICE monitors conditions in detention facilities is through periodic inspections conducted by the Office of Enforcement and Removal Operations (“ERO”) Custody Management Division and the Office of Detention Oversight.²⁶⁶ Private companies contracted by ICE Enforcement and Removal Operations conduct these inspections using a checklist derived from the applicable detention standards.²⁶⁷ ERO inspections are used to determine whether a facility—whether government-run or private—should continue receiving funding to hold immigrants. Under a 2009 appropriations law, ICE is prohibited from continuing any contract for the provision of immigration detention services if the two most recent performance evaluations are less than “adequate.”²⁶⁸

Other components of ICE provide further oversight, including targeted medical oversight. The ODO, for example, also conducts periodic inspections and investigations into detainee

²⁶⁵ Ibid.

²⁶⁶ United States Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” February 2016, <http://www.gao.gov/assets/680/675484.pdf>.

²⁶⁷ Ibid.

²⁶⁸ National Immigrant Justice Center, “Lives in Peril: How Ineffective Inspections Make ICE Complicit in Detention Center Abuse,” <http://immigrantjustice.org/lives-peril-how-ineffective-inspections-make-ice-complicit-detention-center-abuse-o>, citing “Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009,” 110th Congress, H.R. 2638, P.L. 110-329 (accessed April 25, 2017).

deaths, including those analyzed earlier in this report.²⁶⁹ Although each monitoring mechanism does not cover every facility used by ICE, the Government Accountability Office found 99 percent of the population in fiscal year 2015 would have been in a facility subject to at least one oversight mechanism.²⁷⁰

These various oversight mechanisms, however, have often failed to identify or rectify serious problems in medical care. Inspection reports are not routinely released publicly. But the ones that are publicly available, on ICE's FOIA Library website or posted publicly by organizations who obtained them via the Freedom of Information Act, show no indication that dangerous substandard medical practices, like the unlicensed practice of medicine by low-level personnel or substantial use of isolation for individuals with mental health needs, were flagged or resulted in any penalties for the facility.

Four of the 18 deaths investigated by ODO in the 2012-2015 period occurred at Eloy Detention Center. As previously noted, the four reports identified recurring problems. In the reports for the first three deaths, which all occurred in 2012, the ODO noted there was confusion among medical and facility staff as to who had the authority to make an emergency 911 call, and in the latter two cases of Garcia-Maldonado and Guadalupe-Gonzalez, the ODO found the facility violated the 2011 PBNDS requirement of "access to specified 24-hour emergency medical, dental, and mental health services" due to this confusion. The reports for the three suicides also noted that Eloy failed to have a local suicide prevention plan, despite "detainee Deniz-Sahagun's suicide being the third at EDC since April 2013 and the fifth since 2005."²⁷¹

While significant problems with medical and mental health care at Eloy Detention Center undoubtedly predated the deaths, the ERO and ODO inspections conducted before the deaths failed to discover them. (No inspection reports after 2012 are publicly available.) The 2012 ERO report, dated January 31 to February 2, 2012, noted there was one suicide

²⁶⁹ United States Government Accountability Office, "Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care," February 2016, <http://www.gao.gov/assets/680/675484.pdf>.

²⁷⁰ Ibid.

²⁷¹ US Immigration and Customs Enforcement, "Detainee Death Review – Jose De Jesus Deniz-Sahagun, JICMS #201506640," <https://www.ice.gov/sites/default/files/documents/FOIA/2016/ddr-denizshagun.pdf>.

attempt in November 2011, and that there was appropriate policy and procedure for suicide intervention.²⁷²

A 2016 report by the American Civil Liberties Union, Detention Watch Network, and National Immigrant Justice Center, analyzed the death at Eloy of Pablo Gracida-Conte due to cardiomyopathy. The ODO investigation into his death included the conclusions of an ODO team doctor, who found “[Mr.] Gracida’s death might have been prevented if the providers, including the physician at [Eloy], had provided the appropriate medical treatment in a timely manner.”²⁷³ Yet the ODO’s 2012 inspection report, while it mentioned his death, found that people detained in Eloy were seen for sick call in a timely manner and sick call slips were effectively and expediently triaged. Eloy also passed its 2011 and 2012 ERO inspections.²⁷⁴

The inspections that occurred at York County Prison before and after Tiombe Carlos’s death in October 2013 similarly raise questions about the adequacy of ICE’s oversight system. ODO in its death review found several violations of the applicable detention standards, including a failure to create a mental health treatment plan. However, in 2011, ICE Enforcement and Removal Operations (“ERO”) inspected York and found the facility was in compliance, even while noting there had been six suicide attempts, including by one person held in ICE detention, since the previous ERO inspection.²⁷⁵ In 2014, after Ms. Carlos’s death, an ODO inspection did not mention her death nor any of the deficiencies it had found in her case, and whether these deficiencies had been corrected.²⁷⁶

The ODO review of the death of Morales-Ramos identified several problems with the care he received at Theo Lacy Facility where he was detained from March 2011 to May 2014, including that “[nursing staff] often assessed detainees without reviewing their medical record prior to or during the assessments,” and that there was no “problem list” in each

²⁷² National Immigrant Justice Center, Immigration Detention Transparency and Human Rights Project, “2012 ERO Inspection of Eloy Detention Center, January 31, 2012 to February 2, 2012,” <https://www.documentcloud.org/documents/1865593-eloy-az-2012-ero-inspection.html> (accessed January 5, 2017).

