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DETENTION AND REMOVAL: IMMIGRATION DETAINEE MEDICAL CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW

OF THE

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HOUSE OF REPRESENTATIVES

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DETENTION AND REMOVAL: IMMIGRATION DETAINEE MEDICAL CARE

THURSDAY, OCTOBER 4, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP,
REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1 p.m., in Room 2141, Rayburn House Office Building, the Honorable Zoe Lofgren (Chairwoman of the Subcommittee) presiding.

Present: Representatives Lofgren, Berman, Sánchez, Conyers, and King.

Staff Present: Ur Mendoza Jaddou, Majority Chief Counsel; David Shahoulian, Majority Counsel; Andrea Loving, Minority Counsel; and Benjamin Staub, Professional Staff Member.

Ms. LOFGREN. I would like to welcome the Subcommittee Members, our witnesses, members of the public to the Subcommittee's hearing on immigration detainee medical care.

According to the General Accountability Office, GAO, nearly 300,000 men, women and children were detained by Immigration and Customs Enforcement, otherwise known as ICE, in 2006, tripling the amount of 2001 when less than 100,000 were detained.

With a large increase of detainees in ICE custody, it is incumbent upon this Congress to ensure that ICE is properly executing its responsibility of providing safe and humane treatment of detainees in their custody.

Recent reports suggest that ICE is not doing its job. In just the last few years, there have been several reports of individuals detained by ICE that suggest unsafe and inhumane treatment in ICE in contracted detention facilities.

For example, the Boston Globe recently reported the case of a man who died in ICE custody due to epilepsy complications despite the fact that his sister twice attempted to provide necessary medication to detention officials, according to his family. His sister says she was turned away both times.

Another reported case involves Victoria Arellano, who was taken off HIV drugs while in custody and subsequently died after serious complications and lack of appropriate medical care for several months. Reports indicate that fellow inmates tended to as much care as they could possibly provide on their own and repeatedly informed detention officials of Arellano's illness.

These and other cases have spawned questions from several Members of Congress, but so far few answers have been provided.

There are two critical questions I hope we can address today. First, are the medical care standards employed by ICE satisfactory so as to create an environment that supports safe and humane treatment of individuals in ICE custody? Second, if those standards are adequate, are they being implemented in an appropriate manner?

After a preliminary review of the standards and the various reports on the administration of medical care, it appears we could have problems on both levels.

The DIHS Medical Dental Detainee Coverage Services Packet specifically states that medical care in ICE detention facilities is to be provided primarily for emergency care. Care for, and I quote, "accidental or traumatic injuries incurred while in the custody and acute illnesses is not required but simply reviewed for appropriate care. Care for other illnesses, including pre-existing illnesses that are serious but not life threatening, is also not automatic but simply reviewable for appropriate care."

Furthermore, these reviews are conducted in Washington, D.C. by nurses, not physicians, who are away from the patients and simply reviewing paperwork submitted by other health care professionals recommending such care.

With this policy, it is no wonder there are reports of unsafe and inhumane medical treatment in ICE custody. This policy fails to recognize a fundamental principle of medical care in detention. The patient is detained and there is no other option but care authorized by ICE. Yet the policy only ensures emergency care and considers other care even in serious cases on a case-by-case basis.

I hope that today's hearing will help us further understand and clarify the problems that exist in providing medical care to those in ICE custody so that we may begin to find solutions to what appears to be a very serious problem.

I would now recognize our distinguished Ranking Member, Congressman Steve King, for his opening statement.

Mr. KING. Thank you. First, I want to tell you and thank you on your willingness to work together and to ensure that U.S. Immigration and Customs Enforcement has the opportunity to give its side of the story at the same time as the statements made by the other witnesses are made here and an opportunity to respond and rebut if necessary.

Earlier this week I was concerned that ICE wouldn't get that opportunity, but they will have today, and I appreciate that.

We all agree that when a person is in Government custody, he or she should receive adequate medical care. The issue before us today is whether or not ICE detainees are receiving that adequate medical care. Since American taxpayers pay over 72 million each year for ICE detainee health care, we should ensure that the care is cost effective and that it is competent.

Much has been made in media reports about the number of detainee deaths while in ICE custody. And so I began to ask some questions about that, and I think it has been reported that 25 deaths in ICE custody for the fiscal year 2004, 16 deaths in the fiscal year 2005, 17 deaths under ICE custody in 2006 and 11 in fiscal year 2007, although that may go up because I don't think we actually have the final number on that. But when you look at the

total number of ICE detainees in those years, it means the chance of death in 2004 while under ICE custody was one in 8,196.

And in 2005 it was one in 12,912. In 2006 it was one in 13,288 and so far in 2007 the chance of death while in ICE custody one in 23,146.

Those numbers don't mean very much, Madam Chair, until you compare them then to the death rate in our Federal Bureau of Prisons, which is one in 603 for 2006, one in 761 in 2007. The State prison death rate was one in 466 in 2005 and one in 464 in 2004, one in 459 in 2003.

But finally the death rate in local prisons was as high as one in 1,519 in 2005, one in 1,376 in 2004 and one in 1,425 in 2003.

And so I will recognize that this is a total number of inmates that have passed through these institutions during these periods of time. And I will recognize that there is a faster turnover during ICE incarceration than certainly our Federal penitentiary and certainly for our local institutions, but, regardless, when you make adjustments for that, it appears that the fatalities under ICE are—if they are atypical of that under other institutions, they appear that they are lower. And so those odds of death are safer in ICE institutions, by these statistics at least.

And in December of 2006, DHS Inspector General issued a report in which he found instances of noncompliance with ICE detention medical standards at four of the five detention facilities that were studied.

After that, ICE convened a working group to review the national standards and detention management control worksheets. The working group made several recommendations with ICE, and—that ICE is continuing to implement. Many of the ICE detention centers have more than adequate medical facilities. I have a couple of posters that will be on display down here that show the type of facilities at some of these centers. They seem to have updated equipment and respectable personnel.

I would just like to mention one additional point. The death rates for ICE detainees do not even come close to the accidental and illness death rates of those serving in the active duty U.S. Military. For instance, in 2006, one in 2,004 military personnel died by accident or illness. And in 2005, that was one in 1,509. And in 2004, it was one in 1,614.

So I think we need to take an objective look at this. Yes, we have a responsibility, as this Congress has accepted sometime well over 100 years ago, to provide quality health care for the inmates in all of our institutions, including the ICE detention centers, and I just ask that we want to see ICE meet those standards, meet their own guidelines, have a system in place to have that check on services that are provided, and then put it in the perspective of the fact that people don't live forever and they die in some places, and if there are reasons for that for a single individual, we ought to look into that, but I don't see at this point that the statistics support the idea that there is an endemic flaw in the ICE health care.

So I am interested in the testimony, and Madam Chair, I appreciate this hearing, and I would yield back the balance of my time.

Ms. LOFGREN. I would now like to recognize the Chairman of the Committee, Mr. Conyers, for his opening statement.

Mr. CONYERS. Thank you, Madam Chairwoman.

This is an important hearing. I am still complaining about the fact that immigration ended up in the Department of Homeland Security, but I am trying to give it up with some grace.

I am drawn to this hearing not only by the fact that immigration detention deaths are being examined out of the Immigration Customs Enforcement, but the fact that we have a Haitian presence here today. I am really pleased that we have got attorney Cheryl Little, who has been working in this area and is the head of the Florida Immigrant Advocacy Center for so many years.

When I first began going to Haiti, I was in touch with the lawyers and other leaders that were working with her on the Haitian immigration crisis. Today, we have the pleasure of having her before us and also to have the distinguished writer, Ms. Edwidge Danticat, a Haitian of great distinction in terms of our literary contributions. I am very pleased that she is here as well.

Now for me, this coincides perfectly because I am going to Haiti this weekend, and I will be joining Dr. Ron Daniels of New York and many others there. This plays into an issue, and hovering in this background is this double standard on immigration policy with reference to Haitians that come to this country.

There are two policies: There is a standard and then there is the Haitian policy. And counsel for Ms. Lofgren advises me that we are putting together a very close examination of what these two different policies are and what they mean.

This hearing is important to me for all of those reasons, and I will ask unanimous consent to put my written remarks into the record.

And thank you.

Ms. LOFGREN. Without objection, so ordered.

If the Ranking Member of the full Committee comes, he would certainly also be permitted to submit his statement.

We have been called away to votes on the floor of the House, and so we are going to go and comply with our obligation there.

I would just like to note that under the rules of this Committee, testimony is due to the Committee 48 hours in advance. Sometimes people are a little bit late but I will note that what the Government handed me was still hot when I got it coming in here, and I recall when Jim Sensenbrenner chaired the Immigration, chaired the Judiciary Committee and the head of then INS came and did the same thing, he refused to let him testify.

Now there has been a discussion. The minority is saying are we going to allow this. My inclination would be to allow it, but to note that this really falls way below what we expect of our witnesses and especially the Government with all of the resources.

So we are going to sort this out. We will have our staffs discuss it and make sure we are all on the same wavelength.

We are going to recess the hearing until a certain time so people can go get a cup of coffee or something, not just sit in the room, and we will try and be back here about 2:30, and so we will see you all then.

And we are in recess until 2:30.

[Whereupon, at 1:20 p.m., the Subcommittee was in recess, to reconvene at 2:30 p.m., this same day.]

[2:40 p.m.]

Ms. SÁNCHEZ. [Presiding.] In the interest of time, I want to apologize to our witnesses, we have no control over the vote schedule. But I appreciate your patience. And because of our busy schedules and the fact that more votes are likely to be called, I would ask that other Members submit their written statements for the record.

Without objection, all opening statements will be placed into the record.

Without objection, the Chair is authorized to declare a recess of the hearing at any point.

We have two distinguished panels of witnesses here today to help us consider the important issues before us. I am pleased to welcome Gary Mead, the assistant director of management in the Office of Detention and Removal Operations at Immigrations and Customs Enforcement. Prior to joining ICE in 2006, Mr. Mead served with the U.S. Marshal Service. He worked as the associate director for administration, the associate director for operations support, and the assistant director for management and budget. He holds his bachelor's degree from the State University of New York, a master's from Bowling Green State University, and graduated from the management program of the National Defense University here in Washington. Welcome, Mr. Mead.

Mr. Mead is joined by Dr. Timothy Shack, medical director at the Immigrant Health Services to assist in responding to any questions that we may have for Mr. Mead.

Mr. Mead and Dr. Shack, again, thank you for joining us. We have just gotten a bell, but I am going to ask you to go ahead and begin your testimony because I think we should be able to accommodate your testimony before we head across for votes.

At this time I would invite you to give us your oral testimony.

TESTIMONY OF GARY E. MEAD, ASSISTANT DIRECTOR FOR DETENTION AND REMOVAL, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, ACCOMPANIED BY TIMOTHY SHACK, M.D., MEDICAL DIRECTOR, IMMIGRANT HEALTH SERVICES

Mr. MEAD. Thank you, Madam Chairman and distinguished Members of the Subcommittee, it is my privilege to appear before you to discuss the medical care of immigration detainees.

DRO's core mission is the apprehension, detention, and removal of deportable aliens. In carrying out our mission, one of our highest priorities is to provide the best possible health care to those in our custody.

DRO partners with the U.S. Public Health Service's Division of Immigration Health Services to provide detainee health care. DIHS includes more than 600 doctors, nurses, and other health care professionals. During fiscal year 2007, DRO spent almost $100 million on detainee health care to ensure the highest quality health care, DIHS medical facilities must be in compliance with the applicable health care standards from the American Correctional Association, the National Commission on Correctional Health Care, the Joint Commission, and the ICE National Detention Standards.

During fiscal year 2007, approximately 300,000 individuals passed through ICE custody. Approximately 25 percent of these de-

tainees had chronic health care problems including hypertension and diabetes. Many of these detainees first learned of these conditions as a result of the health screening and medical exams they received while being processed into custody. They received the appropriate medical treatment for their conditions that they would otherwise not likely have received.

ICE health care policy requires that all detainees receive an initial health screening upon arrival at a detention facility to determine the appropriate medical, mental health, or dental treatment that is needed. Included in this process is either a chest x-ray or a skin test for TB. Immediate attention is provided to those detainees who present a danger or immediate risk to themselves or others, such as infectious diseases, uncontrolled mental health disorders, or conditions that would deteriorate if not immediately seen by medical personnel.

Detainees also receive a physical examination within 14 days of arrival to identify medical conditions requiring monitoring or treatment. A detainee with a medical condition requiring followup treatment will be scheduled for as many appointments as needed, including to outside medical providers or facilities.

ICE standards also require that all detainees have access to sick call. Procedures are in place to ensure that all sick call slips are received by the health care service provider in a timely manner. All facilities are required to have regularly scheduled times when medical personnel will be available to see detainees. In emergencies, medical staff or 911 are called immediately.

During fiscal year 2007, as of June 30, DIHS completed more than 518,000 total medical visits, including 138,000 intake screenings, 12,000 dental visits, 16,000 mental health visits, 41,000 short stay unit visits, 134,000 chronic disease visits, 64,000 physical exams, 71,000 sick call visits. By July 31 of last fiscal year, DIHS had filled more than 170,000 prescriptions and completed more than 427,000 pill line distributions. By the end of August 2007, DIHS had completed more than 124,000 x-rays.

The DIHS managed care program has a benefit package described in the health care services available to all ICE detainees. The services address imminent threats to life, limb, hearing, or sight, rather than elective or nonemergency conditions. Conditions that would cause suffering or deterioration of a detainee's health are also covered. This program has a network of more than 500 hospitals, 3,000 physicians, and 1,300 other health care facilities that provide a wide range of medical services.

Detainees who require medical care beyond what can be provided at the detention facility access that care through treatment authorization requests. TARs are submitted to the DIHS managed care program. More than 40,000 TARs are submitted each year. The average turnaround time for a TAR is 1.4 days, with 90 percent being approved. Specialized procedures regularly approved through the TAR process include heart surgery, cancer treatment, dialysis, and a variety of general surgical procedures including gallbladder, appendicitis, and orthopedics.

Before I conclude, I would like to make a few quick comments regarding detainee deaths. During the past 4 years, approximately 1 million people have passed through our custody. Unfortunately,

66 have died. We are always saddened by the death of a detainee. DRO reports all death to the Office of Professional Responsibility, the DHS Office of the Inspector General, local medical authorities or coroners who frequently perform autopsies. DIHS also conducts an independent review of all custody deaths.

I would like to thank you, Madam Chairman and Members of the Subcommittee, for the opportunity to appear before you today, and I look forward to answering any questions you may have.

[The prepared statement of Mr. Mead follows:]

PREPARED STATEMENT OF GARY E. MEAD

Good afternoon, Chairwoman Lofgren and distinguished Members of the Subcommittee. My name is Gary Mead, and I am the Assistant Director of Detention and Removal Operations (DRO) at U.S. Immigration and Customs Enforcement (ICE). It is my privilege to appear before you to discuss the medical care and treatment of immigration detainees.

DRO's core mission is the apprehension, detention, and removal of inadmissible and deportable aliens. In carrying out our mission, one of our highest priorities is to provide the required health care to those in our custody. We take this responsibility very seriously and have created an outstanding detainee health care program, of which we are very proud.

DRO partners with the U.S. Public Health Service's (PHS) Division of Immigration Health Services (DIHS) to provide or arrange health care for ICE DRO detainees. DIHS staff consists of more than 600 doctors, nurses, and other health care professionals. During Fiscal Year 2007, DRO spent almost $100 million on detainee health care.

To ensure the highest quality of health care delivery services, DIHS medical facilities must be in compliance with applicable health care standards from the American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCHC), the Joint Commission, and the ICE National Detention Standards.

During Fiscal Year 2007, approximately 300,000 individuals passed through ICE custody.

At a minimum, two examinations must be performed on every detainee. It should be noted that approximately 25% of these detainees have chronic health care problems, including hypertension and diabetes. Many of these detainees first learn of these conditions as a result of the health screening and medical examinations they receive while being processed into custody. They then receive the appropriate treatment for their condition that they would have otherwise not likely have received.

ICE health care policy requires that all detainees receive an initial health screening immediately upon arrival at a facility to determine the appropriate medical, mental health, and/or dental treatment that is needed. Included in this process is either a chest x-ray or skin test for tuberculosis. Immediate attention is provided to detainees who present a danger or an imminent risk to themselves or others, such as infectious diseases, uncontrolled mental health disorders, or conditions that would deteriorate if not addressed immediately by medical personnel.

In addition to the initial health care screening, ICE policy also requires that detainees receive a health appraisal and physical examination within 14 days of arrival to identify medical conditions that require monitoring or treatment. A detainee with a medical condition requiring follow up treatment will be scheduled for as many appointments as needed. Scheduled visits include appointments made in advance for ambulatory care or specialty care clinics. Unscheduled visits are performed as needed to attend to emergent or urgent conditions.

During screenings, evaluations, and visits, a medical professional assesses the detainee's health and treatment requirements and arranges any medications, consultations, or other services needed. If language difficulties prevent the health provider or officer from directly communicating with a detainee for purposes of completing a medical screening or health evaluation, the officer is required to obtain translation assistance. ICE most commonly provides translation services through our contracts with AT&T and Languages Services Associate, Inc.

In addition to the initial screening and medical evaluation, the ICE standard on Medical Care requires that all detainees, regardless of classification, have access to sick call. Detainees have the opportunity to request health care services provided by a physician or other qualified medical officer in a clinical setting. Procedures are in place to ensure that all request slips are received by the health service provider in a timely manner.

The sick call process allows detainees to access non-emergent medical services, and all facilities are required to have regularly scheduled times when medical personnel will be available to see detainees who have requested services. For emergent or urgent medical services, detainees may notify a correctional officer or other facility personnel at any time that a problem occurs, and medical staff or 911 will be called immediately.

In Fiscal Year 2006, DIHS staff had more than 491,000 detainee visits. These visits included 16,000 dental, 17,000 mental health, 28,000 short stay unit visits, 150,000 chronic disease visits, 54,000 physical exams, 61,000 sick call visits, and 327,000 pill line distributions. DIHS also completed more than 103,000 chest x-rays during intake screening.

As of June 30, 2007, DIHS showed an increase in total caseload with more than 518,000 total visits, broken down as 138,000 intake screenings, 12,000 dental, 16,000 mental health, 41,000 short stay unit visits, 134,000 chronic disease visits, 64,000 physical exams, 71,000 sick call visits, and 427,000 pill line distributions.

Medical care provided at each detention facility also includes access to necessary prescription medications. Prescriptions written for detainees by the health service provider are filled either by an on-site pharmacy or by a local community pharmacy. If a prescription medication is not readily available and a detainee has a supply of the medication needed or can obtain a supply of the medication from a family member, that medication may be used as long as the facility's medical staff can verify the validity of the medication to ensure it is appropriate for the detainee to take and to prevent contraband from entering a facility. By July 31, DIHS had filled more than 170,000 prescriptions, already exceeding the more than 136,000 prescriptions filled in Fiscal Year 2006. By the end of August 2007, DIHS had completed more than 124,000 chest x-rays.

The ICE Medical Program has an established covered benefits package that delineates the health care services, medical products and treatment options available to any and all detainees in ICE custody. The ICE covered services package emphasizes that benefits are provided for conditions that pose an imminent threat to life, limb, hearing or sight, rather than to elective or non-emergent conditions. Medical conditions which the local treating physician believes would cause suffering or deterioration of a detainee's health are also assessed and evaluated through the DIHS Managed Care Program. The DIHS Managed Care Program has a network of more than 500 hospitals, 3000 physicians, and 1300 other health care facilities that provide a wide range of medical care and services.