²⁷³ American Civil Liberties Union, Detention Watch Network, and National Immigrant Justice Center, “Fatal Neglect: How ICE Ignores Deaths in Detention,” <https://www.aclu.org/report/fatal-neglect-how-ice-ignores-death-detention>.

²⁷⁴ *Ibid.*

²⁷⁵ National Immigrant Justice Center, Immigration Detention Transparency and Human Rights Project, “2011 ERO Inspection of York County Prison,” October 23, 2011, <http://www.documentcloud.org/documents/2067782-york-county-pa-2011-ero-inspection.html> (accessed January 5, 2017).

²⁷⁶ US Department of Homeland Security, Immigration and Customs Enforcement, Office of Professional Responsibility, Inspections and Detention Oversight, “Office of Detention Oversight Compliance Inspection, Enforcement and Removal Operations Philadelphia Field Office, York County Prison, York, Pennsylvania,” March 18-20, 2014, <https://www.ice.gov/doclib/foia/odo-compliance-inspections/2014-York-County.pdf> (accessed January 5, 2017).

patient's medical record. But the ERO and ODO inspections from 2010 through 2013 all find that the facilities meet standards for medical care. The ERO inspection in 2010 did note there were three deaths of non-ICE inmates related to medical issues, and in 2011, noted three more deaths (one ICE, two non-ICE) related to medical issues.²⁷⁷

Other facilities in this set of death reviews similarly passed inspections before and after these immigrants' deaths.

Inadequate Grievance Procedures

Standard 6.2 of the 2011 Performance Based National Detention Standards provides guidance on the procedures detention centers should have for the filing and logging of grievances.²⁷⁸ Most, if not all, immigration detention facilities have at least three types of grievance procedures: oral/informal grievances, written/formal grievances to facility head, and written/formal grievances to ICE. In CIVIC's experience, detention facilities typically have a box for ICE and a box for the facility head so that people in immigration detention can file their formal grievances.²⁷⁹ Under current interpretations of the Freedom of Information Act (FOIA), general data on grievances submitted to the facility heads of privately-run immigration detention facilities are not accessible to the public.

Upon arrival at the facility, people in immigration detention should be informed about the facility's informal and formal grievance procedures in a language or manner they understand. However, people in immigration detention have reported to CIVIC that the grievance procedures are not usually communicated verbally to people in detention upon arrival at the facility. They usually learn about procedures from reading the Detainee Handbook or by word of mouth from other people in detention. The Detainee Handbook is usually only available in English and Spanish. Therefore, if the person is illiterate or does not speak English or Spanish, they might not even know a grievance mechanism exists. A

²⁷⁷ National Immigrant Justice Center, Immigration Detention and Transparency Project, "2010 ERO Inspection – Theo Lacy, California," <http://www.documentcloud.org/documents/2065560-theo-lacy-ca-2010-ero-inspection.html>, and "2011 ERO Inspection – Theo Lacy, California," <http://www.documentcloud.org/documents/2065561-theo-lacy-ca-2011-ero-inspection.html> (accessed January 5, 2017).

²⁷⁸ 2011 Performance-Based National Detention Standards, Section 6.2, "Grievance System," <https://www.ice.gov/doclib/detention-standards/2011/6-2.pdf> (accessed February 16, 2017).

²⁷⁹ CIVIC, as a national network of visitation programs, has more than 1,400 volunteers at 43 immigration detention facilities throughout the US who visit people in detention in-person or respond to calls at CIVIC's hotline, which receives more than 3,000 calls per month. CIVIC's understanding of how the grievance procedures work in practice is based on meetings and phone calls with thousands of immigrants in detention.

2009 report found 40 facilities failed to include any mention of a grievance policy or omitted key portions.²⁸⁰

The 2011 PBNDS states, “Staff and detainees will mutually resolve most complaints and grievances orally and informally in their daily interaction.” Numerous people in immigration detention have complained to CIVIC that facility staff and ICE encourage oral resolution by discouraging written grievances. The 2011 PBNDS states, “If an informal grievance is resolved, the employee need not provide the detainee written confirmation of the outcome, but shall document the result for the record in the detainee’s detention file and in any logs or data systems the facility has established to track such actions.” Dozens of people in detention have told CIVIC they asked for copies of the write-ups of their oral grievances and were never provided with them.