Detainees who require medical care beyond what can be provided at their detention facility, access that care through Treatment Authorization Requests (TARs), which are submitted to the DIHS Managed Care Program. More than 40,000 TARs are submitted each year. The average turnaround time for a TAR is 1.4 days with 90 percent of requests being approved. Specialized procedures regularly approved through the TAR process include heart surgery, cancer treatment, dialysis, and a variety of general surgical procedures including gall bladder, appendicitis, and orthopedics. In fiscal year 2006, there were 465 hospital admissions.

Before I conclude, I would like to make a few comments regarding ICE detainee deaths. During the past four years approximately 1 million persons have passed through our custody. Unfortunately, 64 have died. We are always saddened by the death of a detainee in our custody.

DRO reports all detainee deaths to the ICE Office of Professional Responsibility (OPR) and the DHS Office of the Inspector General (OIG) so that they have an opportunity to determine if an investigation into the circumstances of the detainee's passing is warranted. Deaths are also routinely referred to the local medical examiner or coroner's office who will conduct an autopsy if required. DIHS also conducts an independent review of all in-custody deaths.

While a single death of an ICE detainee is serious matter, the ICE Detainee Health Program has an overall death rate that is well below those in comparable detention or correctional settings. ICE detainee death rate per 100,000 detainees, based on the number of detainees booked into custody per Fiscal Year, was ten deaths in Fiscal Year 2004; seven deaths in Fiscal Year 2005; and seven deaths in Fiscal Year 2006. The comparatively low death rate among ICE detainees is remarkable, given that many of the ICE detainees have a history of poor or no health care before coming into ICE's custody.

In conclusion, our comprehensive detainee health program is based on state of the art medical care, sound management, continuous review and process improvement. DIHS staff consists of highly motivated correctional health care professionals who are dedicated to providing high quality services. The scope of ICE's medical services and operational processes is continually monitored by both internal and external healthcare experts with the ultimate goal of providing the best possible health care

to those in our custody. As I mentioned at the start of my statement, the well being of our detainees is among our highest priorities and we take this responsibility very seriously.

I would like to thank you, Ms. Chairwoman and Members of the Subcommittee, for the opportunity to appear before you today, and I look forward to answering any questions you may have.

Ms. SÁNCHEZ. Thank you for your testimony, Mr. Mead. Unfortunately, the bells beckon and we have votes on the floor. I think this is a natural point in time to take a break to head over for votes. When we come back, we will begin with questioning, and we appreciate that both of you will be available for that. Again, I beg your indulgence and I recognize your patience, and we will be back from voting as quickly as possible.

We stand in recess.

[Recess.]

Ms. LOFGREN. [Presiding.] The Subcommittee will come back into order.

At this point I understand that the testimony has been concluded, and we will go into questions for our witnesses; and I would turn first to the Ranking Member, Mr. King, for his 5 minutes of questions.

Mr. KING. Thank you, Madam Chair.

And, Mr. Mead, thanks for your testimony.

As I look through some of the material that you provided preliminarily to your testimony being submitted, I notice here that of the—in this material, it says 27,500. I think you testified 30,000 would be the number of beds that are available in a given year. So that would be the snapshot of the number of inmates that you could max out at.

I am presuming that. I will let you define that more precisely in a moment.

But as I also look at this information, it says 65 percent are located in State and local prison jail facilities, 19 percent are in commercial contract facilities and 14 percent are in ICE-owned service processing centers; that leaves another 2 percent there for the Federal Bureau of Prisons.

My question is, of these fatalities that are the subject of this hearing, how many of those fatalities took place in the State and local prisons that are—represent the 65 percent of the overall inmates; how many took place in ICE commercial—in the commercial facilities; how many took place in ICE facilities? Can you break that down?

Also, I would presume that the medical care in those State and local-run facilities—at 65 percent, I would presume that medical care would be identical to that of the other inmates that are incarcerated in the same facilities.

Could you shed some light on those components as part of the question that I have asked you?

Mr. MEAD. Yes.

Off the top of my head, I can't break down those 66 between State and local contract or Government-owned and operated, but the 66 were the total deaths from everyone in our custody.

The State and local facilities in most cases come under the same accreditation requirements as the Federal facilities do, and they

answer to State authorities, county authorities; and many, as I said, have exactly the same accreditation as ours.

In addition, when it comes to housing our detainees, they must be in compliance with our ICE detention standards; and those detention standards are applied to our own facilities, our contract facilities, and the State and local facilities.

So you are correct that the care received across the board is relatively consistent.

Mr. KING. Do those health care practitioners, though, in our State and those that—of that 65 percent, say, primarily in our State institutions and the local, are they the same health care providers in most instances as they are for the other inmates in the same institution?

Mr. MEAD. Yes. Whatever health care program county inmates, for example, are afforded and whoever is providing that health care—our detainees are ICE detainees—get the same medical program.

Mr. KING. Then if there is an issue here of, I will say, an unusual number of deaths, which I don't know that the statistics support—if there is an issue here, wouldn't it be an issue then that cast that same question for the balance of the inmates within those facilities that two-thirds of the ICE inmates are incarcerated in?

Mr. MEAD. Yes. If there were an aberration there, it would be applied across the same or the entire population at that county facility, because our detainees do not get special health care while in there.

However, if there is health care required beyond what the county jail can provide, we do manage that centrally through DIHS, and we can remove them from that facility and provide health care elsewhere. And it is not a reflection on the county; it is just a reflection on what their——

Mr. KING. I will submit at least one question to be answered after this hearing, at least one, and that one will be the question that asks you to break down those deaths into those categories which are ICE facilities and those which are ICE-approved facilities.

Within those actually four different categories, I ask you, do those deaths include suicides or homicides?

Mr. MEAD. They include suicides; and during the past 4 years, we have not had a homicide.

Mr. KING. Can you tell me how many are suicides out of the 66?

Mr. MEAD. I would say it is approximately 13 over the past 4 years. I can confirm that after the fact, but I would say it is about 13.

Mr. KING. Thirteen of 66. And then the numbers that show the deaths for 2007 shows 11 with the data that I have. Is that a current number and does that complete the fiscal year?

Mr. MEAD. As far as I know, that completes the fiscal year.

Mr. KING. So that would indicate the numbers that trend—I shouldn't say "trend" because we only have a 4-year snapshot for me, 16, 17 and then one number larger than that down to 11. If one could draw a trend, that would indicate that it is going at least in a positive direction.

Mr. MEAD. Yes, sir.

Mr. KING. I would make that point.

And then, as you transition, you have also written information here that shows a number, about 254,000 total, that were processed by ICE, and your testimony says 300,000.

What is the right number?

Mr. MEAD. Hopefully, the 254 would have either been the last fiscal year or a year-to-date number. Our 2007 number in terms of passing through our custody is approximately 300,000.

Mr. KING. And these inmates are being processed through—it takes time to process them. If you could process them more quickly, would that have an effect on the number of inmate deaths that you have?

Mr. MEAD. Conceivably, the average length of stay in our custody would be a factor, certainly on illnesses that are, what, related to longer term care.

Mr. KING. Mr. Mead, I would just ask you to reflect upon—you heard my opening statement with regard to the number of deaths in our U.S. military, nonrelated to hostilities, and those numbers being higher than the numbers of the inmates in ICE care; and the balance of the statistics that were part of that opening statement that I made, how do you explain that—that, apparently, if your interest is to improve the statistical odds of your survival, joining the military in a time not of war seems to be statistically, or being a part of a—let me just say that compared to being an ICE inmate—I would like to hear you respond to that.

Mr. MEAD. I am not in a position to comment on the military issue, but the ICE health care program is an extremely robust program.

We do a lot of screening. As I mentioned in my opening statement, last year DIHS completed over 500,000 medical visits for the detainees in our custody. Many of our detainees receive almost daily attention.

So it is an aggressive program, and we do everything possible to maintain the best quality of life for the detainees in our custody.

Mr. KING. Thank you.

Madam Chair, I yield back.

Ms. LOFGREN. I will be very brief because I know we have another panel that has been waiting all afternoon. I just want to make one comment, and I will have one question.

Before I was in Congress, I served on the Board of Supervisors in Santa Clara County, the fourth largest county in California, and one of my jobs was to oversee the county jail, then one of the largest jails in America. And a major focus was the medical care that needed to be provided because once you have somebody in custody, it is all on you. They can't go to another doctor.

You take up whether they are charged with murder or jaywalking, you have the same obligation for their care. And I would just note that when I was in charge of that, we didn't have to call Washington, D.C., to get permission for treatment of an inmate in the county jail as the—as is the case for ICE detainees.

So to say the two populations are being treated the same, simply is incorrect and I think very misleading. I would also like to note some skepticism that I have about your testimony.

On page 6 you note that the DRO reports all detainee deaths to the ICE Office of Professional Responsibility and the DHS Office of the Inspector General. However, we have a letter from the Inspector General of DHS to Senator Dayton, just last year, 1 year ago, where he pointed out—and I won't mention the woman's name because I don't know whether there is a privacy issue—but Ms. X had died, but we were unaware of her death until the complaint was received from the complainant some number of months later. So I guess it makes me skeptical about the testimony that you have given to us.

And finally, I have this question: For the deaths that are reported, does it include individuals who are released and then expire for the lack of treatment they received in custody or only those who die while they are actually in your facilities?

Mr. MEAD. Well, not necessarily in our facilities. They could still be in our custody and at a hospital, but those who die later are not included.

Ms. LOFGREN. And the stories that we have, it is not years later; it seems to be a direct cause of the neglect received in the facility.

At this point—my time has not expired, but it is already 3:30, and there are no other Members to ask, I would thank you for being here for your testimony. Note that the record is open for 5 days and additional questions may be forthcoming, and if they are, we would ask that you answer them promptly.

Thank you very much. I thank all of you for your willingness to be here today and for your patience for all of the votes that we had on the floor.

We will now call the next panel.

Seated first on the panel, we would like to extend a warm welcome to Francisco Castaneda, a former ICE detainee. Mr. Castaneda immigrated to the United States from El Salvador with his family in 1982 at the age of 10 to escape that nation's civil war.

His family moved to Los Angeles where he went the school and began working at the age of 17.

Mr. Castaneda has a 14-year-old daughter, who is with us here today, and has celebrated his 12th anniversary with his girlfriend, Cynthia.

He entered ICE's custody in March of 2006 and will tell us about it.

Next, we are joined by Edwidge Danticat, the renowned American author and niece of the Reverend Joseph Danticat, a deceased detainee. She was born in Haiti and moved to the United States to join her family at the age of 12.

She has written several critically acclaimed books including Breath, Eyes, Memory, an Oprah Book Club section; Krik!Krak!, a National Book Award finalist; and the Farming of Bones, an American Book Award winner. She earned her bachelor's degree from Barnard College and her MFA from Brown University.

I would like to extend a welcome to June Everett, the sister of Sandra Kenley, a deceased ICE detainee. Ms. Everett and her sister grew up in Barbados. Ms. Kenley raised Ms. Everett and her two other siblings while their mother worked to provide for their family.

Ms. Everett, a U.S. Citizen, currently resides outside of Washington in New Carrollton, Maryland, and has become an advocate for ICE detainee family members since her sister's death.

Next, I am pleased to introduce Tom Jawetz, an immigration detention staff attorney with the American Civil Liberties Union.

Prior to his work as an immigration detention staff attorney, Mr. Jawetz worked on the ACLU's National Prison fellowship and the Immigrant and Refugee Rights Project at the Washington Lawyers Committee for Civil Rights and Urban Affairs. He clerks for U.S. District Court Judge Kimba Wood of New York and served as an AmeriCorps member in South Carolina.

Mr. Jawetz graduated with honors from both Dartmouth College and the Yale University School of Law.

I am also pleased to welcome Dr. Allen Keller, an Associate Professor of Medicine at the New York University School of Medicine and Director of the Bellevue/NYU Program for Survivors of Torture.

Dr. Keller also directs NYU's School of Medicine Center for Health and Human Rights, chairs the policy committee of the National Consortium of Torture Treatment Programs and served on the American College of Physicians Ethics and Human Rights Committee. He additionally worked as a source advocacy fellow with Human Rights First and led a study on asylum seekers at the request of the U.S. Commission on International Religious Freedom.

He completed his medical education and residency at NYU and served as the hospital's Chief Resident in the early 1990's.

And finally we would like to welcome Cheryl Little,

the Cofounder and Executive Director of Florida Immigrant Advocacy Center, or FIAC. FIAC, based in Miami, provides free legal assistance to immigrants of all nationalities.

Ms. Little began her career in immigration law with the Haitian Refugee Center after graduating with her bachelor's degree from Florida International University and her law degree with honors from the University of Miami's School of Law.

Well, thank you all for your willingness to tell us your stories and to give us your information and share your expertise. Each of your written statements will be made part of the record in its entirety.

We would ask that you summarize your testimony in about 5 minutes, and there is a machine that is not—it is hidden but when 4 minutes have gone by, a yellow light will go on. That means you have got 1 minute more. When the red light goes on, it means your time is up; and we would ask, if at all possible, you summarize so we can hear the other witnesses. And then we will have questions.

So we will start, if we could, with Mr. Castaneda for your 5 minutes of testimony.

TESTIMONY OF FRANCISCO CASTANEDA, FORMER DETAINEE

Mr. CASTANEDA. Good afternoon. Thank you to the Chairwoman Lofgren for inviting me to——

Ms. LOFGREN. Could we move the mike?

Mr. CASTANEDA. Thank you to the Chairwoman Lofgren for inviting me and to the Immigration Subcommittee for holding this hearing.

My name is Francisco Castaneda. I was held in immigration detention over 2 months and was just released this past February, due to my medical condition, after many letters from the ACLU were sent on my behalf.

First, I would like to tell you a little bit about myself.

I am 35 years old. I came to the United States from El Salvador with my mother and siblings when I was 13 years old to escape from the civil war. My family moved to Los Angeles where I went to school and began working at the age of 17. My mother died of cancer when I was pretty young before she was able to get us legal immigrant status.

After my mom died, I looked to my community for support and found myself wrapped up in drugs instead, which today I deeply regret. I worked doing construction up until I went to prison on a drug charge, where I spent just 4 months before I was transferred into ICE detention.

When I entered ICE custody at the San Diego Correctional Facility in March 2006, I immediately told them I had a very painful lesion on my penis. After a day or two, Dr. Walker examined me and recognized that the lesion was a problem. He said he would request that I see a specialist right away. But instead of sending me directly to a specialist, I was forced to wait and wait and wait.

All the while, my pain got worse. I started to bleed even more and it smelled really bad. I also had discharge coming out of it. Dr. Walker submitted a request to the Division of Immigration and Health Service. After more than a month, it was finally granted.

When I saw an oncologist, he told me it might be cancer; I needed a biopsy. He offered to admit me to a hospital. He admitted me for the biopsy, but ICE refused to permit a biopsy and told the oncologist that they wanted to try a more cost-effective treatment.

I was then referred to a urologist, but I only got to see the urologist 2½ months later, after I filed a request and a grievance with ICE. The urologist said I needed an incision to remove the lesion and stop the pain and bleeding, and also said I needed biopsy to figure out if I had cancer. ICE and the Division of Immigration Health Services never did either of those things. They said that it was "elective surgery."

My pain was getting worse day by day. When you are in detention, you can't help yourself. I tried to get medical help every day. Sometimes I would show the guards my underwear, the blood on it, to get them to take me to medical; but they would say they couldn't help me for nothing.

Several more requests for biopsy were denied. They told me in writing that I couldn't get the surgery after—they told me I could get the surgery after I left the facility and was deported.

In late November 2006, I was transferred from San Diego to San Pedro Service Processing Center. When I got there, I immediately filed sick call slips about my problem. After a few days I saw a doctor. I told him about my pain and showed them the blood in my boxer shorts and asked them to examine my penis. They didn't

even look at it. One of them said I couldn't be helped because I needed elective surgery.

In the middle of December, I noticed a lump in my groin. It hurt a lot. It was a little bit smaller than a fist, so I filed a sick call slip about it. I never got any treatment for it. I later found out it was a tumor; the cancer had already spread.

In beginning of January, they put me in handcuffs and leg shackles and drove me to the emergency room. When I got there, the officer tried to find someone to see me. But he was told I would have to wait in line like everybody else. After about an hour over the following time, all chained up, they took me back to San Pedro, and I never got to see no one.

Back when I was in San Diego, another detainee give me the phone number from the ACLU and said, They might be able to help you. I called them and spoke with them and told them about my story and about how much pain I was in. When I got to San Pedro, he sent letters and called the people at the facility to try to help me get medical care.

Finally, around the end of January, Immigration agreed to let me get a biopsy. They made an appointment with the doctor. But just before the surgery, they released me from custody. A doctor actually walked me out of San Pedro and told me I was released because of my serious medical condition. The first thing I did was call a doctor to see whether I could still get my biopsy; the secretary told me I had canceled it.

I then went back to emergency room at Harbor-UCLA on my own and I waited to see the doctor and finally got my biopsy. A few days later, the doctor told me I had cancer, I would have to have a surgery right away to remove my penis. They said if I didn't have the surgery, I would be dead in less than 1 year.

On February 14th, Valentine's Day, after I was released from custody, I had the surgery to remove my penis. Since then I have been through five aggressive week-long rounds of chemotherapy. The doctor said my cancer spreads very fast—it had already spread to my lymph nodes.

I am sure you can imagine how this feels. I am a 35-year old man with my life on the line. I have a young daughter, Vanessa, who is only 14. She is here with me today because she wanted to support me and because I want her to see her father do something for the really good so that she would have that memory of me. The thought that her pain and mine could have been avoided almost makes this too much to bear.

I have to be here today because I am not the only one who didn't get the medical care I needed. It was routine for the detainees to have to wait weeks or months to get basic care. Who knows how many tragedies can be avoided if ICE only remembers that regardless of why a person is in detention and regardless of where they will end up, they are still humans and they deserve basic care, humane medical care.

In many ways, it is too late for me; short of a miracle, the most I can hope for are for some good days with Vanessa and some justice. My doctors are working on my good days; and thankfully, my attorneys at Public Justice here in Washington, Mr. Conal Doyle in California, and the ACLU are working on the justice not just for

me but for many others who are suffering and who will never get the help unless ICE is forced to make major changes in the medical care provided to immigrant detainees.

I am here to ask each of you, the Members of the Congress, to bring an end to the unnecessary suffering that I and too many others have been forced to endure in ICE detention.

Thank you for your time.

Ms. LOFGREN. Thank you. Thank you, Mr. Castaneda for your willingness to be here and to explain your tragic experience.

[The prepared statement of Mr. Castaneda follows:]

PREPARED STATEMENT OF FRANCISCO CASTANEDA

Presentation on Medical Care and Deaths in ICE Custody
Francisco Castaneda

For a Hearing on "Detention and Removal: Immigration Detainee Medical Care" before the House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law

October 4, 2007

Good afternoon. Thank you to Chairwoman Lofgren for inviting me, and to the Immigration Subcommittee for holding this hearing. My name is Francisco Castaneda. I was held in immigration detention for over 10 months, and was just released this past February due to my medical condition, after many letters from the ACLU were sent on my behalf.

First, I would like to tell you a little bit about myself. I am 35 years old. I came to the United States from El Salvador with my mother and siblings when I was ten years old to escape from the civil war. My family moved to Los Angeles where I went to school and began working at the age of 17. My mother died of cancer when I was pretty young, before she was able to get us all legal immigration status. After my mom died, I looked to my community for support, and found myself wrapped up in drugs instead, which, today, I deeply regret. I worked, doing construction, up until I went to prison on a drug charge, where I spent just four months before I was transferred into ICE detention.