In addition to these three types of grievance procedures, the 2011 PBNDS also allows for emergency grievances, stipulating that they must be reviewed “as soon as practicable by appropriate personnel.” Moreover, people in immigration detention can submit complaints to the Office of the Inspector General at DHS through its hotline or to the Office for Civil Rights & Civil Liberties (“CRCL”) at DHS by mail. CRCL investigations, however, do not necessarily result in a quick response to the complainant. CIVIC has filed more than 125 complaints with CRCL, and has found that when CRCL decides to investigate a case, it takes approximately one year for the investigation to be completed, and the organization or individual that submitted the complaint is not provided with a report of the outcome. CIVIC has sought information on the outcome of investigations but has never received a response.²⁸¹

²⁸⁰ National Immigration Law Center, American Civil Liberties Union of Southern California, and Holland & Knight, “A Broken System: Confidential Reports Reveal Failures in US Immigrant Detention Centers, 2009, <https://www.nilc.org/wp-content/uploads/2016/02/A-Broken-System-2009-07.pdf> (accessed February 16, 2017). The report analyzed reviews by ICE covering 53 facilities, out of which 40 were found to have inadequate grievance policies. According to the report, the government was required to produce all facility reviews conducted by ICE in 2004 and 2005 in the course of litigation, but the government failed to produce all the reviews. The report states, “There is no doubt, therefore, that the detention standards violated reported and analyzed here comprise just a fraction of the violations documented by ICE in 2004 and 2005.”

²⁸¹ For example, in one case, CIVIC filed a complaint with both CRCL and the Office of Inspector General. When it sought an update, it received an email from the “Joint Intake Center” stating any information about the investigation would only be available through a Freedom of Information Act request.

Inadequate Data Collection

The 2008 and 2011 Performance-Based National Detention Standards specify that the administrator overseeing a facility’s medical care “shall implement a system of internal review and quality assurance.”²⁸² The 2000 National Detention Standards make no mention of quality assurance, but according to the National Commission on Correctional Health Care, quality assurance, defined as “a process of ongoing monitoring and evaluation to assess the adequacy and appropriateness of the care provided and to institute corrective action as needed,” is “an essential aspect of any well-run system.”²⁸³

However, the US government’s own reports into ICE’s detention system and medical care in particular have highlighted ICE’s inability to analyze data gathered through its various oversight mechanisms, or to capture all medical care grievances received through various channels. The 2016 GAO report stated that better tracking of costs, oversight mechanisms, and grievances would help ICE improve its “ability to manage and oversee the provision of medical care across facility types.”²⁸⁴

As part of its investigation, Human Rights Watch submitted four separate requests under the Freedom of Information Act in January 2016 to ICE and other components of the Department of Homeland Security on various aspects of medical care in the immigration detention system. ICE responded to each but did not respond fully to all of our questions, giving no explanation as to whether the information was exempt under FOIA or unavailable.

Even when ICE answered our questions, the information it provided was severely limited and suggests ICE is not gathering basic data on its facilities in a consistent fashion. For example, Human Rights Watch requested information on medical clinic staffing at the 100 facilities with the highest average daily population for fiscal years 2012 to 2016 in two separate FOIA requests. In response to one request, we received a spreadsheet with what appeared to be medical staffing information for 24 facilities. According to the spreadsheet, Eloy Detention Center, South Texas Detention Facility, and LaSalle Detention Center, the

²⁸² US Immigration and Customs Enforcement, “2008 Operations Manual ICE Performance-Based National Detention Standards,” <https://www.ice.gov/detention-standards/2008>, and “2011 Operations Manual ICE Performance-Based National Detention Standards,” <https://www.ice.gov/detention-standards/2011>.

²⁸³ National Commission on Correctional Health Care, “Correctional Health Care: Guidelines for the Management of an Adequate Delivery System,” December 2001, <http://static.nicic.gov/Library/017521.pdf> (accessed December 16, 2016).

²⁸⁴ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” February 2016, <http://gao.gov/products/GAO-16-231>.

field for “physician” is marked as “zero” for at three of the last five years. But it is not clear exactly what that means. The fields are inconsistent—some years are marked “FY” for fiscal year, some are marked “CY” for calendar year, and some just have the year.

In facilities where a physician is indicated, hours available are stated as “7 am – 9 pm/7 days per week.” According to Dr. Stern, it is highly unlikely one physician is working those hours. He noted further that the lack of a physician on staff is not, in and of itself, evidence of a substandard medical care system, but in his opinion, the data provided in this spreadsheet was “useless” and indicative of inconsistent definitions of key terms. The apparent lack of clear records suggested to him that ICE likely does not keep accurate records on medical staffing at its facilities.²⁸⁵