When I entered ICE custody at the San Diego Correctional Facility in March 2006, I immediately told them I had a very painful lesion on my penis. After a day or two, Dr. Walker examined me and recognized that the lesion was a problem. He said he would request that I see a specialist right away.

But instead of sending me directly to a specialist, I was forced to wait, and wait, and wait, and wait. All the while, my pain got worse. It started to bleed even more and smell really bad. I also had discharge coming out of it. Apparently the Division of Immigration Health Services was deciding whether to grant the request. Dr. Walker submitted the request more than once and, after more than a month, it was finally granted. When I saw an oncologist he told me it might be cancer and I needed a biopsy. He offered to admit me to a hospital immediately for the biopsy, but ICE refused to permit a biopsy and told the oncologist that they wanted to try a more cost-effective treatment.

I was then referred to a urologist, Dr. Masters, but I only got to see that urologist two-and-a-half months later, after I filed sick call requests and grievances with ICE. The urologist said I needed a circumcision to remove the lesion and stop the pain and bleeding, and also said I needed a biopsy to figure out if I had cancer. ICE and the Division of Immigration Health Services never did either of those things. They said that it was "elective surgery."

My pain was getting worse by the day. When you are in detention, you can't help yourself. I knew I had a problem, but with everything you have to ask for help. I tried to get medical help everyday. Sometimes I would show the guards my underwear with blood in it to get them to take me to medical, but then they would say they couldn't do anything for me. All they gave me was Motrin and other pain pills. At one point, the doctor gave me special permission to have more clean underwear and bedsheets, because I was getting blood on everything. A guard from my unit once told me he would pray for me because he could see how much I was suffering.

Several more requests for a biopsy were denied. They told me in writing that I could get the surgery after I left the facility—when I was deported.

In late November 2006, I was transferred from San Diego to the San Pedro Service Processing Center. When I got there I immediately filed sick call slips about my problem. After a few days I saw the doctors. I told them about my pain and showed them the blood in my boxer shorts and asked them to examine my penis. They didn't even look at it—one of them said I couldn't be helped because I needed "elective surgery." They just gave me more pain pills.

In the middle of December, I noticed a lump in my groin. It hurt a lot and was a little bit smaller than a fist, so I filed a sick call slip about it. Another detainee told me it could be a hernia. I never got any treatment for it, and I later found out that was a tumor, because the cancer had already spread.

In the beginning of January, one of the guards told me I was going to Harbor-UCLA Medical Center. They put me in handcuffs and leg shackles and drove me in a van to the emergency room. When I got there the officer walked all around trying to find someone to see me, but he was told I would have to wait in line like everyone else. After about an hour of following him all chained up, he took me back to San Pedro and I didn't get to see anyone.

Back when I was in San Diego, another detainee gave me the phone number for the ACLU and said they might be able to help me. I called them, and spoke with Mr. Tom Jawetz, here, and told him my story and about how much pain I was in. When I got to San Pedro he sent letters and called the people at the facility to try to help me get medical care. Finally, around the end of January, immigration agreed to let me get a biopsy. They made an appointment with the doctor, but just before the surgery they released me from custody. A doctor actually walked me out of San Pedro and told me I was released because of my serious medical condition and he encouraged me to get medical attention.

The first thing I did was call the doctor to see whether I could still get my biopsy. The secretary told me ICE had cancelled it. I then went back to the emergency room at Harbor-UCLA—the same place they had left me in the waiting room in shackles—and I waited to see a doctor and finally get my biopsy. A few days later, the doctor told me that I had cancer, and would have to have surgery right away to remove my penis. He said if I didn't have the surgery I would be dead within one year. On February 14—Valentine's Day—nine days after ICE released me from custody, I had the surgery to remove my penis. Since then, I have been through five aggressive week-long rounds of chemotherapy. Doctors said my cancer spreads very fast—it had already spread to my lymph nodes and maybe my stomach.

I'm sure you can at least imagine some of how this feels. I am a 35-year-old man without a penis with my life on the line. I have a young daughter, Vanessa, who is only 14. She is here with me today because she wanted to support me—and because I wanted her to see her father do something for the greater good, so that she will have that memory of me. The thought that her pain—and mine—could have been avoided almost makes this too much to bear.

I had to be here today because I am not the only one who didn't get the medical care I needed. It was routine for detainees to have to wait weeks or months to get even basic care. Who knows how many tragic endings can be avoided if ICE will only remember that, regardless of why a person is in detention and regardless of where they will end up, they are still human and deserve basic, humane medical care.

In many ways, it's too late for me. Short of a miracle, the most I can hope for are some good days with Vanessa and justice. My doctors are working on the good days and, thankfully, my attorneys at Public Justice here in Washington, Mr. Conal Doyle in California, and the ACLU are working on the justice – not just for me, but for the many others who are suffering and will never get help unless ICE is forced to make major changes in the medical care provided to immigrant detainees.

I am here to ask each of you, members of Congress, to bring an end to the unnecessary suffering that I, and too many others, have been forced to endure in ICE detention.

Thank you for your time.

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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY

IN RE: FRANCISCO CASTANEDA	**FRANCISCO CASTANEDA'S SUPPLEMENTAL INFORMATION FOR THE HOUSE JUDICIARY COMMITTEE'S SUBCOMMITEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW HEARING ON "DETENTION AND REMOVAL: IMMIGRATION DETAINEE MEDICAL CARE"** **Date: Thursday, October 4, 2007** **Time: 1:00 p.m.** **Location: Room 2141 Rayburn House Office Building**

INTRODUCTION

The United States Government caused the amputation of Mr. Francisco Castaneda's penis on Valentine's Day, 2007, by knowingly and purposefully refusing to provide basic and inexpensive medical care. The Government's purposeful neglect allowed the development of metastatic penile cancer that will likely cause Mr. Castaneda's death. Liability is aggravated because the Government repeatedly refused

to provide a simple and inexpensive diagnostic test over a ten-month period despite numerous orders to do so by off-site medical specialists.

The Government's refusal to provide Mr. Castaneda reasonable and humane medical care during his detention was tantamount to torture. He was forced to endure one of the most painful, terrifying, and humiliating experiences imaginable. Mr. Castaneda continually pleaded for a biopsy, but was denied the treatment that would have prevented months of pain and the eventual amputation of his penis. For ten months, Mr. Castaneda endured extreme pain, swelling, tumor growth, bleeding, discharge, a foul odor, and the inability to urinate standing up, all with the knowledge that his mother had died of cancer at age thirty-nine and doctor after doctor informed him that he needed a biopsy to rule out cancer.

Mr. Castaneda is a thirty-five year old man who immigrated to the United States from El Salvador in 1982 with his mother. He has lived continuously in the United States since that time. He has a twelve-year relationship with his girlfriend Cynthia and has a fourteen-year old daughter from a previous relationship. Mr. Castaneda is an undocumented alien and the United States commenced deportation proceedings, detaining him as a "pre-trial detainee" pending the resolution of those proceedings, although he had no history of violent crimes.

Mr.Castaneda was first detained by Immigration and Customs Enforcement ("ICE") on or about March 27, 2006, at the San Diego Correctional Facility ("SDCF"), a contract detention facility operated by Corrections Corporation of America ("CCA"). On November 24, 2006, Mr. Castaneda was transferred to the San Pedro Service Processing Center ("San Pedro"), another ICE detention facility, where he remained until his release on or about February 5, 2007.

On March 28, 2006, Mr. Castaneda was examined by Lieutenant Anthony Walker, an ICE Physican's Assistant, as part of the medical intake screening process at SDCF. Lieutenant Walker noted Mr. Castaneda's history of genital warts and his plan called for a urology consult "ASAP" with a request for a biopsy.

Medical personnel filed a Treatment Authorization Request ("TAR") form in April with the Division of Immigration Health Services ("DIHS"), requesting approval to have the lesion removed for purposes of a biopsy and surgical correction. For unknown reasons, The TAR was not approved until May 31, 2006, two months after Lieutenant Walker ordered the consult and biopsy. During this delay, the Government did nothing to treat the problem.

On June 7, 2006, the Government sent Mr. Castaneda to an outside specialist of its choice—John R. Wilkinson, M.D., a hematologist/oncologist. Mr. Castaneda had a history of fungating lesion on the left side of his foreskin. The lesion was growing, and Dr. Wilkinson documented agreement with the medical staff at SDCF "that this may represent either a penile cancer or a progressive viral based lesion." His medical records state:

> "strongly agree[d] that it requires urgent urologic assessment of biopsy and definitive treatment. In this extremely delicate area and [sic] there can be considerable morbidity from even benign lesions which are not promptly and appropriately treated…I spoke with the physicians at the correctional facility. I have offered to admit patient for a urologic consultation and biopsy. Physicians there wish to pursue outpatient biopsy which would be more cost effective. They understand the need for urgent diagnosis and treatment."

The cancer specialist's offer to admit Mr. Castaneda for urologic consultation and biopsy, and his opinion that urgent diagnosis and treatment was essential, was communicated to Government doctors. Nevertheless, the Government determined that the biopsy, a simple and inexpensive diagnostic measure to rule out a life-threatening disease, was not "cost effective," was "elective," and refused to follow Dr. Wilkinson's unambiguous order for urgent treatment. The Government continued to do nothing to treat the problem.

On June 30, 2006, Lieutenant Walker informed Mr. Castaneda that he did not have cancer *because* a biopsy had *not* been done. This was documented in the same medical record that showed Mr. Castaneda's condition continued to deteriorate: he was

bleeding from his penis, had drainage and discharge, a foul odor, pain, swelling, and difficulty urinating.

The Government documented in a TAR form on July 12, 2006, that it spoke with Dr. Wilkinson, an oncologist, and Dr. Masters, a urologist, who "both strongly recommend admission, urology consultation, surgical intervention via biopsy/exploration" and noted that the lesion was "exploding." [1] Nevertheless, the Government failed to schedule the biopsy through Wilkinson or Masters and, instead, brought Mr. Castaneda to a Hospital Emergency Room, further delaying his treatment. A doctor at the Hospital declined to treat Mr. Castaneda on an *emergent* basis and referred him back to his treating urologist, Dr. Masters.

Recognizing the severity of Mr. Castaneda's condition, Lieutenant Walker submitted Mr. Castaneda's case for early release so that he could seek medical evaluation and treatment on his own, but this request was apparently denied. Mr. Castaneda's continued requests for a diagnostic biopsy were denied as "elective." The Government continued to do nothing to treat the problem.

Mr. Castaneda was finally brought in for a urologic consult with Dr. Masters on August 22, 2006, almost five months after Lieutenant Walker's original recommendation, and Dr. Masters ordered a circumcision to "relieve the ongoing side effects of the lesion including infection and bleeding and to provide a biopsy for further analysis."

The Government refused to follow Dr. Master's order for circumcision and biopsy and denied Mr. Castaneda the treatment he so desperately needed, which was medically necessary for diagnosis of cancer and to relieve his extremely painful and dangerous condition.

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[1] Wilkinson and Masters were doctors chosen by the Government to evaluate Mr. Castaneda. Neither Mr. Castaneda nor his legal representatives had anything to do with the selection of these medical providers.

Mr. Castaneda's condition continued to deteriorate throughout the late summer and fall, but the Government still refused to provide medical care, despite Mr. Castaneda's continued complaints and the multiple orders to do so by general and specialist physicians.

On October 25, 2006, another TAR form seeking approval for surgery was denied on the provably false grounds that "the local oncologist and urologist are not impressed of possible cancerous lesions" and stated that "there is an *elective component* to having the circumcision completed." This same TAR form also documented that ICE officials were aware that Mr. Castaneda would be detained in their custody for "quite some time" and would therefore be unable to obtain treatment on his own in the near future. Still, the Government did nothing to treat the problem.

In November, the penile lesion had grown to 2.5 centimeters in diameter and Mr. Castaneda was experiencing profuse penile bleeding. The Government "treated" these serious medical conditions by authorizing an increase in Mr. Castaneda's boxer shorts allotment and prescribing laxatives.

Mr. Castaneda was transferred from SDCF to San Pedro in late November. In the transfer records, the Government denied Mr. Castaneda had any health concerns. San Pedro was informed that Mr. Castaneda had "No Current Medical Problems" and was not taking any pain medications or antibiotics.

The ACLU National Prison Project wrote Government officials on December 5, 2006, pleading with them to allow Mr. Castaneda the medical care he so desperately needed. This plea fell on deaf ears. The Government still refused to treat the problem even after a third off-site specialist, urologist Lawrence Greenberg, M.D., recommended surgical correction and biopsy on December 14, 2006.

Ten months after Lieutenant Walker's original request for a biopsy, and only after prolonged pressure from the ACLU National Prison Project, a fourth off-site specialist examined Mr. Castaneda on January 25, 2007, and ordered a biopsy to definitively diagnose what he believed was "most likely penile cancer." A biopsy was then

scheduled, but the Government refused to acknowledge this order and released Mr. Castaneda from custody a few days before the scheduled biopsy, presumably so it would not have to pay for the procedure. The Government *never* allowed Mr. Castaneda to receive any treatment for his obvious penile disease during his entire ten-month detention.

Mr. Castaneda's penis was amputated on Valentine's Day, 2007, after he was examined and evaluated at Harbor-UCLA Hospital.

Harbor-UCLA doctors diagnosed him with invasive squamous cell carcinoma after obtaining, as a result of the amputation, a biopsy of the 5.5 centimeter tumor that had grown untreated while in Government custody. Mr. Castaneda has been diagnosed with metastatic cancer and is currently undergoing chemotherapy at Harbor-UCLA in the hope of shrinking a massive inguinal tumor that is too large for surgical removal. Doctors now fear the cancer has already spread to his stomach.

The prognosis for metastatic penile cancer is poor and Mr. Castaneda now has a possible life expectancy of less than 2 years, a profound result of the Government's refusal to provide him the most basic medical care in a timely fashion. He will have to endure painful and grueling medical treatment, including chemotherapy and surgery, during the remaining years of his life. Mr. Castaneda will also incur a crushing debt for the medical expenses incurred in treating metastatic penile cancer.

MEDICAL CHRONOLOGY

A. Francisco Castaneda entered ICE Custody on March 27, 2006, where He was Immediately Diagnosed by an ICE Medical Provider with a Penile Lesion that Required a Urology Consult "ASAP" with Biopsy to rule out Cancer.

Mr. Castaneda immediately brought his medical condition to the attention of the SDCF prison staff upon admission – specifically informing them of a lesion on his penis that was becoming painful, growing in size, bleeding, and exuding discharge.

On March 28, 2006, Mr. Castaneda was examined by Lieutenant Anthony Walker, a Physican's Assistant, as part of the medical intake screening process at SDCF. Lieutenant Walker noted Castaneda's history of genital warts and his plan called for a urology consult "ASAP" with a request for biopsy. (Exhibit 1)

B. After a Lengthy Delay, Mr. Castaneda Finally Saw Oncologist John Wilkinson, M.D., who Ordered "Urgent Diagnosis and Treatment" of the Penile Lesion, including Biopsy and Circumcision on June 7, 2006.

Despite a request for a urology consult ASAP, Mr. Castaneda was next seen by a medical provider on April 11, 2006, when Lieutenant Walker again assessed Mr. Castaneda as having a penile lesion that required them to rule out cancer. Lieutenant Walker also documented that Mr. Castaneda's mother died of pancreatic cancer at age thirty-nine. (Exhibit 2)

Mr. Castaneda was not seen again until April 28, 2006, when he informed Lt. Walker that the lesion on his penis smelled worse and was now draining puss. Lieutanant Walker noted that the lesion was more macerated[2] at the glans (penis head) and emitted a foul odor. (Exhibit 3)

Medical personnel filed a Treatment Authorization Request ("TAR") form in April with the Division of Immigration Health Services ("DIHS"), requesting approval to have the lesion removed for purposes of a biopsy and to have circumcision of the penis. The TAR form noted that Mr. Castaneda's penile lesion had grown, and that his pain level was measured at 8 out of 10 during urination and erection. The TAR form also observed that "[patient] ("pt") has been treated for possible infections to no avail. Lesion has foul odor." The form further documented Mr. Castaneda's strong family history of various cancers, and concluded that a biopsy should be performed "due to family history and pt discomfort, sooner the better." (Exhibit 4)

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[2] macerate /mac·er·ate/ (mas´er-at): to soften by wetting or soaking.

For unknown reasons, the TAR form was not approved until May 31, 2006, two months after Lieutenant Walker ordered the consult and biopsy. (Exhibit 4)

On June 7, 2006, the Government sent Mr. Castaneda to an outside specialist of its choice—John R. Wilkinson, M.D., Hematology Oncology Diplomat. Mr. Castaneda had a history of fungating lesion on the left side of his foreskin. The lesion was growing and Dr. Wilkinson documented his agreement with the medical staff at SDCF "that this may represent either a penile cancer or a progressive viral based lesion." His medical record states:

> "strongly agree[d] that it requires urgent urologic assessment of biopsy and definitive treatment. In this extremely delicate area and [sic] there can be considerable morbidity from even benign lesions which are not promptly and appropriately treated…I spoke with the physicians at the correctional facility. I have offered to admit patient for a urologic consultation and biopsy. Physicians there wish to pursue outpatient biopsy which would be more cost effective. They understand the need for urgent diagnosis and treatment." (Exhibit 5).

Dr. Wilkinson also documented that there was "no evidence of regional lymphadenopathy, no sign of distant metastasis." (Exhibit 5). This meant that there was no evidence that the cancer had spread at that point.

C. The Government Determined that the Biopsy, a Diagnostic Measure to Rule out a Life-Threatening Disease, was "Elective" and Refused to Follow Dr. Wilkinson's Order for Definitive Treatment, Despite His Offer to Admit Mr. Castaneda for Urologic Consultation and Biopsy and his Opinion that Urgent Diagnosis and Treatment was Essential.

On June 7, 2006, Esther Hui, M.D. documented a conversation she had with Dr. Wilkinson regarding his examination of Mr. Castaneda. Dr. Hui specifically noted that Mr. Castaneda had a penile lesion that required a biopsy and that Dr. Wilkinson had offered to admit Mr. Castaneda to the hospital. She then documented that the biopsy, a diagnostic procedure to rule out a life-threatening disease, was an "elective outpatient

procedure" and therefore refused to admit Mr. Castaneda for treatment at that time. (Exhibit 6). She also never made arrangements for an outpatient biopsy even though Dr. Wilkinson's note documented that Dr, Hui wished "to pursue outpatient biopsy which would be more cost effective."

On June 12, 2006, Mr. Castaneda filed a grievance asking for the surgery recommended by Dr. Wilkinson: "[Dr. Wilkinson] gave his professional opinion and recommended that I should be admitted and that surgery should be performed. At this time, Dr. Hui decided against the proposed surgery and denied the admittance. I am in a considerable amount of pain and I am in desperate need of medical attention." (Exhibit 7)

D. Lieutenant Walker informed Mr. Castaneda that He Did Not Have Cancer *Because* a Biopsy Had *Not* Been Done, Despite the Fact that Mr. Castaneda's Condition Continued to Deteriorate: He was Bleeding from his Penis, had Drainage and Discharge, a Foul Odor, Pain, Swelling, and Difficulty Urinating.

On June 23, 2006, Mr. Castaneda informed Lieutenant Walker that his penis was getting worse: there was more swelling to the area, a foul odor, drainage, it was more difficult to urinate, and he was bleeding from the foreskin. Lieutenant Walker documented that there was "obvious slightly purulent drainage[3] from foreskin of penis next to lesion on penis." Nevertheless, the Government did nothing to treat the problem. (Exhibit 8)

On the same day, Dr. Wilkinson's office received a telephone call from SDCF reporting that Mr. Castaneda's "foreskin lesion is increased in size and pressing further on his penis causing increasing discomfort." Dr. Wilkinson noted that Mr. Castaneda was to see Dr. Robert Masters, M.D., a urologist, and sent a copy of Mr. Castaneda's medical records to Dr. Masters. (Exhibit 5).