This is consistent with reports by the Government Accountability Office of ICE’s inability to analyze the outcome of its oversight mechanisms across facilities or grievances received regarding medical care throughout the system.²⁸⁶ The GAO found that data from ICE’s various oversight mechanisms are not collected in a way that allows for system-wide analysis. According to the GAO, field medical coordinators (FMCs) do site-visits of facilities that are not staffed by IHSC and hold people for more than 72 hours. FMC site visit results are stored and tracked but no overarching analysis is done by FMCs or by IHSC. Self-assessments for facilities with an average daily population of less than 10 people are not even stored in a database. Although the self-assessments provide a space to note if there are repeat findings from previous years, ICE officials do not track this information. Detention service managers (DSMs), ICE staff who are to provide “informal, on the spot guidance for corrections of minor deficiencies,” are permanently based at 42 facilities, with a roving DSM at another 11 facilities. DSMs only began tracking “key metrics from weekly narrative reports” at the start of fiscal year 2016.²⁸⁷

²⁸⁵ Human Rights Watch email and telephone correspondence with Dr. Stern, May 31, October 6 and 12, and December 13, 2016; January 17 and March 5 and 11, 2017. Shortly before publication of this report, we received a response to a separate FOIA request which also requested information on medical staffing. The documents we received did not respond fully to our request, but we received another spreadsheet listing 117 facilities and what appears to be information on the number of full and part time medical staff at each facility. This list does not include the facilities provided in the previous response we received. It is unclear why some facilities are on one list and not the other.

²⁸⁶ US Government Accountability Office, “Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care,” <http://www.gao.gov/assets/680/675484.pdf>.

²⁸⁷ Ibid.

The GAO explained, “Without such analysis, ICE management is not well-positioned to assess the medical care performance of facilities over time, by contracted standards, or by facility type; thereby, limiting ICE’s ability to plan and manage overarching changes to detainee medical care.”²⁸⁸

The GAO identified a similar failure to analyze medical complaints. There are several avenues by which individuals in detention can file a grievance regarding medical care, including the Office of Civil Rights and Civil Liberties, the Office of Inspector General, and the ICE Detention and Reporting Information Line. Medical complaints are forwarded to IHSC. But only CRCL is required to review and report on the number of complaints it receives and their disposition, and IHSC does not maintain a database that can be searched and analyzed. Rather, it uses an IHSC tasking email inbox to process and store complaints.²⁸⁹ As a result, the GAO concluded ICE is not able to readily determine the overall volume of complaints, their status, or outcome. IHSC does not analyze the facilities where complaints are most commonly filed or differences across facility type.²⁹⁰

Two Examples of Creative Medical Advocacy

Despite the documented failures of medical care in immigration detention facilities, there have been relatively few lawsuits filed against ICE or immigration detention facilities.

In part this is likely due to the low rate of legal representation among people in immigration detention. In the US immigration system, indigent persons do not have a right to court-appointed counsel, and a recent national study found only 14 percent of people in immigration detention have legal representation.²⁹¹

In part, it is likely due to the relatively few remedies available for people in immigration detention who suffer because of substandard medical care. ICE’s detention standards are not legally enforceable. Although immigration detention is a federal form of confinement,

²⁸⁸ Ibid.

²⁸⁹ Ibid.

²⁹⁰ Ibid.

²⁹¹ Ingrid Eagly & Stephen Shafer, American Immigration Council, “Access to Counsel in Immigration Court,” September 2016, https://www.americanimmigrationcouncil.org/sites/default/files/research/access_to_counsel_in_immigration_court.pdf (accessed February 16, 2017).

case law varies from state to state because each state has its own tort laws and medical malpractice laws.

Lawsuits arising out of substandard medical care in detention are extraordinarily difficult to win. Jonathan Feinberg, a lawyer who regularly litigates prisoners' rights cases explained that there exists a high standard for inadequate medical care currently in US case law. "You have to prove deliberate indifference," he explained. "[There are] a ton of cases that say as long as the medical providers do something, it's not deliberate indifference." There are also statutory limits placed on lawsuits against federal agencies.²⁹² The lawyer also pointed out that most medical care cases in correctional contexts are "reactive to bad outcomes" after a person has already died or has experienced irreversible damage to their health, and do not necessarily push the correctional system to provide the necessary and appropriate care immediately.²⁹³

Given these barriers, individuals committed to improving medical care in immigration detention facilities have turned to novel forms of advocacy. Two examples are detailed below.

CIVIC's Push for Independent Medical Oversight Boards

On May 10, 2016, CIVIC and its local affiliate First Friends of NJ & NY filed a multi-individual complaint with the Office for Civil Rights and Civil Liberties at DHS summarizing complaints from 61 women and men detained at Hudson County Correctional Facility (HCCF).²⁹⁴ The complaint includes allegations of long delays or denials in care, repeated failures by medical staff to use interpretation services for non-English speaking patients, and unlawful co-pay charges, among others. These issues were not unknown to HCCF; as the complaint noted, 121 people detained at HCCF submitted medical grievances between January 2014 and March 2016, but HCCF only took corrective action in 2.48 percent of the cases. CIVIC's complaint urged ICE to terminate its contract with HCCF or take immediate steps to improve HCCF's health care practices.

²⁹² Human Rights Watch telephone interview with Jonathan Feinberg, June 10, 2016.

²⁹³ *Ibid.*

²⁹⁴ Community Initiatives for Visiting Immigrants in Confinement, "Hudson County Correctional Facility," <http://www.endisolation.org/Hudson> (accessed December 1, 2016). See also, Nina Bernstein, "Health Care at New Jersey Immigrant Jail is Substandard, Watchdog Groups Say," *New York Times*, May 11, 2016, http://www.nytimes.com/2016/05/12/nyregion/health-care-at-new-jersey-immigrant-jail-prompts-claim.html?_r=0 (accessed December 1, 2016).

The complaint also recommended the formation of a board of independent medical observers comprised of advocates who would meet with representatives of ICE, HCCF, and Hudson County to discuss and address medical concerns.

Hudson County responded by retaining a committee to determine whether HCCF and its private health care provider CFG Health Systems were currently providing all necessary and appropriate medical services. The committee was composed of two doctors, one attorney, and one retired judge, who received financial compensation. Their report, submitted on October 24, 2016, conceded that “CFG and its medical staff have not fully complied with ICE’s and the National Commission on Correctional Health Care’s national detention standards for health services in jails.” According to CIVIC, however, it also essentially absolved Hudson County, HCCF, and CFG of any wrongdoing.

On November 15, 2016, CIVIC and First Friends of NJ & NY submitted their responses to the report, outlining their concerns over the committee’s flawed methodology, such as its reliance on unverified statements made by HCCF staff.

Notably, the committee’s report ended with an attenuated version of the advocates’ original demand, recommending the establishment of an ad hoc committee of representatives from not only advocacy organizations but also ICE, Hudson County, and the medical provider, to meet on a regular basis to discuss and address medical care concerns. Hudson County followed this recommendation and established the ICE Detainee Medical Review Ad Hoc Committee by executive order on November 3, 2016, though it did not solicit input from advocacy groups. CIVIC and other advocacy organizations were disappointed by this failure to consult and by shortcomings in the executive order, such as lack of full access to the facility for the committee and its status as a resolution rather than an ordinance, but they are hopeful that it will pave the way towards improving medical care at HCCF and consider it a transitional step towards the creation of a more permanent independent medical oversight board.

Based on evaluations of medical oversight boards for detention centers in the United Kingdom, CIVIC recommends independent medical oversight boards be comprised of non-governmental physical and mental health clinicians, advocates, and other community members. They should have the power to conduct unannounced inspections, privately talk with all detained people who are interested and willing, review data on the medical

grievances filed, investigate allegations of medical malpractice and abuse, and make policy recommendations. CIVIC plans to closely follow the development and outcomes of the ICE Detainee Medical Ad Hoc committee at HCCF, the first of its kind in the country, and fight for the establishment of independent medical oversight boards at HCCF and at other facilities as long as immigration detention continues.

New York Lawyers for Public Interest Health in Detention Program

New York Lawyers for Public Interest (NYLPI) created a Health in Detention program to address lack of access to medical care in three New Jersey immigration detention facilities that house New York City residents. Working with immigration attorneys, they conduct advocacy on behalf of individuals who are detained or who were recently detained and had a negative health outcome, and initiate impact litigation based on patterns they identify. They are also developing a network of medical providers who are available to provide medical reviews and analysis for advocacy related to lack of access to medical care in detention.

New York City is unique in funding a legal representation program for all indigent individuals in detention, through the New York Immigrant Family Unity Project. But as Laura Redman, director of the Health Justice Program, explained, even with universal representation in immigration cases there is a need for a separate medical advocacy project because immigration attorneys do not necessarily have the time or funding to conduct advocacy that is not always directly related to the immigration case.

Reena Aurora, senior staff attorney, noted that their advocacy has found more immediate success in some areas more than in others. “ICE has not been very responsive to inquiries on medical care,” she said. She noted the handful of humanitarian parole requests they made were denied. However, she stated, “We’ve been more successful with immigration judges getting bond based on medical needs, so they can go back to their community and get medical care that’s available to them.”²⁹⁵

Furthermore, because of the organization’s concerted advocacy in three facilities, they have been able to develop a more sustained analysis of patterns of poor care than individual attorneys or legal services organizations focused on immigration cases can do. In July 2016, NYLPI filed a lawsuit on behalf of two individuals against Orange County, New

²⁹⁵ Human Rights Watch telephone interview with Laura Redman, Reena Aurora, and Sola Stamm, September 20, 2016.

York, alleging county officials discharged two people with serious psychosocial disabilities from immigration detention without medication or any continuity of care discharge planning, in violation of their constitutional rights.²⁹⁶ The plaintiffs were held at Orange County Jail, the same facility as “Luke R.,” who, in the analysis above, received severely inadequate mental health care and was disciplined with solitary confinement instead of getting reasonable accommodation for his psychosocial disability.