[3] Purulent: Pertaining to pus; containing or composed of pus.

On June 30, 2006, Lieutenant Walker authored a late entry progress note, stating that Mr. Castaneda "DOES NOT have cancer at this time due to not having a biopsy performed and evaluated in a laboratory." Walker told Mr. Castaneda that he did not have cancer, although Walker documented that he was not sure "what the lesion would present, if and when, the biopsy was completed." The medical record documented that "this is something that can be managed also upon his release as well if that is the concern here, that there is "a three-year history with the past few months of the lesion looking and acting a bit more angry," and that there is "a severe deformed uncircumcised foreskin growth that could use attention but this lesion is an impediment at this time according to Dr. Masters." Walker counseled Mr. Castaneda to be patient and wait. (Exhibit 9)

On July 12, 2006, Lieutenant Walker responded to Mr. Castaneda's grievance, stating: "Not resolved. Patient wants further evaluation, assessment and treatment. Patient will be reassessed and further outside resources readdressed. Patient (sic) explained that he was never denied any treatment but pre authorization must be gained prior to any treatment."

On July 12, 2006, Lieutenant Walker again examined Mr. Castaneda and noted that the "lesion on his penis was draining clear, foul malodorous smell, cultures before were negative for growth, negative RPR, negative HIV, foreskin bleeding at this time, and patient states his colon feels swollen, previous rectal exam showed slightly swollen prostate, deferred today." The assessment at that time was still "unknown etiology of penile lesion." (Exhibit 10).

On the same day, Lieutenant Walker authored another late entry progress note. The note stated that Castaneda "was not denied any treatment by Dr. Hui, although there was no active Treatment Authorization Request (TAR) form placed for approval by DIHS headquarters in Washington, DC, nor was there an emergent need." (Exhibit 11).

E. A July 13th TAR Form Documented That Dr. Wilkinson and Dr. Masters Both Strongly Recommended Admission, Urology Consultation, and Surgical Intervention via Biopsy/Exploration; Nevertheless, ICE failed to schedule a Biopsy Through Wilkinson or Masters and Instead Brought Mr. Castaneda to a Hospital Emergency Room Which Further Delayed Mr. Castaneda's Treatment.

A TAR form was submitted on July 13, 2006, seeking ER evaluation and treatment for Mr. Castaneda despite the fact that Lieutenant Walker documented that there was no emergent need to treat Mr. Castaneda the day before. There is no documentation explaining why the Government did not schedule him for the circumcision and biopsy that was ordered by Dr. Wilkinson the month before and Lieutenant Walker three months prior.

However, the TAR form documented that ICE officials spoke with Dr. Wilkinson and Dr. Masters, who:

> "both strongly recommended admission, urology consultation, surgical intervention via biopsy/exploration under anesthesia to include circumcision if non-malignant, with return follow-up with oncology depending upon findings, and potential treatment or surgery of any malignant findings."

The TAR form also documented that Mr. Castaneda's penis was bleeding, had drainage, malodorous smell and the "lesion now appears to be "exploding" for lack of better words, definitely macerated." The request for inpatient urology and oncology evaluation and treatment was approved. (Exhibit 12).

The Government failed to arrange for this evaluation with the treating doctors that were familiar with Mr. Castaneda's condition, Dr. Wilkinson and/or Dr. Masters.[4] Instead, ICE inexplicably brought Mr. Castaneda to the Emergency Room at Scripps Mercy Chula Vista on July 13, 2006, which ultimately delayed his treatment further. Mr.

[4] Wilkinson and Masters were doctors chosen by the Government to evaluate Mr. Castaneda. Neither Mr. Castaneda nor his legal representatives had anything to do with the selection of these medical providers.

Castaneda was examined by Juan Tovar, M.D., at the Scripps ER, who noted a 1.5 cm by 2 cm fungating lesion[5] on his penis with discharge but no lymphadenopathy,[6] and made arrangements for admission to the hospital. His impression was: "penile mass, rule out cancer, versus infectious etiology." (Exhibit 13).

F. The Hospital Declined to Treat Mr. Castaneda on an *Emergent Basis* and Referred Him Back to His Treating Urologist, Dr. Masters.

Daniel Hunting, M.D., a Scripps urologist, performed a very brief examination of Mr. Castaneda on July 13th, did not obtain a history of Castaneda's prior family history of cancer, and believed Mr. Castaneda's lesion was "probably condyloma" (genital warts). Dr. Hunting referred him back to his "primary treating urologist" (Dr. Masters) rather than admit him to the hospital on an emergent basis when all Mr. Castaneda required was a simple outpatient procedure. As a result, a circumcision and biopsy was not performed at Scripps to rule out cancer at that time. (Exhibit 14).

On July 17, 2006, Lieutenant Walker again examined Mr. Castaneda, noting that the penile lesion had grown and he had severe phimosis,[7] bleeding, drainage and foul odor. Lieutenant Walker documented that he spoke to Dr. Wilkinson and Dr. Masters who both strongly recommended a circumcision and biopsy. He also documented that he spoke to a charge nurse at Scripps who stated the urologist diagnosed condyloma acuminate (genital warts), "no need for biopsy but will need a resection[8] of the penis

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[5] The National Cancer Institute (NCI) defines "fungating lesion" as: A type of skin lesion that is marked by ulcerations (breaks on the skin or surface of an organ) and necrosis (death of living tissue) and that usually has a bad smell. This kind of lesion may occur in many types of cancer, including breast cancer, melanoma, and squamous cell carcinoma, and especially in advanced disease.

[6] Lymphadenopathy (lim-fad-e-NOHP-ah-thee) is the swelling of the lymph nodes.

[7] Phimosis is medically defined as "stenosis (tightness) of the preputial ring with resultant inability to retract a fully differentiated foreskin." In other words, the foreskin is so tight it cannot be pulled back completely to reveal the glans.

[8] Resection: Surgical removal of part of an organ.

due to severe phimosis and gross condyloma." The Government not only refused to allow the biopsy ordered by Mr. Castaneda's treating physicians, but also never performed the resection ordered by Dr. Hunting—which would have provided a tissue sample for biopsy. (Exhibit 15).

G. Recognizing the Severity of Mr. Castaneda's Condition, Lieutenant Walker Submitted Mr. Castaneda's Case for Early Release, But Was Denied, And The Government Continued to Deny Mr. Castaneda's Requests for a Biopsy.

Recognizing the gravity of Mr. Castaneda's condition, Lieutenant Walker submitted Mr. Castaneda for early release on July 18th to further his opportunities for testing and potential treatment due to the ER's failure to perform testing. (Exhibit 16). However, this request was apparently denied and Mr. Castaneda was not released.

On July 26, 2006, David Lusche, P.A., documented that he explained to Mr. Castaneda "that while a surgical procedure might be recommended long-term, that does not imply that the federal Government is obligated to provide that surgery if the condition is not threatening to life, limb or eyesight." He also noted that his interaction with Mr. Castaneda "was conversational and calm, not confrontational." (Exhibit 17).

On July 28, 2006, Mr. Castaneda filed a grievance against Mr. Lusche. That grievance was also denied. Mr. Lusche completed the Grievance Officer's Report and wrote: "I have met with Mr. Castaneda and explained that the urologist informed us that surgery at this point is elective in nature. As such the federal Government will not approve this (elective) surgery. We will continue to monitor Mr. Castaneda's status at his request using the sick call system." (Exhibit 18).

On August 9, 2006, Castaneda was again examined by David Lusche, noting that Mr. Castaneda's foreskin was inflamed and that there was a whitish growth approximately 8 mm in diameter noted at the inferior margin of the foreskin. Lusche

again denied Castaneda's request for surgery as elective. He documented that Mr. Castaneda "expressed understanding, but calmly stated he does not agree with the decision." (Exhibit 19).

On August 10, 2006, Mr. Castaneda again requested a biopsy via sick call slip. (Exhibit 20). On August 11, 2006, Lieutenant Walker submitted a TAR form requesting "biopsy lesion on penis, surgical correction of glans penis, circumcision, by Dr. Robert Masters." (Exhibit 21).

H. Mr. Castaneda Was Finally Brought For a Urologic Consult with Dr. Masters Almost Five Months After Lieutenant Walker's Original Recommendation, and Dr. Masters Ordered a Circumcision to "Relieve the Ongoing Side Effects of the Lesion Including Infection and Bleeding And To Provide a Biopsy For Further Analysis."

On August 22, 2006, almost five months after Lieutenant Walker's recommendation for a Urology Consult, Mr. Castaneda was taken to see Dr. Robert Masters, M.D.[9] Dr. Masters observed the lesion and concluded that Mr. Castaneda had genital warts and may have urethral condylomata (i.e., genital warts inside of his urethra). Dr. Masters determined that Mr. Castaneda was in need of a circumcision, which would relieve the "ongoing medical side effects of the lesion including infection and bleeding" and would provide a biopsy for further analysis.

Dr. Masters finished the report that he prepared for Lieutenant Walker, by stating: "We will arrange for admission for circumcision at a local hospital. My principal hospital is Sharp Memorial." (Exhibit 22).

[9] Although several prior medical records and TAR forms reference Dr. Masters, he did not actually examine Mr. Castaneda until August 22, 2006. Until that point, it appears he only reviewed his medical records.

I. The Government Refused to Follow Dr. Masters' Order for Circumcision and Biopsy and Denied Mr. Castaneda the Treatment He So Desperately Needed, Which Was Medically Necessary for Diagnosis of Cancer and To Relieve His Extremely Painful and Dangerous Condition.

The Government denied Mr. Castaneda treatment and he was never brought to the hospital for biopsy and circumcision pursuant to Dr. Masters' order. Lieutenant Walker documented his conversation with Dr. Masters on August 22, 2006. Walker characterized Dr. Masters as stating that the "elective procedures this patient may need in the future are cytoscopy and circumcision." Lieutenant Walker did not document Dr. Masters' conclusion that cancer needed to be ruled out via biopsy and his offer to admit Mr. Castaneda for treatment at Sharp Memorial Hospital. Despite Walker's continued use of the term "elective," that word does not appear anywhere in Dr. Masters' or Dr. Wilkinson's reports, the only specialist physicians who had documented performing a full examination of Mr. Castaneda. (Exhibit 23).

On August 24, 2006, Walker told Mr. Castaneda that "according to policy," the Government would prevent him from having a circumcision with a cystoscopy because it was "elective." Again, Lieutenant Walker documented that release for medical reasons would be discussed with the medical team so that Mr. Castaneda could pursue treatment, surgery, and follow up. Nevertheless, the Government did nothing to treat the problem and did not permit Mr. Castaneda to seek treatment on his own. (Exhibit 24).

On August 26, 2006, Castaneda was seen by medical staff because of "complaints of a stressful situation regarding his medical status, being unable to sleep at night as ICE won't allow surgical operation for the lesion on penis." He was then prescribed Diphenhydramine, an antihistamine. (Exhibit 25).

On August 28, 2006, Mr. Castaneda again requested treatment at sick call because he had stress and could not sleep. He attributed the stress to the chronic

medical problems which the Government refused to have corrected. He was prescribed Trazodone, a psychoactive compound with sedative and anti-depressant properties, and a psychology consult, which he apparently never received. Government doctors were indifferent to one of the well known side effects of Trazodone: priapism, a prolonged and painful erection in males. (Exhibit 26).

On August 30, 2006, Mr. Castaneda received a memo from Lieutenant Commander Stephen Gonsalves, the Health Services Administrator at SDCF. The memo informed Mr. Castaneda that:

> "the off site specialist you were referred to for your medical condition reports that any surgical intervention for the condition would be elective in nature. An independent review by our medical team is in agreement with the physician's assessment. The care you are currently receiving is necessary, appropriate and in accordance with our policies."

This unsupported conclusion is directly contradicted by Dr. Wilkinson and Dr. Masters' reports and by the Government's TAR forms that specifically documented the off-site specialists strong recommendations for surgical intervention and diagnostic biopsy. (Exhibit 27).

J. Mr. Castaneda's Condition Continued to Deteriorate But the Government Still Refused to Treat the Pain, Bleeding, Discharge, Foul Odor and Growth of the Tumor on His Penis, Despite Multiple Orders from Independent Physicians To Do So.

On September 8, 2006, Mr. Castaneda was seen by Joanne Galano, RN, who received a sick call request stating, "I have a lot (sic) pain and I'm having discharge." She noted that 800 mg of Ibuprofen was having no effect on his pain, he was having white discharge at night, and documented that "It's getting worse. It's like genital warts, but they're getting bigger." (Exhibit 28).

On September 12, 2006, the records document that Mr. Castaneda via sick call request again stated that he is having more penile lesion discharge and discomfort. (Exhibit 29).

On September 14, 2006, Cindy Butler, RN, documented that Mr. Castaneda complained that: "My situation is getting worst and worst! I'm suffering pain, I cannot sleep because of the pain. Also the discharge does not stop nor the bleeding. It smells really bad! States that the antibiotic prescribed two days ago is not effective now, nor has it ever been in the past." The Government still did nothing to treat the problem. (Exhibit 30).

On September 18, 2006, Mr. Castaneda was denied a request to be prescribed amoxicillin. (Exhibit 31).

On September 26, 2006, Lieutenant Walker examined Mr. Castaneda's penis and noted "another condyloma type lesion is forming and foul odor emitting from uncircumcised area with mushroomed wart." Apparently, Walker discussed releasing Mr. Castaneda to obtain medical care, but was denied by ICE because Castaneda was a "mandatory hold due to legal status." (Exhibit 32).

On October 4, 2006, Bonnie Sawyer, NP, would not reorder Castaneda's prescription for trazodone, a drug for insomnia and depression. (Exhibit 33).

On October 17, 2006, the records reflect that the medical staff was informed by prison personnel that Mr. Castaneda was bleeding from his penis and had blood on his shorts. (Exhibit 34).

K. Another TAR Form Seeking Approval for Surgery Was Denied on the Provably False Grounds that "the Local Oncologist and Urologist are Not Impressed of Possible Cancerous Lesions" and Documented That ICE Officials Believed Mr. Castaneda Would Be Detained For "Quite Some Time" and Unable To Obtain Medical Care.

On October 23, 2006, records document that Walker submitted a TAR form for surgery which was pending. (Exhibit 35 and 36). On October 25, 2006, the request

was denied because a DIHS Staff Physician stated that "circumcisions are not a *covered benefit*."

The October 25 TAR form erroneously stated that "Patient has been seen by local urologist and oncologist and both are not impressed of possible cancerous lesions, however, there is an elective component to having the circumcision completed." (Exhibit 37). This unsupported conclusion stated the opposite of the July 13, 2006 TAR form, which documented that Dr. Wilkinson, the oncologist, and Dr. Masters, the urologist, both "strongly recommended...surgical intervention via biopsy/exploration" to rule out cancer via biopsy. This conclusion is also directly contradicted by the doctors' reports. (Exhibit 12).

The TAR form also documented that ICE authorities denied Mr. Castaneda's request for release to seek medical care. Incredibly, it stated Mr. Castaneda "is not able to be released to seek further care due to mandatory hold and according to ICE authorities, may be with this facility for quite a while." (Exhibit 37). This document proves that high-ranking Government authorities were *aware* Mr. Castaneda needed treatment and also knew he would be unable to receive it in the foreseeable future.

On or about October 29, 2006, Walker told Mr. Castaneda that multiple requests to Washington, D.C. seeking authorization for surgery had been denied.

L. The Government Treated the Explosion of the Penile Tumor to 2.5 Centimeters in Diameter and Profuse Penile Bleeding by Authorizing an Increase in Mr. Castaneda's Boxer Shorts Allotment and Prescribing Him Laxatives.

On November 9, 2006, Cindy Butler, RN, documented that Mr. Castaneda's "symptoms have worsened. States he feels a constant pinching pain, especially at night. States he constantly has blood and discharge on his shorts. 'It's getting worse, and I don't even have any meds-nothing for pain and no antibiotics.' Also complains of a swollen rectum which he states make bowel movements hard." In response to all of these complaints, he was prescribed milk of magnesia and docusate sodium, a laxative.

Mr. Castaneda was informed that the TAR form was "in place for surgery and is pending approval" despite the fact that the TAR was denied two weeks before. (Exhibit 38).

On November 14, 2006, Mr. Castaneda was seen by David Lusche, who documented that Castaneda complained of a new, second lesion on the underside of his penis and he requested assistance to obtain more fresh underwear. (Exhibit 39).

On November 15, 2006, the medical records document that the penile lesion was growing and that Mr. Castaneda could not stand and urinate because the urine "sprays everywhere" and he could not direct the stream. Lusche's examination documented a genital wart that was white in color and moist in appearance, approximately 2.5 cm in diameter, and noted light pink underwear stains. Lusche treated this condition by making a request for 7 pairs of cleaned boxer shorts weekly. (Exhibit 40).

M. Mr. Castaneda was Transferred from SDCF to San Pedro In Late November and the Transfer Sheet Listed "No Current Medical Problems" and No Pain Medications or Antibiotics.

Mr. Castaneda was transferred from SDCF on November 17, 2006. (Exhibit 41). The "Medical Summary of Federal Prisoner/Alien in Transit" sheet, signed by Cindy Butler listed no "current medical problems" and listed Trazodone as the only prescribed medication, with no medication for pain or antibiotics. (Exhibit 42).

On November 23, 2006, Mr. Castaneda was examined at the LA/Santa Ana Staging area and was noted to have "other penile anomalies." (Exhibit 43).

Mr. Castaneda was booked into the San Pedro Federal Facility on November 24, 2006. (Exhibit 44). On information and belief, Mr. Castaneda's medical records were transferred with him and were provided to medical personnel at San Pedro. On or about Friday, December 1, 2006, Mr. Castaneda filed a sick call slip at San Pedro SPC, complaining of pain, bleeding and discharge from his penis.[10]

[10] No sick call slips were produced by the Government in response to Mr. Castaneda's FOIA request, although the other medical records produced document numerous sick call slip requests.

On or about Sunday, December 3, 2006, Mr. Castaneda filed two more sick call slips complaining about his continuing pain, bleeding and discharge. Mr. Castaneda also requested a clean set of blankets, because he had soiled his original sheets with blood and discharge from his penis.

N. The ACLU National Prison Project Wrote Government Officials on December 5, 2006, Pleading with Them to Provide Mr. Castaneda the Medical Care He So Desperately Needed, But the Government Still Refused to Treat the Problem Despite Yet Another Urologist's Recommendation for Surgical Correction and Biopsy.

ACLU National Prison Project attorneys became involved in Mr. Castaneda's case on or about December 5, 2006. The ACLU sent a letter to multiple SDCF and Health Services Administration ("HSA") officials, carefully recounting Mr. Castaneda's medical history since entering ICE custody. The letter fully informed these officials of the situation, including that "Mr. Castaneda, who has a strong family history of cancer, legitimately fears that his long term health is being jeopardized by the lack of appropriate medical care he continues to receive in ICE custody. In the short term, Mr. Castaneda continues to experience severe pain, bleeding, and discharge." Among other requests, the letter asked for confirmation that arrangements had been made to appropriately treat Mr. Castaneda. (Exhibit 45).

It appears that a TAR form was filed sometime on or about December 5, 2006, seeking a second professional opinion and follow up due to the degree of phimosis and hypospadia,[11] stating "he should have a biopsy of this lesion as well to ensure its status." (Exhibit 46).

The TAR form was approved on December 5, 2006 for "urology consult only. Please submit treatment plan and clinical assessment if other care recommended." The TAR sought a consultation with Lawrence Greenberg, M.D., because of a "history of

[11] Hypospadia is an abnormal condition in males in which the urethra opens on the under surface of the penis.

severe HPV infection causing large, painful, penile warts, has bleeding and pain from the lesions. May also have an underlying structural deformity of penis." (Exhibit 47).

As a result of this advocacy by the ACLU, Mr. Castaneda was transported to the office of Lawrence S. Greenberg, M.D. on December 14, 2006. Dr. Greenberg reviewed Mr. Castaneda's medical records, which were provided to him by an ICE officer, and then physically examined Mr. Castaneda's penis. Dr. Greenberg noted the blood and discharge and asked why Mr. Castaneda had not had surgery.

Dr. Greenberg informed Mr. Castaneda that he required a circumcision and remarked that Mr. Castaneda's penis was a "mess." At the end of the visit, Dr. Greenberg stated that Mr. Castaneda required surgery and that he would send a fax recommendation to the doctor at San Pedro later that day. (Exhibit 48).

When Mr. Castaneda left Dr. Greenberg's office he was transported back to San Pedro and was told that he would be seen by the medical staff either on Friday, December 15, or on Monday, December 18.

Mr. Castaneda was not seen by the medical staff on either the 15th or 18th despite filing a sick call slip on the 18th that reported a lump that had developed in his groin over the weekend.

On December 19, the ACLU attorney telephoned various officials regarding Mr. Castaneda's medical care. The December 5 letter was again emailed to the Officer in Charge at that time. The Officer in Charge replied to the email, stating: "I am in receipt of your request. I am currently dealing with a couple serious issues this date. I will however, consult with the affected departments tomorrow and see what can be done concerning your request."

Mr. Castaneda was forced to suffer through the Christmas holidays with no medical treatment.

On December 26, 2006, Shelly Hollandsworth, RN, documented Mr. Castaneda's complaint of blood coming from his penis. Despite the fact that ICE had received Dr. Greenberg's report by December 15, Nurse Hollandsworth had no knowledge of the

report. (Exhibit 49). Mr. Castaneda was provided no treatment despite Dr. Greenberg's report, the email from the ACLU, and Mr. Castaneda's disturbing medical presentation, which included a lump in his groin.

On January 11, 2007, Mr. Castaneda was again seen by Nurse Hollandsworth who still reported a "knowledge deficit related to follow up." (Exhibit 50). Danielle Didonna also authored a note on January 11, stating that Mr. Castaneda had been seen by Dr. Greenberg "who recommends advanced urology specialty care. Patient must have a biopsy and further treatment recommendations made." She also documented that Mr. Castaneda was in severe pain that was not being alleviated by pain medication. She documented that Mr. Castaneda was to have another specialty evaluation with biopsy. The assessment was to rule out carcinoma of penis secondary to HPV infection. (Exhibit 51).

On January 19, 2007, Ranjana Natarajan, Esquire, of the ACLU faxed yet another letter and request for medical treatment on Mr.Castaneda's behalf to George Molinar, Norma Bouales-Garibei, Chris Henneford, and Claudia Mazur, higher level government officials. (Exhibit 52).

Forty days after Dr. Greenberg's surgical consult order, on January 24, 2007, the records reflect that a TAR form for a specialty urology consult with Asghar Askari, M.D. was verbally approved by Dr. Collins, presumably an ICE doctor. (Exhibit 53).

O. A Fourth Off-Site Specialist Examined Mr. Castaneda Ten Months After Lieutenant Walker's Original Examination, and Ordered a Biopsy to Diagnose What Was "Most Likely Penile Cancer" Yet the Government Refused to Honor this Order and Released Mr. Castaneda From Custody, Presumably So It Would Not Have to Pay for the Procedure.

On January 25, 2007, Mr. Castaneda was seen by Dr. Askari who diagnosed a fungating penile lesion with possible left lymphadenopathy that was "most likely penile cancer." He ordered a penile biopsy on an out-patient basis under general anesthesia. He communicated these findings to the Government. (Exhibit 54).

On January 29, 2007, Tom Jawetz, Esquire, of the ACLU again wrote to ICE officials, urging them to provide Mr. Castaneda the care that had been ordered for him for the past ten months. (Exhibit 55). A biopsy was finally scheduled for Mr. Castaneda in February, although there is no record of this in documents produced by ICE.

Instead of providing him the treatment ordered by Dr. Askari, ICE abruptly released Mr. Castaneda from custody, presumably to avoid having to pay for the biopsy that was originally recommended by Lieutenant Walker on Mr. Castaneda's first day of admission in March 2006, by Dr. Wilkinson on June 7, 2006, by Dr. Masters on August 22, 2006, and Dr. Greenberg on December 14, 2006. The Government ultimately released Mr. Castaneda without ever providing the simple and inexpensive procedure essential to diagnosing a serious and life-threatening medical problem.

P. Mr. Castaneda's Penis Was Amputated on Valentine's Day After He Went to the Emergency Room of Harbor-UCLA Hospital And Was Diagnosed With Invasive Squamous Cell Carcinoma.

After his release from ICE custody, Mr. Castaneda went to the emergency room of Harbor-UCLA Hospital in Los Angeles on February 8, 2007. He was scheduled for a biopsy in the Urology Clinic on February 12, 2007 and was admitted on February 13th with a diagnosis of squamous cell carcinoma of the penis. (Exhibit 56).

His penis was amputated on Valentine's Day. (Exhibit 57).

The partial penectomy left Mr. Castaneda with a two centimeter stump. (Exhibit 57). The remaining eight centimeter sample of his penis was sent to pathology, which revealed that Mr. Castaneda had "Invasive Squamous Cell Carcinoma (5.5 cm in size), keratinizing type." The tumor extended 4.5 cm in depth. (Exhibit 58).

Q. Mr. Castaneda Was Diagnosed With Metastatic Cancer and Is Currently Undergoing Chemotherapy at Harbor-UCLA in the Hope of Shrinking a Massive Inguinal Tumor that is Too Large for Surgical Removal; His Prognosis is Poor.

Unfortunately, Harbor has confirmed that Mr. Castaneda has metastatic cancer that has spread to his groin or inguinal region in the form of a large nodal mass that measured approximately 7 centimeters as of March 14, 2007. (Exhibit 59). This fast-growing cancer was notably increased in size from a February 8, 2007 scan. (Exhibit 59).

Mr. Castaneda is currently undergoing chemotherapy at Harbor-UCLA with the hope of shrinking the inguinal tumor to a size where surgical removal is a viable option. Doctors fear the cancer has already spread to his stomach. (Exhibit 60). Unfortunately, his prognosis is poor and his life is in imminent jeopardy.

Ms. LOFGREN. Ms. Danticat.

TESTIMONY OF EDWIDGE DANTICAT, AUTHOR AND NIECE OF REVEREND JOSEPH DANTICAT, DECEASED DETAINEE

Ms. DANTICAT. Madam Chair, Members of the Subcommittee. I thank you very much for the opportunity to appear before you.

I come today not in my own name, but in the name and in the stead of a loved one who died while in the custody of the Department of Homeland Security and ICE officials in the Krome Detention Center in Miami. His name was Joseph Danticat and he was 81 years old.

He had been living in the same neighborhood in Haiti for more than 50 years, but on October 24th, 2004, United Nations troops and Haitian police forces launched a military operation there. Their goal was to oust armed neighborhood gangs. However, during the clash that followed, they used his roof to fire and kill more than a dozen of his neighbors.

After these forces left the neighborhood, because of the shots had been fired from his roof, the gangs threatened his life, and so he fled and eventually traveled to the United States where he had been a very frequent visitor for more than 30 years.

He had a passport and a valid visa when he arrived at Miami International Airport. However, because he requested asylum, he was arrested and taken to the Krome Detention Center where the medications he was taking for high blood pressure and an inflamed prostate were taken away from him.

A few days later, on the morning of his credible fear hearing, he became ill and began to vomit. Vomit was shooting out of his mouth, his nose as well as the tracheotomy hole he had in his neck that he had for cancer surgery. Still, when a medic arrived at the scene, the medic accused him of faking his illness. I am not just saying this; it was in an OIG report that we got through FOIA.

Later that morning, his condition was worse and with shackles on his feet, he was transported to Miami's Jackson Memorial Hospital. He arrived in the emergency room there at 1 p.m. And was transferred to the prison Ward D where he was first seen by a physician 24 hours after he arrived. Later that evening, he was sweating profusely and complained of weakness, and soon after, he was found dead by an immigration guard.

There are certainly many heartbreaking elements to my uncle's death. However, there are certainly very crucial moments where the medical system in detention failed him.

First of all, the fact that his medication, which he had been taking for many years in a careful balance that took into consideration his high blood pressure and his status as a cancer survivor, that was taken away and that was one.

Secondly, the fact that he was not taken seriously when he became ill at a public hearing; and having been accused of faking his illness was certainly another.

Furthermore, the fact that he was not seen by a physician when he was brought to an emergency room was surely detrimental. And finally, the fact that he was not permitted by criminal officials and Homeland Security officials to see his loved ones during his final hours must have left him feeling less than human at best.

After my uncle died—and by the way, his death was not reported until it was in the press contrary to these things—the Department of Homeland Security simply gave my family a corpse, a cadaver, and a cause of death, which they said was acute and chronic pancreatitis, which my uncle had never shown any symptoms of before he became ill at Krome and for which he was never screened, tested, diagnosed or treated while he was either at Krome or Jackson Memorial.

We were given no further explanations or clarification concerning his last days, and in order to receive his medical records, we had to file those FOIA requests that I mentioned.

Recently, in an article entitled New Scrutiny As Immigrants Die in Custody, Nina Bernstein, a New York Times reporter, quoted Jamie Zuieback, a spokesman for the Department of Homeland Security as saying, quote, that "Anybody who violates our immigration laws is going to get the same treatment by ICE regardless of their medical condition."

It is worth noting that my uncle and many others who have died and are dying in the custody of the Department of Homeland Security and ICE officials did not violate any immigration laws. All my uncle did was request asylum, which I believe is an internationally acknowledged human right.

Furthermore, if it is the intention of the Department of Homeland Security and ICE official to criminalize the right of a person to seek asylum and then see that lack of medical attention given to that person as part of the punishment, then more and more people will continue to die.

Today, our loved ones are being referred to in this hearing as "detainees." But when they enter the system they are in sick, we quickly learn that they are prisoners; as family members, we quickly learn that. But even prisoners deserve to be treated fairly, decently and humanely.

Death in custody will continue to increase if we neglect to care for people who have already suffered great traumas before getting here and are dying, hurt and uncared for, in immigration jails.

Many people like my uncle, who in spite of the designation that he was given as Alien No. 2704199, was a father, a grandfather, a brother, an uncle, a friend who is missed and treasured every day by those of us who loved him.

Thank you.

Ms. LOFGREN. Thank you very much, Ms. Danticat.

[The prepared statement of Ms. Danticat follows:]

PREPARED STATEMENT OF EDWIDGE DANTICAT

Madame Chairwoman and Members of the Committee and Subcommittee:

I thank you very for the opportunity to submit for the record this testimony concerning immigration detainees and medical care.

I write today not in my own name, but in the name—and stead—of a loved one who died while in the custody of Department of Homeland Security and Immigration and Customs Enforcement officials, and the Krome Detention Center in Miami. His name was Joseph Nosius Dantica and he was 81 years old. He was the patriarch, the head, of our family. He was a father of two and grandfather of fifteen, an uncle to nearly two dozen of us, a brother, a friend, and even, after having survived throat cancer, which took away his voice, a minister to a small flock in Port-au-Prince, Haiti. He had been living in the same impoverished neighborhood in Haiti for more than fifty years when on October 24, 2004, United Nations troops and Haitian police forces launched a military operation there. Their goal was to oust

armed neighborhood gangs. However, during the clash that followed, they used the roof of his church to fire at and kill more than a dozen of his neighbors. After these forces left the neighborhood, because the shots had been fired from his roof, gang members came to my uncle's home and threatened to kill him. He was able to flee and eventually travel to the United States, where he has been a frequent visitor for more than 30 years. He had with him a passport and a valid multiple-entry visa, which would have expired in 2008. However because he requested what he termed "temporary" asylum, he was immediately arrested and taken to the Krome Detention Center in Miami, where the medications he was taking for his high blood pressure and inflamed prostate were taken away from him. He made this known as much as he could, to his son, to his lawyer, and to me on the phone, and to the medical staff at Krome where he was held in the short stay medical unit. However his pleas were ignored by those who had taken his medication away.

On the morning of his credible fear hearing, my uncle became ill as a result of this. To those who saw him, including his lawyer, he appeared to be having a seizure and he began to vomit. Vomit shot out of his mouth, his nose, as well as the tracheotomy hole he had in his neck as a result of the throat cancer operation. The vomit was spread all over his face, from his forehead to his chin, down to the front of his dark blue Krome issued overall.

According to a report prepared by the Office of the Inspector General of the Department of Homeland Security, fifteen minutes passed before help arrived. When a medic and nurse arrived at the scene, the medic accused my uncle of faking his illness. To prove his point, the medic grabbed my uncle's head and moved it up and down. It was rigid rather than limp, he said. Besides, my uncle would open his eyes now and then and seemed to be looking at him.

"You can't fake vomit," my uncle's lawyer, John Pratt shot back. "This man is very sick and his medication shouldn't have been taken away from him."

The medications were indeed taken away, replied the medic, in accordance with the facility's regulations, and substituted with others.

Later that morning, my uncle's condition worsened and with manacles on his ankles, he was transported to Miami's Jackson Memorial Hospital. My uncle's medical records from Krome and from Jackson Memorial Hospital indicate that he arrived in the emergency room at Jackson Memorial Hospital around 1:00 PM with an intravenous drip in progress from Krome. He was evaluated by a nurse practitioner at 1:10 PM.

At 4:00 PM, during a more thorough evaluation by the nurse practitioner, he complained of acute abdominal pain, nausea and loss of appetite. At 5 PM, he was transferred to the hospital's prison area, Ward D. The records indicate that he was seen for the first time by a physician at 1:00 PM the next day, exactly twenty-four hours after he'd been brought to the emergency room. At 7:00 PM, after more than twenty hours of no food and sugarless IV fluids, my uncle was sweating profusely and complained of weakness. He was found to be hypoglycemic, with a lower than normal sugar level of 42 mg/dl. At 7:55 PM, his heart rate rose to 110 beats per minute. An electrocardiogram (EKG) was performed at 8:16 PM. The next note on the chart shows that he was found pulse-less and unresponsive by an immigration guard at 8:30 PM. He was pronounced dead at 8:46 PM.

There are certainly many heartbreaking elements to my uncle's death. However, there are certainly moments where the medical system in detention failed him. First of all, the fact that his medication, which he had been taking for many years in a careful balance that took into consideration his high blood pressure and his status as a cancer survivor, had been taken away was one. Secondly the fact that he had not been taken seriously when he fell ill during the credible fear hearing, had been accused of faking his illness, was another. The lack of instant and serious response to his becoming ill at the credible fear hearing implied that his symptoms might also not have been taken seriously elsewhere away from the view of others. Furthermore, the fact that he was not seen by a physician soon after he was brought to the emergency room by Krome officials was also part of his continually sub par medical attention. Also the fact that he was not permitted by Homeland Security and Krome officials to see loved ones, who also wanted to see him, during his final hours must have left him feeling less than human, at best.

After my uncle died, the Department of Homeland Security simply gave my family a corpse and a cause of death-acute and chronic pancreatitis—which he'd never shown any symptoms of before he became ill at Krome and for which he was never screened, tested, diagnosed, or treated while he was at the Krome medical unit or at Jackson Memorial Hospital. We were given no further explanations or clarification concerning his last days. In order to receive his medical records, with the help of the Florida Immigrant Advocacy Center, we had to file Freedom of Information Act requests as well as a lawsuit. From the perspective of a family member, this

is a nightmare. Not only did we tragically lose our loved one, but we had to fight a huge bureaucracy to find out what happened to them.

Recently in an article entitled "New Scrutiny as Immigrants Die in Custody," Nina Bernstein, a New York Times reporter, quoted Jamie Zuieback, a spokeswoman for The Department of Homeland Security, as saying that "Anybody who violates our national immigration law is going to get the same treatment by I.C.E. regardless of their medical condition." First of all, my uncle and many of the others who have died, and are dying in the custody of the Department of Homeland Security and I.C.E officials did not violate any immigration laws. All many of them have done, was request asylum, which is an internationally acknowledged human right. Furthermore, if this, as stated by Ms. Zuieback to the New York Times, is the general attitude of and implied policy of Department of Homeland Security and I.C.E officials—to criminalize the right of a person to seek asylum and then see the lack of medical attention and care given to them as part of the punishment—then more people will continue to die in their care.

During our efforts to see my uncle in his last days, we were consistently told that Department of Homeland Security Officials, I.C.E and Krome officials had the right to make decisions in his medical care. In that type of situation, this can mean that they literarily have our loved ones' lives in their hands. Therefore, if our loved ones are sick, they should be treated. If they need emergency care, they should get it. They are called detainees, but really they are prisoners. As family members we quickly learn that. But even prisoners deserve to be treated fairly and decently and humanely. This is what we consistently tell jailers of other countries. How about we practice some of it here ourselves?

Immigration detention is one of the fastest growing forms of incarceration in the United States. Deaths in custody will only increase if we neglect to care for people who are withering away and dying unheard and neglected. People like my uncle who was not just Alien #27041999, but a father, a grandfather, a brother, and uncle, a friend, a clergyman, who was extraordinarily loved and greatly treasured and is missed every single day by those who loved him very very much.

Ms. LOFGREN. Ms. Everett, are you able to proceed now?

TESTIMONY OF JUNE EVERETT, SISTER OF SANDRA KENLEY, DECEASED DETAINEE

Ms. EVERETT. I have to.

I would like to thank Congresswoman Lofgren and all of the Members of the Subcommittee for inviting me to speak today.

My name is June Everett. My sister is Sandra Marina Kenley. To find out after reading the papers recently that more than 62 immigrants have died and continue to die while in U.S. custody since about the time of my sister's death is shocking and disheartening.

My sister was one of those immigrants who died in jail on the ICE supervision. I cannot tell you the stories of all of these other deceased immigrants, but I can tell you my sister's story.

Sandy came to America when she was 20 years old and lived here for nearly 33 years.

My sister was not illegal but a legal permanent resident. She was not a terrorist. She was a human being, one that made mistakes like all of us. She was a—she was human enough to turn her life around and to pursue her dreams. She became a nurse, had just bought a new car and took custody over her granddaughter. My sister worked in this country for at least 25 years before becoming disabled.

In 2005, Sandie visited Barbados to show off her granddaughter, over whom she had custody. When she returned to this country, she was stopped by an ICE officer and asked to report to the immigration office for questions. When she did, Sandie was asked to return without her granddaughter. When she returned a few weeks

later, she again brought her granddaughter. She was the child's sole custodian.

The officer sent her away and told her to return without her granddaughter. My sister again reported to the authorities for questioning, as requested. Three times she went to Dulles airport to answer immigration questions. This time she did not return.

Her son, who is here today, and I were with her the day she was taken into custody. Sandie was detained for an old misdemeanor drug charge for which she hadn't even served any jail time. She also had already fulfilled the court's requirement for that charge. She completed her probation early and never went back on drugs.

At the airport, we told the ICE officer of my sister's medical condition. She was disabled. She had a bleeding fibroid that needed surgery. She had a date set for that surgery. She had high blood pressure and high cholesterol and took medication for those conditions. Despite all of this, ICE determined that she needed to be detained.

Sandie wasn't a threat to anyone, and she was not a flight risk, proving that going back three times. She had her whole family in this country and had just shown up for questions three times.