²⁹⁶ *Charles v. Orange County*, Case No. 16-cv-5527 (US District Court, Southern District of New York), complaint, filed July 12, 2016.

V. US and International Legal Standards

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

-International Covenant on Civil and Political Rights, Article 10(1)²⁹⁷

Right to Reasonable Medical Care and Health

Right to Reasonable Medical Care Under US Law

The Eighth Amendment to the US Constitution protects all convicted prisoners from “cruel and unusual punishment” and requires corrections officials to provide a “safe and humane environment.”²⁹⁸ Prisoners have a right to health care that is not shared by the general population. As Justice Marshall explained in the Supreme Court decision, *Estelle v. Gamble*:

These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or lingering death, the evils of most concern to the drafters of the Amendment.²⁹⁹

In *Estelle*, the Supreme Court established a narrow interpretation of the Eighth Amendment, requiring prisoners to demonstrate that officials were “deliberately indifferent to serious medical needs.”³⁰⁰

People held in immigration detention, however, are not convicted prisoners. Rather, they are in civil detention, held under administrative provisions. Their constitutional protection derives from the Fifth Amendment, which prohibits the imposition of punishment upon any person in the custody of the United States without due process of law.³⁰¹

²⁹⁷ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992, art. 10(1).

²⁹⁸ *Estelle v. Gamble*, 429 U.S. 97 (1976).

²⁹⁹ *Ibid.* at 100.

³⁰⁰ *Ibid.* at 104.

³⁰¹ *Wing Wong v. United States*, 163 US 228 (1896).

Few courts have considered the precise scope of the right to health care for individuals in immigration detention, as distinct from people in other civil or pretrial detention. Many federal courts adjudicating claims of inadequate medical care brought by people in pretrial and civil detention have applied the same “deliberate indifference” standard developed under Eighth Amendment jurisprudence to these claims.³⁰² Others have argued that a distinct, and perhaps more stringent, standard should apply.³⁰³ The Court of Appeals for the Ninth Circuit has held that the conditions of confinement for people in administrative detention must be superior not only to those of convicted prisoners, but also to those of people in pre-trial criminal detention.³⁰⁴

Right to Health under International Law

Under international law, people who are detained have a right to be treated with humanity and respect for their inherent dignity, and that right includes access to appropriate medical care.

The United States is a party to the International Covenant on Civil and Political Rights (ICCPR).³⁰⁵ Under the ICCPR, governments should provide “adequate medical care during detention.”³⁰⁶

More broadly, the Human Rights Committee has explained that states have a “positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of their liberty,” stating that the deprivation of liberty itself should be the only form of punishment:

³⁰² See *Cuoco v. Moritsugu*, 222 F.3d 99 (2nd Cir. 2000) (“We have often applied the Eighth Amendment deliberate indifference test to pre-trial detainees bringing actions under the Due Process Clause of the Fourteenth Amendment.... We see no reason why the analysis should be different under the Due Process Clause of the Fifth Amendment.”).

³⁰³ See *Cupit v. Jones*, 835 F.2d 82 (5th Cir 1987) (“Today, we conclude that pretrial detainees are entitled to reasonable medical care unless the failure to supply that care is reasonably related to a legitimate governmental objective. In so holding, we recognize that the distinction as to medical care due a pretrial detainee, as opposed to a convicted inmate, may indeed be a distinction without a difference, for if a prison official acted with deliberate indifference to a convicted inmate’s medical needs, that same conduct would certainly violate a pretrial detainee’s constitutional rights to medical care. However, we believe it is a distinction which must be firmly and clearly established to guide district courts in their evaluation of future cases involving the constitutionality of all conditions imposed upon pretrial detainees.”)

³⁰⁴ *Jones v. Blanas*, 393 F.3d 918 (9th Cir. 2004), at 934. See also *Hydrick v. Hunter*, 500 F.3d 978, 994 (9th Cir. 2007) (finding that “the Eighth Amendment provides too *little* protection for those whom the state cannot punish”).

³⁰⁵ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc. A/6316 (1966), 999 UNTS 171, entered into force March 23, 1976, ratified by the U.S. on June 8, 1992, arts. 6, 7 10(1).

³⁰⁶ *Pinto v. Trinidad and Tobago* (Communication no. 232/1987), Report of the Human Rights Committee, vol. 2, UN Doc A/45/40, p. 69.