Sandie was taken to the Pamunkey Regional Jail in Virginia. I know she complained constantly about not getting her medicine. When the prison officer finally gave her her pills after many weeks, they were the wrong ones, not the ones we had given the ICE official that day at Dulles airport.

Those pills made her very sick. She was hemorrhaging nonstop. Blood pouring down her legs and spilling on the floor of her cell. My sister was scared and suffering unnecessarily. My sister did everything she could to get help, but no one would do anything. Then, on December 18, 2005, I received a call saying my sister had died in jail.

I have so many questions about Sandie's death, and ICE has made it so very difficult for me to learn what happened. There needs to be some transparency, some oversight, and ultimately some accountability.

Sandie died trying to do the right thing. She died because the American system failed her—a system we believed in, a system that needs fixing before more lives are lost unnecessarily. What am I supposed to tell my grandniece, Nakita, about her grandmother's death? What am I supposed to tell Nakita about American principles?

I am here because I believe that what happened to my sister ought not happen to anyone else. I urge you to conduct the necessary oversight over my sister's tragic and preventible death and fix the problem of inadequate medical care in immigration detention centers that has resulted in too many avoidable deaths.

Sandie's death was one that was avoidable from the onset.

I thank you for your time.

Ms. LOFGREN. Thank you, Ms. Everett.

[The prepared statement of Ms. Everett follows:]

PREPARED STATEMENT OF JUNE EVERETT

Presentation on Medical Care and Deaths in ICE Custody

Testimony by June Everett

For a hearing on "Detention and Removal: Immigration Detainee Medical Care" before the House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law

October 4, 2007

I would like to thank Congresswoman Lofgren and all of the members of the Subcommittee for inviting me to speak today.

My name is June Everett and my sister is Sandra Marina Kenley. To find out after reading the papers recently that more than 62 immigrants have died and continue to die while in U.S. custody since about the time of my sister's death is shocking and disheartening. My sister was one of those immigrants who died in jail under ICE supervision.

I cannot tell you the stories of all these other deceased immigrants, but I can tell you my sister's story. We grew up in Barbados. My sister was the eldest of four children. Sandie raised my siblings and me when our mother was at work. At the age of 15, she graduated with honors from high school and began teaching Spanish—English is our native language. My whole family grew up with hopes and dreams of coming to America to better our lives. We met many tourists in Barbados who painted a picture of a country that was fair and just. My sister died holding onto these beliefs and dreams.

Sandie came to America when she was 20 years old, and lived here for nearly 33 years as a legal immigrant.

In 2005, she visited Barbados to show off her granddaughter, over whom she had custody. When she returned to this country, she was stopped by an ICE officer at the Miami airport and asked to report to the immigration office at Dulles airport to answer questions. She did that, but they gave her a date to return and told her not to bring her granddaughter. When she returned a few weeks later she again brought her granddaughter—she was the child's sole custodian. The officers again sent her away told her to return without her granddaughter. About one month went by and she again reported to the authorities for

questioning, as requested. This was the third time she went out to Dulles airport to speak with the officers to answer their questions. This time, she did not return.

Her son and I were with her the day she was taken into custody. She was detained for old misdemeanor drug charges for which she was not required to serve any jail time. When she was detained, she had already fulfilled the court's requirements for those charges. She completed her probation early and never went back on drugs. At the end of the interview, when the ICE officer asked her if she had anything to add, my sister said: "I would like to say that I realized that I had a drug problem and I prayed to the Lord to get over it. And he helped me to get over it. . . . I have been drug free for three or four years. I turned my life around and I am trying to raise my first granddaughter. I am trying to do positive things with my life."

At the airport we told the ICE officer of my sister's medical condition. She was disabled. She had a bleeding fibroid and needed surgery. She had high blood pressure and high cholesterol and took medication for those conditions. Despite all this, ICE determined that she needed to be detained. Sandie wasn't a threat to anyone and she was not a flight risk—she had her whole life and family in this country and had just showed up for questioning three times. That day, ICE became her judge and jury for the same crime she had put behind her.

Sandie was taken to the Pamunkey Regional Jail in Virginia. I know she complained constantly about not getting her medicine. When the prison officers finally gave her pills after many weeks, they were the wrong ones, not the ones we had given the ICE official that day at Dulles airport. Those pills made Sandie very sick. My sister didn't want me to cause waves, because she said that if you speak out, "They send you far, far away where no one can reach you or find you."

I did everything I could to save my sister's life. Advocates called the jail on her behalf, while I searched for lawyers to help. I even went back to Dulles to try to find the ICE officials to beg them to get my sister the care she needed or to release her, since she was no threat to anyone.

Even though she was afraid of retaliation, my sister did everything she could to get help also. She was hemorrhaging non-stop. Blood poured down her legs and spilled on the floor

of her cell. My sister was scared and suffering unnecessarily. But no one would do anything.

She was looking forward to her 53rd birthday. She could not wait to celebrate with me the next year, when I would turn 50. We made big plans, but they never happened. Instead, I got a call on December 18, 2005, saying my sister had died in jail.

Sandie's death certificate says she died of acute coronary insufficiency/hypertensive cardiovascular disease, but there is so much conflicting information. I have so many questions that have not been answered and ICE has made it so very difficult for me to learn what happened. There needs to be some accountability, some transparency, and some oversight.

I buried my sister Sandie here in America, on January 4th, 2006. So, she is still here in this country, but dead. What sense does this make? When she could still be here, alive, had she been given the chance to fulfill her American dream? What good has this done for our country or anyone? Instead, it has brought shame and disgrace to a country that is supposed to stand up for human rights.

My sister was not illegal. She was not a terrorist. She was a human being. One that made mistakes like all of us. She was human enough to turn her life around and to pursue her dreams. She became a nurse, had just bought a new car, and took custody over her granddaughter. My sister worked in this country for at least 25 years before becoming disabled.

Sandie died trying to do the right thing. She died because the American system failed her. A system we believed in. A system that needs fixing now, before more lives are lost unnecessarily.

What am I supposed to tell Sandra's granddaughter, Nakita, about her grandmother's death? What am I supposed to tell Nakita about American principles? How many more lives have to be shattered before the system is fixed?

Thank you for listening to my sister's story today. I am here because I believe that what happened to her ought not happen to anyone else. Already we are too late for some.

I urge you to ask tough questions about my sister's treatment, and about all those other innocent people that have seen their health deteriorate, or have died awaiting a judge's decision or deportation.

I thank you for your time.

Ms. LOFGREN. Mr. Jawetz.

TESTIMONY OF TOM JAWETZ, IMMIGRATION DETENTION STAFF ATTORNEY, ACLU NATIONAL PRISON PROJECT

Mr. JAWETZ. My name is Tom Jawetz. I am the immigration detention staff attorney for the National Prison Project of the American Civil Liberties Union.

The ACLU is currently involved in a class action lawsuit regarding inadequate medical care for immigration detainees at the San Diego Correctional Facility. I would like to thank Chairwoman Lofgren and Members of the Subcommittee for inviting me here today to speak about a serious and growing problem in immigration detention—horribly inadequate medical care that leads to unnecessary suffering and death.

This issue lies at the center of one of our country's most basic principles: that everyone is entitled to fair and humane treatment.

Today, the ACLU requests that this Committee do the following four things:

One, eliminate the procedural hurdles that prevent on-site, treating clinicians from providing necessary medical care to detained immigrants;

Two, fix the serious substantive deficiencies in the DIHS Covered Services Package to ensure that detainees receive adequate and appropriate medical care;

Three, require immigration authorities to publicly report every death; and

Four, codify improved and binding detention standards, including legislation prohibiting retaliatory transfers of detainees who complain about poor medical care and conditions of confinement.

ICE detains nearly 300,000 people each year; approximately one-quarter are identified as suffering from some chronic health condition. Detainees are scattered across the country in hundreds of county jails and in a handful of facilities run by ICE or private prison companies. Some are detained for weeks, many are detained for months or years.

Recent reports from the DHS Office of Inspector General and the Government Accountability Office confirm that there are nationwide problems with medical care and detention. The policies that were testified to today are not being followed, and these reports demonstrate that.

The system for providing necessary medical care suffers from several fatal flaws:

First, detainees may not receive specialty services such as a biopsy or an MRI unless on-site medical personnel obtain authorization from off-site managed care coordinators with the Division of Immigration Health Services in Washington, D.C. This results in unreasonable delays in medical care and unjustifiable refusals to provide authorization.

My statement is based not only on my experience and the experience of the ACLU with our clients, but also on the criticisms of jail officials whose hands are often tied by the DIHS bureaucracy. In York County, Pennsylvania, where detainees have been housed for years, the deputy warden wrote in a letter to a local ICE officer that DIHS had, quote, "set up an elaborate system that is pri-

marily interested in delaying and or denying medical care to detainees. There is nothing easy about working with DIHS. If something can be delayed, it is delayed. If it can be denied, it is denied. If something can be made difficult, it is made difficult."

Second, the treatment authorization decisions made by those managed care coordinators, who are the nurses, not doctors—and there are three of them in D.C. for the entire country—are made in accordance with deeply flawed policies. Those policies emphasize that detainees primarily receive emergency care only literally when life or limb is at stake. This policy is blatantly inconsistent with established principles of constitutional law and basic notions of decency.

The terrible consequence of poor medical care for ICE detainees is that it can result in death. Recently, ICE revealed that 62 people have died in their custody since 2004. Since that announcement, at least three other detainees have died.

In their written testimony, they say 62 and in—64, rather; 64, I think it is; in the oral testimony today it was 66. I don't really know what the right answer is, what the right number is.

Since that announcement, at least three others have died. Some of these deaths were undoubtedly the result of poor health care, yet ICE appears to have no legal obligation to publicly report deaths that take place in their custody and concedes that not every in-custody death is investigated.

Congress must rectify this problem to ensure some amount of transparency and accountability.

Two and a half months ago, Victoria Arellano passed away after spending 8 weeks in detention. Ms. Arellano was a transgender, HIV-positive detainee who, by all appearances, had her disease well under control before she entered ICE custody.

In detention, she was taken off of the HIV medication she required to fend off opportunistic infections and her health quickly began to deteriorate. She developed a high fever, complained of severe pain, nausea, stomach cramps, and began vomiting blood and suffering from diarrhea. Nevertheless, it was fellow detainees and not qualified medical personnel who took care of her in the weeks preceding her death.

After Ms. Arellano's death became public, detainees quoted in the press about her lack of care were transferred to facilities across the country, as far as away as Texas. Such transfers have taken place following other deaths. They appear retaliatory, they hinder investigations, and they intimidate other detainees into silence.

The ACLU has called on the Department of Homeland Security Office of Inspector General to investigate Ms. Arellano's death and the suspicious transfer of these detainees.

Congress ought to pass legislation requiring the detainees receive adequate treatment. This grossly deficient care is inexcusable and immoral, but is often common and often unchecked. While ICE has issued standards for the treatment of detainees, they are not enforceable regulations. Comprehensive immigration reform may have stalled in the Senate, but Congress cannot remain idle while innocent people detained by the Federal Government continue to suffer unnecessary pain and death.

I applaud the efforts of the Chairwoman and Members of the Subcommittee to perform the oversight that the executives is either unable or unwilling to perform, and I urge this Committee to reform a broken health care delivery system that allows people to die.

Congress should fix the procedural and substantive barriers that now prevent detainees from receiving adequate care, and require immigration authorities to publicly report every detainee death. Congress should also pass legislation to codify and improve binding immigration detention standards.

On behalf of the ACLU, I would like to thank the Subcommittee for taking the time to explore this important issue, and I look forward to the opportunity to answer your questions.

Ms. LOFGREN. Thank you very much.

[The prepared statement of Mr. Jawetz follows:]

PREPARED STATEMENT OF TOM JAWETZ

Presentation on Medical Care and Deaths in ICE Custody
Tom Jawetz of the ACLU National Prison Project

For a hearing on "Detention and Removal: Immigration Detainee Medical Care" before the House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law

October 4, 2007

Good afternoon. My name is Tom Jawetz and I am the immigration detention staff attorney for the National Prison Project of the American Civil Liberties Union (ACLU). The ACLU is a non-partisan organization with hundreds of thousands of members and 53 affiliates nationwide. For more than 80 years, the ACLU has fought to defend the Constitution and our precious civil liberties against assault.

I would like to thank Chairwoman Lofgren and members of the subcommittee for inviting me here today to speak about a serious and growing problem in immigration detention—horribly inadequate medical care that leads to unnecessary suffering and death. This issue lies at the center of one of our country's most basic principles: that everyone is entitled to fair and humane treatment. Our Constitution guarantees all persons the right to due process, including adequate medical care, when they are deprived of their liberty.

Today, the ACLU requests that this Committee do the following four things:

(i) Eliminate the procedural hurdles that currently prevent on-site, treating clinicians from providing necessary and appropriate medical care to immigrants in detention;
(ii) Fix the serious substantive deficiencies in the DIHS Covered Services Package to ensure that detainees receive adequate and appropriate medical care consistent with the ICE Detention Standard on Medical Care and well-established principles of constitutional law;
(iii) Require that immigration authorities publicly report every death of a detainee in its custody; and
(iv) Codify improved and binding immigration detention standards, including legislation prohibiting retaliatory transfers of those detainees who complain about inadequate medical care or conditions of confinement.

In June 2007, the ACLU filed a class action lawsuit on behalf of immigration detainees at the San Diego Correctional Facility (SDCF). The lawsuit charges that immigration and corrections officials fail to provide adequate medical and mental health care to SDCF detainees. Our 11 named plaintiffs suffer from mental illness, chronic health conditions, and serious injuries that have not been appropriately treated while in U.S. Immigration and Customs Enforcement (ICE) custody. As a result, they have endured lengthy periods of unnecessary suffering and anxiety. Our lead plaintiff, Eamma Jean Woods, suffers from a genetic disorder of the nervous system that causes tumors to develop on her body. Prior to being detained in July 2006, Ms. Woods was scheduled to undergo surgery to remove a painful tumor on her finger, but she missed that appointment because she was detained. More than one year has passed and she has not yet seen a neurologist or oncologist to determine the proper treatment for her growing tumor.

The ACLU focused on SDCF because of its troubling history of providing inadequate care. Although we focused on SDCF, we do not believe that the inadequate care provided at SDCF represents an isolated incident. Rather, the ACLU believes, after studying numerous immigrant detention facilities across the country, that SDCF is simply the tip of the iceberg and that there are inhumane and unconstitutional conditions in detention facilities across the country. In short, we see an endemic problem that Congress must address.

Today you will hear testimony from Francisco Castaneda, who suffered tremendous pain and was allowed to develop metastatic penile cancer while detained for eight months at SDCF. Mr. Castaneda was ultimately released from ICE custody—and was subsequently diagnosed with the cancer for which he is now receiving treatment—only after vigorous advocacy by the ACLU. While investigating poor treatment at SDCF, the ACLU also learned about a detainee whose leg was rotting and causing a putrid smell in his housing unit. That man, Martin Hernandez Banderas, was finally taken to the emergency room, but not before developing gangrene in his foot and leg and a potentially fatal bone infection. From January 11-15, immigration medical staff described his leg as emitting "a normal, healthy tissue type odor" and showing "no sign of active infection, pus or purulence." But when he arrived at the hospital just two days later, doctors observed a "large right leg/foot ulceration . . . deep, with foul smelling and yellow drainage." Doctors advised Mr. Banderas that to save his life, he might have to lose his foot. Mr. Banderas was released from ICE custody while still in the hospital after the ACLU began to inquire about his poor care—the ICE officers who came to the hospital to release him told him he was costing the government too much money.

As I mentioned above, the problem of poor medical care extends far beyond the walls of SDCF. There are about 30,000 immigrants in detention on any given day, and nearly 300,000 each year.[1] According to ICE, approximately one quarter of these people are identified as suffering from some chronic health condition.[2] Detainees are scattered across the country in hundreds of county jails as well as a handful of facilities run by ICE or private prison companies. Although some may be detained for a matter of weeks, many are detained for months or years.

The system for providing necessary medical care to immigration detainees suffers from several fatal design flaws. First, critical medical decisions are made by off-site Managed Care Coordinators (MCCs) rather than on-site clinicians. This is because no detainee may receive diagnostic testing such as a biopsy or an MRI, specialty care, or surgery, unless and until on-site medical personnel obtain prior authorization from the Division of Immigration Health Services (DIHS) in Washington, D.C. This process results in both unreasonable delays in the provision of medical care, and unjustifiable refusals to provide authorization. This statement is based not only on what we observe with our own clients, but also on the criticisms of jail officials whose hands are tied by the DIHS bureaucracy. In connection with a lawsuit that resulted from DIHS's refusal to authorize necessary medical care for a detainee, the Warden of York County Prison stated: "We believe that the policies that are being followed by the DIHS are designed to try to minimize the medical expense by dragging out the requests for medical care so that the INS inmate can be deported before the cost is incurred. This policy, I believe, is inappropriate and results in delayed delivery to INS inmates of constitutionally required health care."[3] The frustration of York County Prison

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[1] U.S. Immigration and Customs Enforcement, *Detainee Health Care Fact Sheet*, June 26, 2007, available at http://www.ice.gov/pi/news/factsheets/detaineehealthcare.htm.
[2] *Id.*
[3] Affidavit of Warden Thomas Hogan, Apr. 7, 2006, *Yarzue v. Hogan*, No. 4:05-CV-01414-JFM-JVW (M.D. Pa.), ¶¶ 13-14.

officials was expressed even more clearly by the prison's Deputy Warden in a letter to a local ICE officer. In that letter, the Deputy Warden wrote that DIHS had,

> set up an elaborate system that is primarily interested in delaying and/or denying medical care to detainees. . . . There is nothing easy about working with DIHS. If something can be delayed, it is delayed. If it can be denied, it is denied. If something can be made difficult, it is made difficult. Most importantly, if there is some bureaucratic procedure that will delay/deny treatment to a detainee, place the "ball back in our medical department's court" and "cover the backsides" of DIHS, you can be assured that DIHS will do it.[4]

Second, the treatment authorization decisions made by the MCCs—who are themselves nurses, not doctors—are made in accordance with a DIHS Detainee Covered Services Package that is deeply flawed. By its own terms, the DIHS package primarily provides health care services for emergency care only. Until very recently, emergency care was defined as "a condition that poses an imminent threat to life, limb, hearing, or sight" and coverage did not extend to pre-existing conditions.[5] This standard is inconsistent with the ICE Detention Standard on Medical Care, which requires that detainees "have access to medical services that promote detainee health and general well-being" and makes no distinction between pre-existing conditions and all others.[6] Perhaps more important, such a standard is inconsistent with established principles of constitutional law and basic notions of decency.[7]

Two recent government reports reinforce that there is a nationwide, persistent problem with the medical treatment of immigrant detainees. In December 2006, the DHS Office of Inspector General (OIG) released a report of an audit done at five detention facilities.[8] The OIG found instances of non-compliance with ICE health care standards at four of the five facilities, and noted that ICE inspectors routinely failed to note instances of facility non-compliance with standards related to health care.[9] In July 2007, a report by the Government Accountability Office (GAO) similarly found problems with detention conditions, and specifically noted that officials at various detention facilities reported difficulties in obtaining approval for outside medical and mental health care for detainees.[10]

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[4] Letter from Deputy Warden Thomas to Joe Sallemi, D.A.D.D. of 11/28/05.

[5] Division of Immigration Health Services, Summary of Changes to the DIHS Detainee Covered Services Package, Aug. 25, 2005; Division of Immigration Health Services, DIHS Detainee Covered Services Package, Aug. 25, 2005.

[6] INS Detention Standard, Medical Care (Sept. 20, 2000), 1, available at http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf.

[7] ICE detention is civil, not criminal, in nature. As a result, immigration detainees derive their protections from the Due Process Clause of the Fifth Amendment, and are entitled to conditions that are at least as good, if not better than, convicted prisoners. *See, e.g.*, *Jones v. Blanas*, 393 F.3d 918, 932 (9th Cir. 2004). The government's obligation to provide medical care to detainees is not discretionary; it follows from the fact that by depriving a person of liberty, the government deprives the person of the ability to care for himself and his basic needs, such as adequate medical care. *DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189, 198-200 (1989).

[8] Department of Homeland Security, Office of Inspector General, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, OIG-07-01 (December 2006), available at http://www.dhs.gov/xoig/assets/mgmtrpts/OIG_07-01_Dec06.pdf.

[9] *Id.* at 1, 36.

[10] U.S. Government Accountability Office, *Alien Detention Standards: Telephone Access Problems Were Pervasive at Detention Facilities; Other Deficiencies Did Not Show a Pattern of Noncompliance*, GAO-07-875 (July 2007), 18 ("According to ICE, when outside medical care appears warranted, then ICE will make the determination through a Managed Care Coordinator provided by [U.S. Public Health Service]. Officials at some facilities told us that the

The terrible consequence of poor medical care for ICE detainees is that it can result in death. Recently, ICE revealed that 62 people had died in their custody since 2004.[11] Since that announcement at least three other detainees have died.[12] Although some of these 65 deaths may not have been preventable, others were undoubtedly the result of poor health care.

As a member of a national civil liberties organization, I regularly receive complaints from detainees, immigration attorneys, and people of faith from around the country, reporting abuse and mistreatment of people in ICE custody. Yet despite my best efforts, I have been able to identify only 20 in-custody deaths over this time period. In June 2007, the ACLU filed a Freedom of Information Act request to obtain information about these in-custody deaths, but that request has not yet yielded additional information. ICE appears to have no legal obligation to publicly report deaths that take place in their custody and ICE concedes that not every in-custody death results in an autopsy or even further investigation.[13] Congress must rectify this problem to ensure some amount of transparency and accountability.

Today you will listen to the testimony of Edwidge Danticat and June Everett, both of whom lost loved ones who were detained in ICE custody. In December 2006, the ACLU began to investigate the death of Abdoullai Sall, a taxi cab mechanic with no criminal record, who was detained for two months in a Virginia jail until his death. While in custody, both Mr. Sall and his immigration attorney repeatedly notified DHS and on-site medical personnel that he required medication for a serious kidney problem, but his health rapidly deteriorated. He died on December 2, 2006.

Two and a half months ago, another detainee passed away after spending eight weeks at the San Pedro Service Processing Center. Victoria Arellano was a transgender, HIV-positive detainee who, by all appearances, had her disease well under control before she entered ICE custody. Once she entered ICE custody, Ms. Arellano was taken off of the prophylactic medication she required to fend off opportunistic infections, and her health quickly began to deteriorate. According to reports, she developed a high fever and fellow detainees soaked their bath towels in water to cool her down. She complained of severe pain, nausea, and stomach cramps, and began vomiting blood and suffering from diarrhea. Again, it was fellow detainees who took care of her, using a cardboard box as a makeshift garbage can to collect her vomit. She died on July 20, 2007.

One disturbing feature common to both cases is that detainees who attempted to make public facts surrounding each of these deaths were quickly transferred to different facilities. These transfers, which appear retaliatory in nature under the circumstances, can be expected to hinder any investigations into the deaths and intimidate other detainees into silence. The ACLU has called on the DHS OIG to investigate both of these deaths and to look into the suspicious transfers of detainees who witnessed the deaths. The ACLU also joined over 70 national and local organizations outraged by Victoria Arellano's experience in calling upon ICE to implement new policies to ensure that detainees receive adequate

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special medical and mental health needs of detainees can be challenging. Some also cited difficulties in obtaining approval for outside medical and mental health care as also presenting problems in caring for detainees.").

[11] Nina Bernstein, *New Scrutiny as Immigrants Die in Custody*, N.Y. TIMES, June 26, 2007.

[12] Darryl Fears, *3 Jailed Immigrants Die in a Month*, WASHINGTON POST, Aug. 15, 2007.

[13] John P. Torres, Letter to the Editor, N.Y. TIMES, July 4, 2007 ("In each case of a death, the local medical examiner is notified and makes a determination whether an autopsy or further investigation is warranted.").

treatment. This Committee ought to pass legislation prohibiting retaliatory transfers of those detainees who complain about inadequate medical care or conditions of confinement.

This grossly deficient care is inexcusable and immoral. Yet, these detention facilities are not regulated and have little oversight, so unfortunately, such treatment is common and goes unchecked. While ICE has issued 38 standards for the treatment of immigration detainees, they are not enforceable regulations. The standards do not apply to detainees held in Bureau of Prisons facilities, and ICE has been incredibly slow to ensure compliance at other facilities. Recently, Assistant Secretary Myers announced that the standards will be replaced by new "Performance Based Standards," but despite a history of collaborating with NGOs and the public in designing detention standards, ICE has now chosen to work behind closed doors. This is not just a national problem, but also an issue of international concern; the United Nations Committee Against Torture specifically requested information about deaths in ICE custody in February 2006.

Comprehensive immigration reform may have stalled in the Senate, but Congress cannot remain idle while innocent people detained by the federal government continue to suffer unnecessary pain and even death. I applaud the efforts by the Chairwoman and members to perform oversight that the executive is either unable or unwilling to perform and I urge this Committee to reform a broken health care delivery system that allows people to die. Congress must dismantle the current procedural barriers to necessary care in order to permit on-site, treating clinicians to make medical judgments about the appropriate care for detainees. The DIHS Covered Services Package should be significantly modified so that it ensures adequate and appropriate medical care to detainees and is consistent with the ICE Detention Standard on Medical Care and well-established principles of constitutional law. Congress should require that immigration authorities publicly report every death of a detainee in its custody. Finally, Congress should pass legislation to codify improved and binding immigration detention standards, including a prohibition on retaliatory transfers of those detainees who complain about inadequate medical care or conditions of confinement.

On behalf of the ACLU, I would like to thank the Subcommittee for taking the time to explore this important issue, and I look forward to the opportunity to answer your questions.

Ms. LOFGREN. Doctor.

TESTIMONY OF ALLEN S. KELLER, M.D., ASSOCIATE PROFESSOR OF MEDICINE, NEW YORK UNIVERSITY SCHOOL OF MEDICINE

Dr. KELLER. Thank you for the opportunity to testify here today.

I am here on behalf of the Bellevue/NYU Program for Survivors of Torture and Physicians for Human Rights. I am here as a physician who has cared for many immigrants and refugees, including many who have been in immigration detention. I am also here as a scientist who conducted a study looking at the health of asylum seekers in immigration detention.

In this study, done in June 2003, more than 4 years ago—that is when it was released—we documented high levels of psychological distress that worsened the longer that individuals were in detention. We also documented inadequate access to mental health services as well as inadequate medical and dental services.

Unfortunately, recent reports demonstrate that the problems we identified more than 4 years ago remain uncorrected; and I think it is crucial to remember there is a lot more to suffering and morbidity than death. Clearly, that is an important thing to look at, but there is a lot more to the picture.

It is important to remember that like other immigration detainees, asylum seekers are civil detainees, not criminal detainees; and repeatedly we heard from the individuals we interviewed that never did they think when they came to this country, seeking safety and to build a better life, that they would be treated like criminals, placed in facilities such as the Elizabeth Detention Center, a windowless converted warehouse. And these harsh prison conditions were confirmed in a study we conducted with the U.S. Commission on International Religious Freedom for which I serve as an expert.

Access to mental health services was woefully lacking. Furthermore, there were clear disincentives for individuals to report depressive symptoms such as suicidal thoughts because detainees believed, and rightfully so, that if they did, they would be held in solitary confinement if they informed their jailers of these thoughts; and this issue remains a concern today.

In addition to inadequate mental health services, more than half of the individuals we interviewed reported having serious health problems for which they had significant difficulty accessing medical care.

Many detainees complained of difficulty obtaining specialized care, including for chronic conditions. This raises important questions about what care is appropriate and what can reasonably be delayed.

The fundamental problem that we saw appears to persist today, and the health care provided in these facilities that we found then, and now, seems at best a short-term, stopgap "jail mentality"; that is, medical care seems based on the assumption that the patients will be detained for only a few days or weeks while, in fact, many of the individuals we interviewed are detained for much longer. In fact, it would seem that this is going to worsen, given that the trend seems to be to detain more individuals rather than fewer.

In the individuals that we interviewed, for example, one detainee who told us that he was shot in the groin while attending a peaceful demonstration, while in detention his groin pain worsened, he was told that he would have to wait until he was out of detention to get that bullet removed. He remained in detention for 2½ years.

Numerous individuals we talked to describe pain and suffering from dental problems that went unaddressed for months, if not years.

One recent case that I reviewed highlights a number of the problems regarding poor health care—including both medical and psychiatric—involves a woman I will refer to as LC who was from an African country where she suffered repeated trauma, she suffered female genital mutilation, she was raped, she witnessed the murder of several family members. She fled to this country seeking safety. She was imprisoned and recently granted asylum, but she was imprisoned for approximately 6 months. Not surprisingly, when she arrived in this country she was exhausted, and when she learned she was going to be detained she panicked and she subsequently collapsed. At the detention center, she was misdiagnosed as being psychotic. And it should be clear that at that evaluation and as best I could tell from the medical records, these evaluations were done without the use of interpreters, although this woman spoke barely any English.

She was put on a medication Risperdal, an antipsychotic. She had profound significant side effects including lethargy, confusion, and also lactation—production of breast milk. And despite these symptoms, her medications were increased. Finally, she refused to take them and her symptoms improved. Later on when she had severe abdominal pain, she went weeks without proper evaluation, and it was only when her lawyers filed a habeas corpus case that she received medical care. And even then, she wasn't informed of what care she received.

So clearly the problems with health care and immigration which have received recent attention are not new. Many of the problems described, including difficulties and delays, were ones we identified 4 years ago. Congress must do its job of overseeing immigration detention and providing this critical oversight.

It is also essential that there be humane alternatives to detention whenever possible. This, in addition to being morally the right thing to do, is cost effective. Health problems for immigrant detainees need to be adequately addressed from a health perspective, including the pain and suffering and potential morbidity of the individual, as well as from a medical ethics perspective. It does not and should not matter whether a condition is preexisting or began during immigration detention. The individual is in Government custody, and with that comes the responsibility to provide appropriate and needed health services. Thank you.

Ms. LOFGREN. Thank you very much, Dr. Keller.

[The prepared statement of Dr. Keller follows:]

PREPARED STATEMENT OF ALLEN S. KELLER

Statement on Immigration Detainee Medical Care

Allen S. Keller, M.D.

Associate Professor of Medicine, New York University School of Medicine
Director, Bellevue/NYU Program for Survivors of Torture
Member, Advisory Board, Physicians for Human Rights

House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law
Hearing on "Detention and Removal: Immigration Detainee Medical Care"

October 4, 2007

Good Afternoon. Thank you to Congresswoman Lofgren and members of the Subcommittee for inviting me to testify on immigration detainee medical care. My name is Dr. Allen Keller. I am testifying on behalf of the Bellevue/NYU School of Medicine Program for Survivors of Torture and Physicians for Human Rights. I am an Associate Professor of Medicine at New York University School of Medicine. I am Director of the Bellevue/NYU Program for Survivors of Torture and the NYU School of Medicine Center for Health and Human Rights. I am a member of the Advisory Board of Physicians for Human Rights. Previously I served on the American College of Physicians Ethics and Human Rights Committee. I am chair of the Policy Committee of the National Consortium of Torture Treatment Programs, whose approximately 30 member organizations include organizations in more than 20 states caring for torture victims from around the world, many of whom have been imprisoned in U.S. immigration detention facilities.

In June 2003, the Bellevue/NYU Program for Survivors of Torture and Physicians for Human Rights issued a report "From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers."[1] In this study we interviewed 70 asylum seekers held in immigration detention. We documented both high levels of psychological distress, which worsened during the course of detention, and inadequate or non-existent mental health services. We also documented difficulties accessing medical and dental services for painful and sometimes dangerous health problems. Unfortunately, recent reports in major newspapers such as the *New York Times* and the *Washington Post* demonstrate that the problems we identified with regards to accessing health care in immigration detention have not been corrected. In fact, the concerns are even greater today, because current immigration policies continue to expand the use of immigration detention. While our study focused on asylum seekers in immigration detention, the findings clearly have relevance to all immigrant detainees.

The detained asylum seekers we interviewed were held in immigration detention facilities in the New York City area. This included private contract facilities, such as the Elizabeth Detention Center in Elizabeth, New Jersey, and several county jails in New York, New Jersey and Pennsylvania. At the time of our interviews, individuals had already been detained for

[1] Physicians for Human Rights and Bellevue/NYU Program for Survivors of Torture, *From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers* (Boston and New York City, June 2003), available at http://physiciansforhumanrights.org/library/report-persprison.html.

substantial lengths of time. The median length of detention at the time of interview was five months (range 1 month to 4½ years).

As documented in our study, individuals who had fled to the United States under the most difficult circumstances after surviving torture and other forms of brutality abroad were detained under harsh prison conditions. Some were kept in county jail cells, which they sometimes shared with individuals charged with violent crimes. Others were kept in windowless warehouse-like prisons, such as the Elizabeth Detention Facility. Individuals were frequently subjected to segregation—a euphemistic term for solitary confinement—or threats of segregation as a means of punishment and intimidation.

It is important to remember that, like other immigration detainees, asylum seekers are civil detainees, not criminal detainees. Repeatedly we heard from individuals who described how they had come to the United States seeking safety and to build a new life. Never did they think they would be treated like criminals. One individual, who witnessed the murder of his father and fled political persecution in his home country, told us:

> *When I came (to the United States) I never expected to be put in jail. They don't call it jail, they call it detention. But it is jail. I thought I would be free when I got to America. I came here to find peace and be able to live in peace.*

These harsh prison conditions were confirmed in a study on Expedited Removal conducted by the U.S. Commission on International Freedom, for which I served as an expert.[2]

In the Bellevue-NYU/PHR study, we found alarmingly high levels of psychological distress among immigrant detainees that worsened the longer they were in detention. 86% of the detainees interviewed had clinically significant symptoms of depression, 77% suffered from anxiety, and half suffered from posttraumatic stress disorder (PTSD).

Access to mental health services was woefully lacking. Furthermore, there were clear disincentives for individuals to report suicidal thoughts, because detainees believed—and correctly so—that they would likely be held in solitary confinement if they informed their jailers of these thoughts. This issue continues to be a significant concern.

At the time of our study, facilities we visited did not have onsite mental health staff. They relied on outside consultants, who came on a limited or "as needed" basis, making adequate ongoing care difficult if not impossible.

In addition to inadequate mental health services, more than half of the 62 individuals (56%) who reported having serious health problems reported having at least one serious condition for which they had substantial difficulty accessing medical services. Many detainees complained of difficulty obtaining specialized care, including treatment for chronic conditions. This raises important questions about what care is appropriate and what can reasonably be delayed. A

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[2] United States Commission on International Religious Freedom, *Asylum Seekers in Expedited Removal* (Feb. 2005), available at http://www.uscirf.gov/countries/global/asylum_refugees/2005/february/index.html.

fundamental problem we saw—and one which appears to persist today—was that health care was provided with, at best, a short-term, stop-gap, "jail mentality." That is, medical care seemed based on the assumption that patients would only be detained for a few days or weeks, while in fact many of the individuals we interviewed were detained for months or years.

As a result, detainees reported being told that medical conditions perceived as chronic or non-acute could be addressed only after their release from custody. Many also described being aware of bureaucratic difficulties related to obtaining care, including delays in getting approval for certain diagnostic procedures or treatment. Several individuals described being transferred from one facility to the next without their medical information following them. These problems appear to have continued unabated over the ensuing years.

Some examples of difficulties accessing health care that individuals described to us included:

- One detainee reported that while attending a peaceful demonstration in his country of origin, he suffered a gunshot wound to the groin. While in detention, his groin pain worsened. He reported being told that he would have to wait until he was released to have the bullet removed, but he remained in detention for 2½ years.

- A lump on the wrist was a source of pain and frustration for one detainee for several months. In his country, he previously had minor surgery to remove a lump on his wrist, which resulted from his hands had been tied with rope while being beaten. After fleeing his country, while in immigration detention, the growth recurred, even larger and more painful. He was told he would have to wait for release to receive surgery for the condition. After 5 months in detention he was granted asylum and released.

- Another detainee reported a painful testicular lump. An ultrasound was apparently performed, but he stated he was never told the result. He stated: "They only said if I ever get out I could treat it myself."

- Before arriving in the U.S., one detainee had his leg amputated as a result of a severe beating he endured. He arrived in detention with a poorly fitting prosthesis. While in immigration detention for 7 months, he repeatedly complained of pain, but was not seen by a rehabilitative medicine specialist and was never provided a better fitting prosthesis.

Many individuals complained of significant difficulties in accessing needed dental care. For example, one detainee reported a painful wisdom tooth, for which he was given only pain medicine that provided little relief. After five months, the detainee reported that he finally saw a dentist who recommended extraction, but the dentist said there was a delay in having the tooth removed while they awaited approval for surgery from Washington.

> *The doctor gave me Naproxen (an analgesic). The doctor said "I'm sorry for the delay, because there are too many chiefs over me." It was very painful and I put a request in every week for sick call.*

The tooth was only removed after a second request sent to Washington was approved—this occurred approximately one year after he first complained about his tooth.

Similarly, several individuals with eye problems reported difficulty obtaining eye care including glasses. One woman repeatedly complained about needing glasses, but was told that they were "no longer provided." Not getting glasses affected her mental health. She told us, "I like reading. It's the only way I keep myself busy here." She noted that reading without glasses gave her severe headaches. After more than two years in detention, she finally was provided with glasses. Reading was an essential outlet for this woman in trying to cope with the stress of detention.

One recent case which I have reviewed highlights a number of problems regarding poor health care in immigration detention, both medical and psychiatric, including delays in care, inadequate evaluation, treatment and follow up and a failure to use needed interpreters as part of the provision of care.[3] The case involves a young woman (referred to as LC) from an African country who suffered repeated trauma and abuse in her country of origin including female genital mutilation, rape and the murder of several immediate family members because of her ethnicity. Fearing for her continued safety, LC fled to the United States, where upon arrival she was placed in immigration detention where she remained for nearly six months until very recently when she was granted political asylum.

Not surprisingly, upon arrival in the United States, LC was exhausted, and became panicked and terrified when she realized she was being imprisoned. Subsequently, she collapsed. At the detention center she was given Risperdal—an antipsychotic medication. This medication was not medically indicated, as confirmed by evaluations conducted by two outside physicians, including a psychiatrist. These evaluations were arranged by LC's attorney who provided pro-bono legal representation. Furthermore, the woman suffered a number of serious side effects from this medication, including lethargy, confusion and lactation-production of breast milk. Despite these symptoms, the medication was continued for several months and even increased. Subsequently, LC refused to take the Risperdal and these symptoms improved dramatically.

LC did not speak English. According to LC's attorney, interpreters were not used during the provision of medical evaluation and treatment throughout the course of LC's detention. Nowhere in the medical records reviewed, is it noted that an interpreter was used, despite documentation that LC did not speak English.