Not only may persons deprived of their liberty not be subjected to torture, or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation, but neither may they be subjected to any hardship or restraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the ICCPR, subject to the restrictions that are unavoidable in a closed environment.³⁰⁷

The Human Rights Committee has also urged states to specify in their reports whether individuals in detention “have access to such information and have effective legal means enabling them to ensure that those rules are respected, to complain if the rules are ignored and to obtain adequate compensation in the event of a violation.”³⁰⁸

The United States is also a party to the Convention Against Torture. The Committee Against Torture—the monitoring body of the Convention Against Torture—has found that failure to provide adequate medical care can violate the CAT’s prohibition of cruel, inhuman or degrading treatment.³⁰⁹

Other standards provide non-binding, but authoritative, interpretation of fundamental human rights standards for all persons in detention. The Standard Minimum Rules for the Treatment of Prisoners, the Basic Principles for the Treatment of Prisoners and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment establish the consensus that individuals in detention are entitled to a standard of medical care equivalent to that available in the general community, without discrimination based on their legal status.³¹⁰ International standards support the confinement of individuals in administrative and pre-trial detention in non-punitive conditions.³¹¹ The Body of Principles for the Protection of All Persons under Any Form of

³⁰⁷ UN Committee on Human Rights, General Comment No. 21, Article 10, Humane Treatment of Prisoners Deprived of their Liberty, UN Doc. HRI/Gen/1/Rev.1 at 33 (1994), para. 3.

³⁰⁸ UN Human Rights Committee, “Replaces general comment 9 concerning humane treatment of persons deprived of liberty,” General Comment No. 21, U.N. Doc. A/47/40 (1992), para. 7.

³⁰⁹ United Nations Committee Against Torture, “Concluding Observations: New Zealand,” 1998, UN Doc. A/53/44, para. 175.

³¹⁰ UN Standard Minimum Rules for the Treatment of Prisoners, UN General Assembly Resolution 70/175 (2015); Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111 (1990); Body of Principles for the Protection of All Persons Under any form of Detention or Imprisonment, UN General Assembly Resolution 43/173 (1988).

³¹¹ UN Standard Minimum Rules, *supra*, para.8.

Detention or Imprisonment further provides that a proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary.³¹²

In its Guidelines on the applicable criteria and standards relating to the detention of asylum-seekers and alternatives to detention, UNHCR (the UN's refugee agency), states that appropriate medical treatment must be provided where needed, including psychological counselling. Detained individuals needing medical attention should be transferred to appropriate facilities or treated on site where such facilities exist.³¹³

In some cases, state obligations to protect prisoners' fundamental rights, in particular the rights to be free from ill-treatment, the right to health, and ultimately the right to life, may require states to ensure a higher standard of care than is available to people outside prison who are not wholly dependent upon the state for protection of those rights.³¹⁴ In prison, where most material conditions of incarceration are directly attributable to the state, and inmates have been deprived of their liberty and means of self-protection, the requirement to protect individuals from risk of torture or ill treatment can give rise to a positive duty of care, which has been interpreted to include effective methods of screening, prevention and treatment of life-threatening diseases.³¹⁵

The right to health is most explicitly expressed in the International Covenant on Economic, Social and Cultural Rights (ICESCR) which states that every person has a "right to the highest attainable standard of health."³¹⁶ The United States has signed, but not ratified, the ICESCR, a position that requires the government to, at minimum, take no action that would undermine the intent and purpose of the treaty.³¹⁷

³¹² UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, *supra*, principle 24.

³¹³ UNHCR, UNHCR Detention Guidelines ("Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention") (2012), para. 48.

³¹⁴ See, Rick Lines, "From equivalence of standards to equivalence of objectives: the entitlement of prisoners to standards of health higher than those outside prisons," *International Journal of Prisoner Health*, vol 2 (2006), p. 269.

³¹⁵ See, e.g. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/IN/E2002, para. 31.

³¹⁶ International Covenant on Economic, Social, and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, *supra*, Article 12.

³¹⁷ Vienna Convention on the Law of Treaties (VCLT), adopted May 23, 1969, entered into force January 27, 1980, Article 18. The US signed the ICESCR on October 5, 1977.

Rights of Persons with Psychosocial Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) seeks to “promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.”³¹⁸ The UN Special Rapporteur on Torture has pointed out that persons with disabilities are often segregated from society in prisons as well as in other institutions. Inside these institutions, persons with disabilities “are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence.”³¹⁹ The United States has signed but not ratified the CRPD and is therefore not bound by it. The Convention is nonetheless a useful and authoritative guide to how all states should undertake to protect and respect the rights of people with disabilities.

In the context of detention centers, the CRPD principle of accessibility entails having alternative modes of communication available to interact with immigrants in detention centers who may require such support because of their disabilities. The obligation to provide accommodation and procedural accommodation also applies, including the appointment of a representative to assist them in the procedures (grievances, for example).

Further, the authorities should ensure protection of the person’s integrity, including mental health. Without due regard to their condition, some of the rules of detention centers could be harsh if applied to people with mental health conditions and may constitute ill-treatment or even torture. Isolation should be prohibited for persons with disabilities because of its potential harm to their health.

Limits on the Use of Detention for the Control of Immigration

The US government’s failure to provide adequate medical care to people in immigration detention cannot be isolated from its broader failure to maintain a limited detention system in keeping with human rights principles.

³¹⁸ Convention on the Rights of Persons with Disabilities (CRPD), adopted January 24, 2007, G.A. Res. 61/106, U.N. Doc. A/61/106 (2007), entered into force May 3, 2008, signed by the United States on July 30, 2009. The US has not yet ratified the convention, but as a signatory, may not take actions inconsistent with it.

³¹⁹ UN General Assembly, “Torture and other cruel, inhuman or degrading treatment or punishment, Note by the Secretary-General,” A/63/175, July 28, 2008, <http://www.refworld.org/docid/48db99e82.html> (accessed September 27, 2016).

Article 9 of the International Covenant on Civil and Political Rights states, “Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.”³²⁰ With regard to immigration, detention is not per se arbitrary, but the Human Rights Committee has noted “detention must be justified as reasonable, necessary and proportionate in the light of the circumstances and reassessed as it extends in time.”³²¹ The United Nations Working Group on Arbitrary Detention has argued that “immigration detention should gradually be abolished.... If there has to be administrative detention, the principle of proportionality requires it to be a last resort.”³²²

While the United States has a legitimate interest in detaining some non-citizens to guarantee their appearance at hearings and to ensure the deportation of those judged to be removable, many people in detention, including thousands of asylum-seekers, are held under statutory provisions that mandate detention without sufficient individualized review.

The Human Rights Committee has noted with regard to medical care, “Decisions regarding the detention of migrants must also take into account the effect of the detention on their physical or mental health.”³²³ The US detention system regularly detains individuals with serious medical and mental health conditions, sometimes for prolonged periods of time, in facilities ill-equipped to provide appropriate care, without sufficient consideration of the impact of detention on these individuals’ health, leading to sometimes fatal consequences.

The damaging impact of detention and substandard medical care could be greatly reduced by only detaining those who are determined, through individualized hearings, to be a threat to public safety and by making every effort to make use of alternatives to detention wherever possible.

³²⁰ ICCPR, Art. 9

³²¹ UN Human Rights Committee, General Comment No. 35, Article 9 (Liberty and Security of person), CCPR/C/GC/35 (2014), para. 18.

³²² UN Commission on Human Rights, Report of the Working Group on Arbitrary Detention, A/HRC/13/30, January 18, 2010, para. 59.

³²³ UN Human Rights Committee, General Comment No. 35, Article 9 (Liberty and security of person), para. 18.

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We thank the many immigrants and their families and the attorneys who shared their stories for this report in the hope that others would not suffer in the same way. Among the people whose stories were reported to us, some remain detained, some were deported, and some have died since our investigations began.

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Appendix I

Facilities in Which Medical Experts Found Evidence of Subpar Care in Detainee Death Reports or in Individuals' Medical Records

Name of Facility	Location	Type of Facility	Facility Operator	Medical Care Provided by ICE's Immigrant Health Service Corps?	Average Daily Population in 2016
Adelanto Detention Facility	Adelanto, California	Private Facility	Geo Group	No	1,476
Brooks County Detention Center	Falfurrias, Texas	Private Facility	LCS at time of death; Geo Group now	No	0
Eloy Detention Center	Eloy, Arizona	Private Facility	CoreCivic/CCA	Yes	1,482
El Paso County Criminal Justice Center	Colorado Springs, Colorado	County Jail	El Paso County, Colorado	No	11
Etowah County Detention Center	Gadsden, Alabama	County Jail	Etowah County, Alabama	No	261
Houston Contract Detention Facility	Houston, Texas	Private Facility	CoreCivic/CCA	Yes	945
Hudson County Correctional Facility	Kearny, New Jersey	County Jail	Hudson County, New Jersey	No	453
Hutto Detention Center	Taylor, Texas	Private Facility	CoreCivic/CCA	Yes	
Imperial Regional Detention Facility	Calexico, California	Private Facility	MTC Management and Training Corporation	No	696
Joe Corley Detention Facility	Conroe, Texas	Private Facility	Geo Group	No	798

Name of Facility	Location	Type of Facility	Facility Operator	Medical Care Provided by ICE's Immigrant Health Service Corps?	Average Daily Population in 2016
Laredo Processing Center	Laredo, Texas	Private Facility	CoreCivic/CCA	No	342
Orange County Correctional Facility	Goshen, New York	County Jail	Orange County, New York	No	169
Rio Grande Valley Staging Facility	Los Fresnos, Texas	ICE	ICE	n/a	n/a
San Bernardino Hold Room	San Bernardino, California	ICE / Under 72-Hour Facility	ICE	n/a	n/a
San Diego Contract Facility	San Diego, California	Private Facility	CoreCivic/CCA	Yes	678
South Texas Detention Complex	Pearsall, Texas	Private Facility	Geo Group	Yes	1,721
Theo Lacy Facility	Orange, California	County Jail	Orange County, California	No	428
Utah County Jail	Spanish Fork, Utah	County Jail	Utah County, Utah	No	205
York County Prison	York, Pennsylvania	County Prison	York County, Pennsylvania	No	630
Yuba County Jail	Marysville, California	County Jail	Yuba County, California	No	201