Later during her detention, LC developed severe abdominal pain, and despite repeated requests, received inadequate medical evaluation and treatment over the course of several weeks. These requests came from the patient, her pro-bono attorney and the two outside physicians who had voluntarily evaluated LC. Only when her attorney was about to file a petition for habeas corpus for LC to receive immediate and adequate medical care was she brought to a hospital for evaluation and treatment. While her symptoms improved, LC was never informed of her medical condition or explained what treatment she received. Again, it appears that an interpreter was never utilized.

Clearly, the problems with health care in immigration detention, which have received recent attention, are not new. Many of the problems recently described—including difficulties and delays in receiving appropriate care—were ones we identified in our study four years ago.

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[3] LC (not her real initials) received pro-bono legal assistance (after referral by Human Rights First) by Ann Schofield, from the law firm McDermott Will & Emery. Ms. Schofield is willing to provide additional information concerning this case and can be contacted by telephone at (212) 547-5364 or via email at aschofield@mwe.com.

Health problems for immigrant detainees need to be adequately addressed. From a health perspective—including the pain and suffering and potential morbidity of the individual—as well as from a medical ethics perspective, it does not and should not matter whether a condition is "pre-existing" (*i.e.*, present before detention), or began during immigration detention. The individual is in government custody and with that comes the responsibility to provide appropriate and needed health services.

Congress should review the immigrant detention health system and provide critical oversight into the care provided. This includes a review of the policies that determine what kind of care is covered and what kind of care is not covered. It is also necessary to streamline the approval process for providing care. At present, health professionals in immigration detention facilities are unable to provide the care they believe is needed and appropriate.

Recommendations:

1. The Subcommittee on Immigration should conduct a full review of health care and related policies in immigration detention.

This review should include a) a comprehensive, independent investigation into the delivery and quality of health care in immigration detention including investigation of deaths which have occurred in immigration custody; b) an expert analysis of the adequacy of health care policies for immigration detainees, including the adequacy of the "package" of health care services available to detainees; and c) an expert analysis of the model, systems and procedures for delivery of health care to detainees.

2. The Subcommittee on Immigration should legislate to ensure that there is timely and adequate provision of health care, including medical and mental health services for detainees in immigration custody.

The U.S. government has a responsibility to ensure timely access and provision of high quality health services, including medical and mental health services. Timely access to specialized health services including dental care needs to be assured.

Standards for health care in immigration detention need to be reviewed, updated and promulgated.

3. Humane alternatives to detention must be utilized.

Whenever possible, immigrant detainees who are eligible for parole should be paroled. Policies concerning parole, including for medical reasons need to be clearly stated and implemented.

Ms. LOFGREN. And, finally, Ms. Little.

TESTIMONY OF CHERYL LITTLE, EXECUTIVE DIRECTOR, FLORIDA IMMIGRANT ADVOCACY CENTER

Ms. LITTLE. Thank you so much. Good afternoon, and thank you for the opportunity to testify about an extremely important issue that, as we have just heard, profoundly affects the lives of so many people.

As you mentioned, Congresswoman Lofgren, the Florida Immigrant Advocacy Center provides free legal services to immigrants of all nationalities, including many in Immigration and Customs Enforcement detention, ICE detention in Florida and elsewhere.

Lack of access to adequate medical care is one of their chief complaints. Recent reports of more than 60 deaths in immigration detention since 2004 have shed new light on a system in crisis. FIAC is working to try to prevent further deaths, although at times this seems a difficult battle. Detainees report undue delays in obtaining proper medical care or outright denial of such care. Even emergency treatment is delayed or ignored.

Recently, FIAC took the case of Yong Sun Harvill, a 51-year-old South Korean woman who has a history of cancerous tumor, chronic lymphedema, hepatitis C, liver disease, and mental health issues. Yong is currently detained at the Pinal County Jail in Florence, Arizona. There is no on-site physician there. In late September 2007, a board-certified hematologist, oncologist and internist, Dr. Gotardo Rodrigues, reviewed Yong's medical records and, in a letter that has been forwarded to ICE, he concluded, and I am now quoting from the letter, "The consequences of continued, incomplete, and superficial care of Mrs. Harvill may include chronic infections, disability, recurrence and progression of tumors, deteriorating physical and mental health, and other complications that could even lead to her death."

This letter followed a similar letter written by Dr. Rodrigues on July 10, 2007 that was submitted to ICE.

Yong has kept a journal since her transfer to a jail from South Florida to Arizona. On August 29, 2007 she wrote, "I'm afraid, because I have seen in the news how many people have died because they don't get medical care. I don't want to be the next one. They deny special tests that I need. I wish my judge can see how frightened I am. In the meantime, I can only pray to God to help me."

Another of FIAC's clients had been diagnosed with cancer before he was detained at the Krome Detention Center in July 2006. Although a physician recommended that he urgently be referred for prostate surgery in October 2006, it was not until late December of that year, and after FIAC was preparing to sue, that he had surgery.

Sometimes it practically takes an act of Congress for a detainee to receive medical attention. On March 8, 2002, one of FIAC's clients who was detained at the Turner Guilford Knight Correctional Center in Miami was spitting up blood in the presence of an officer. Despite attempts by both the officer and FIAC staff to get the detainee appropriate medical care, this was not done until Congressman John Conyers visited the jail and insisted she be seen by a

doctor. That same day, she was taken to the hospital, 1 month and 2 days after she began spitting blood.

Women often do not receive regular gynecological and obstetric care. One woman who was detained at the Broward Transitional Center in Pompano Beach first brought her symptoms to the attention of the medical staff on December 18, 2003. Although she had the classic symptoms of an ectopic pregnancy, a painful and potentially fatal condition, her concerns were ignored. On several occasions she was simply given Tylenol and told her pain was normal. When she began to bleed profusely, the medical staff still did not take her complaint seriously. On January 4, 2004, when she was finally seen by a doctor, she was immediately taken to the hospital for surgery.

Even children have been deprived of adequate medical care in ICE custody. On April 10, 2003, FIAC staff observed Lormise Guilaume carrying her 2-year-old son, Jordan, who was visibly ill. FIAC requested immediate assistance, and officers called 911. Jordan was rushed to the emergency room of a local hospital. His health had been deteriorating for some time and medical attention, repeatedly requested, was inexcusably delayed. A week before Jordan was rushed to the hospital, Lormise told FIAC, and I am quoting, "My son has been sick for weeks. The problem was that I don't speak English and the doctor didn't speak Creole. I never imagined the United States would treat us like this."

Edwidge Danticat testified earlier about the death of her uncle, Reverend Danticat, while in ICE custody. Danticat's lawyers and family have serious questions about the adequacy of medical care provided him while in ICE custody, including at Jackson Memorial Hospital. FIAC also believes the investigation requested by Congressman Kendrick Meek and conducted by the Office of Inspector General into Reverend Danticat's death was a whitewash, and we wrote a detailed letter of complaint requesting the OIG to reopen their investigation. They declined to do so.

It can be extremely difficult for detainees to access their own medical records, and can even take months for FIAC or other lawyers to access records on their clients' behalf. The process for requesting records is different at each facility where immigrants are detained, but is consistently riddled with bureaucratic red tape. With transfers of detainees from one facility to another becoming more and more routine, it can take months to gather a detainee's medical records. When there is a death, such as in Reverend Danticat's case, it is even more difficult to obtain medical records. FIAC had to sue in Federal court to get his records. The medical records we did obtain contained 31 redacted pages on the basis of privacy, despite the fact that the family had requested them.

There is a serious lack of oversight regarding the adequacy of medical care provided ICE detainees. ICE standards adopted in 2000 to ensure the safe and secure treatment of detainees in immigration custody are not binding, and routinely ignored. These standards must have teeth. And outside independent scrutiny of detainees' medical care is necessary to ensure that DHS carries out its moral and legal responsibility to provide for the health and safety of detainees entrusted to its care. Given the dramatic increase

in the use of ICE detention, the need for proper scrutiny of medical care afforded detainees is more critical than ever. Thank you.

Ms. LOFGREN. Thank you, Ms. Little.

[The prepared statement of Ms. Little follows:]

PREPARED STATEMENT OF CHERYL LITTLE

Written Testimony Before the Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law Committee on the Judiciary House of Representatives "Detention and Removal: Immigration Detainee Medical Care"

Submitted by
Cheryl Little, Esq., Executive Director
Florida Immigrant Advocacy Center

October 4, 2007

Good afternoon. Thank you for this opportunity to testify about an extremely important issue that profoundly affects the lives of so many people.[1]

Florida Immigrant Advocacy Center (FIAC) provides free legal services to immigrants of all nationalities, including many in Immigration and Customs Enforcement (ICE) detention in Florida and elsewhere. Lack of access to adequate medical care is one of their chief complaints.

ICE detainees represent the fastest growing segment of our nation's exploding jail population. This population has tripled in the past decade.[2] ICE currently has funding for 27,500 beds, at an estimated annual cost to U.S. taxpayers of over $1.2 billion.[3] Over 230,000 persons were held in administrative immigration custody last year.[4]

While this recent surge in immigration detention has greatly benefited private prison operating companies, like Corrections Corporation of America and the Geo group, whose stocks sharply increased following President Bush's proposal in February 2006 to increase spending in immigration detention, medical care for the fast-growing ICE detainee population has not kept pace.

Detainees include pregnant women, families, the sick and elderly, legal permanent residents, torture survivors and victims of human trafficking. The majority are held in

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[1] This testimony is based on information obtained through interviews, phone conversations and correspondence. It also includes information garnered from materials produced by the United States government as well as newspaper and other articles.
[2] Detention and Removal of Illegal Aliens," Office of Inspector General, Department of Homeland Security, April 2006.
[3] DHS Fact Sheet: ICE Accomplishments in Fiscal Year 2006, Release Date: October 30, 2006. http://www.dhs.gov/xnews/releases/pr_1162228690102.shtm; Immigration Enforcement Benefits Prison Firms," *The New York Times,* July 19, 2006; Detention and Removal of Illegal Aliens," Office of Inspector General, Department of Homeland Security, April 2006; www.ice.gov, August 7, 2006.
[4] Government officials recently considered buying out-of-service cruise ships or leasing them to create "detention barges." In January 2006, Halliburton was awarded a $385 million contract to house ICE detainees.

local and county jails or warehoused in large, privately run facilities in remote areas--in an oftentimes secret detention world outside of the public eye and subject to little scrutiny. Detainees are not entitled to a court-appointed lawyer and 84% are without attorneys.[5] Many are detained for months or even years.

Like Miami's Krome Detention Center (Krome), a Department of Homeland Security (DHS)-owned and operated facility at the edge of the Everglades, county jails are not designed for long-term prisoners. County jails in Florida are not subject to state supervision.

Regardless of where the detainee is held, approval from the Division of Immigration Health Services (DIHS) is required for diagnostic testing, specialty care or surgery. Even when jail or outside medical personnel have recommended treatment, on-site medical personnel are required to submit a Treatment Authorization Request (TR) to DHS for each and every exam, referral, or treatment. Someone who has never seen the patient has the authority to deny care.

FIAC has written numerous reports documenting our concern that those in immigration custody all too frequently are denied adequate medical care.[6] These reports are based on hundreds of interviews with detainees, FIAC's own observations, and conversations with jail and immigration officials over the past decade.

Deficiencies include difficulty accessing medical records; delayed or denied care; shortage of qualified staff; unsanitary facilities; improper care of mentally ill patients; inadequate care of physically disabled patients; inattention to administration of prescription medication; unavailability of translators; rude and abusive behavior by some clinic staff; and threats of transfer in retaliation for complaints.

Recent reports of more than 60 deaths in immigration detention since 2004 have shed new light on a system in crisis. FIAC is working to try to prevent further deaths, although at times this seems a difficult battle.

Adequacy of Medical Care

Detainees report undue delays in obtaining proper medical care or outright denial of such care. Even emergency treatment is delayed or ignored. Recently, FIAC took the case of Yong Sun Harvill, a 51 year old South Korean woman who has a history of cancerous tumor, chronic lymphedema, hepatitis C, liver disease and mental health issues.

Yong was detained by ICE for nearly seven weeks in Florida's Palm Beach County jail and provided little to no medical care. On May 11, 2007, ICE acknowledged the

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[5] S. Lewis and Paromita Shah, "Detaining America's Immigrants: Is this the Best Solution?," *Detention Watch Network*.

[6] "Krome's Invisible Prisoners: Cycles of Abuse and Neglect;" "Florida County Jails: INS's Secret Detention World;" "Cries for Help: Medical Care at Krome Service Processing Center and in Florida's County Jails;" "INS Detainees In Florida: A Double Standard Of Treatment;" "INS Detainees In Florida: A Double Standard Of Treatment Supplement;" and "Haitian Refugees: A People In Search Of Hope."

seriousness of her condition, but claimed there were no DHS facilities in Florida that could accommodate her medical needs and transferred her to Florence, Arizona.

After being detained in Florence SPC for about one month, from May 11until June 16, Yong was moved again, this time to the Pinal County jail, also in Florence, Arizona. There is no on-site physician at the Pinal County jail.

On June 26, 2007, a doctor at the H. Lee Moffitt Cancer Center and Research Institute in Tampa, Florida, where Yong had been a patient, wrote FIAC:

> "Ms. Harvil's disease is extremely debilitating and painful. She will need continued care at a facility familiar with these types of tumors as they will continue to occur and progress. If not treated properly they can become life-threatening."[7]

In late September 2007, a Board-Certified Oncologist, Hematologist and Internist practicing in Miami-Dade County, Florida, reviewed Yong's medical records. He concluded:

> "The consequences of continued incomplete and superficial care of Mrs. Harvill may include chronic infections, disability, recurrence and progression of tumors, deteriorating physical and mental health, and other complications that could even lead to her death."[8]

This letter followed a July 10, 2007 letter written by this same physician and submitted to ICE.

Yong has kept a journal since her transfer to Arizona. On August 29, 2007 she wrote:

> "I'm afraid because I've seen in the news how people have died because they don't get medical care, I don't want to be the next one. Most ironic thing is ...my husband has the best [health] insurance, and I have to be seeing these county hospitals and doctors, and I can't do nothing about it. [I've been] [t]hirty-two years in America, and immigration doesn't care, they don't care if you die, they take you to the most ugliest county hospital. They deny special tests that I need. Oh God what is going to happen next. I wish my judge can see me how frightened I am.... In the meantime I can only pray to God to help me."[9]

Yong's transfer to Arizona has made it very difficult for her attorneys in Miami and her US citizen husband in Plant City, Florida to lend the crucial support needed at this time.

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[7] Letter to FIAC from G. Douglas Dotson, M.D., Program Leader, H. Lee Moffitt Cancer Center & Research Institute, June 26, 2007.
[8] Letter from Gotardo A. Rodrigues, M.D., To Whom it May Concern, September 27, 2007.
[9] Excerpt from Ms. Harvill's journal, August 9, 2007.

It is FIAC's understanding that ICE's Office of Professional Review is reviewing this case.

Another of FIAC's clients had been diagnosed with cancer before he was detained at Krome in July 2006. Although a physician recommended that he urgently be referred for prostate surgery in October 2006, it was not until late December 2006, and after FIAC threatened to sue, that he had surgery.

The number one complaint from women detained at the Turner Guilford Knight Correctional Center (TGK), many of them asylum seekers, was lack of medical care. TGK is a maximum security county jail in downtown Miami. ICE began detaining women there in December 2000, following allegations of sexual abuse by officers at Krome.

It is FIAC's understanding that the already overwhelmed TGK medical staff responsible for providing medical care to over 1000 of TGK's regular inmates were simply asked to work overtime upon the detainee's arrival from Krome.

Detainees complained that sick call requests were routinely ignored. They said some TGK officers and medical staff who were upset at how they were being treated told them that some nurses "were taking detainees' pink slips and throwing them in the garbage."[10] They also claimed they were charged each time they went to the clinic, even though officials claimed not to charge detainees for medical care.

On June 2, 2001 a FIAC attorney learned about a Haitian woman who was so ill that she could barely walk or talk. She said her vision was badly blurred, she couldn't eat but was thirsty all the time, and that she had made several unsuccessful requests to see a doctor. Attorneys from FIAC had to insist that she see a doctor. That same day, she was rushed to the hospital and diagnosed with chronic diabetes. An officer at TGK told FIAC she had been trying to get this detainee medical attention for days.[11]

Detainees who were diabetic often suffered needlessly:

> "I'm a diabetic and they didn't have a special diet for me there[TGK]. I could only eat the starches. I never got physical therapy and I couldn't move around at all. The changed my meds there. So I gained 80 pounds in that time because I could only eat those starches and couldn't exercise because of my handicap and not getting proper treatment."[12]

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[10] Detainee statement, January 4, 2001.
[11] Women's Commission for Refugee Women and Children, "Innocents in Jail: INS Moves Refugee women from Krome To Turner Guilford Knight Correctional Center, Miami," June 2001 (follow-up Report to "Behind Locked Doors: Abuse of Refugee Women at the Krome Detention Center," October 2000.
[12] Detainee statement, October 5, 2001.

TGK detainees suffering from epilepsy also faced serious delays in getting medical attention.[13] One detainee described her experience:

> "[After I fell down] the officers wouldn't let [another detainee] help me that day. Instead, they made me lie in my own urine and defecation for three hours. I was completely humiliated, the experience was terribly painful. Also, at least 10 officers watched me beat my head against the wall when I had a seizure and only one officer tried to help me, the others just stood around watching. It took three days to get me to the hospital… I can't forget the other detainees who have done everything for me. I don't know what I would have done without their help, they're the ones that took care of me."[14]

FIAC and the Women's Commission for Refugee Women and Children (Women's Commission) were at TGK when a detainee was having a seizure in February 2001. During the seizures, other women housed in the same pod were locked in their cells for more than an hour.

In late July 2007 FIAC wrote the Captain at the Monroe County jail in Key West, Florida to call attention to a detainee who has suffered from seizures for years but had not been given her medications.

In attempting to help another detainee at the Monroe County jail get medical attention, FIAC contacted DIHS. In late August 2006 FIAC had contacted ICE and the Captain of the Monroe County Detention Center in Key West, Florida, on behalf of a detainee who had spent weeks in pain, trying to get medical attention for a leaking breast implant.[15] Receiving no response, FIAC contacted DIHS directly, and officials there quickly responded, informing FIAC that Monroe County jail staff had requested a plastic surgeon consultation, which had been approved by DIHS on August 24, 2006.[16] DIHS also said that jail staff said the appointment for this detainee had not been made and they promised to follow-up.

On March 8, 2002, one of FIAC's clients who was detained at TGK was spitting up blood in the presence of an officer. Despite attempts by both the officer and FIAC staff to get this detainee appropriate medical care, this was not done until Congressman John Conyers visited the jail and insisted she be seen by a doctor. That same day, she was taken to the hospital:

> "FIAC came when I was sick and spitting up blood. They called the clinic. The officer also called the clinic and the clinic said there was nothing wrong with me. The nurse said I would have to spit up blood in a

[13] Detainee statement, February 5, 2001.
[14] FIAC interview, April 6, 2001.
[15] Letter to Marion Dillis, Krome Detention Center Officer-In-Charge to Captain Penny Phelps, Monroe County Detention Center, from FIAC attorney Cheryl Little, August 23, 2006.
[16] Letter to Cheryl Little from Gene Migliaccio, Dr., PH., CAPT, US PHS, Director, September 25, 2006.

> special pail to show them. The next day this delegation [from Washington, DC] came and I showed them the pail with the blood. They took me to the clinic after that and while I was waiting I spit up blood on the floor at the clinic. Then they sent me to Jackson Hospital. I had to spend the night at the hospital and they put me on an IV. They brought me back to TGK. Three days later I went back to Jackson for a test .... They brought me back to TGK the same day and then three days after that I went to Jackson again. That time I spit up blood at the hospital so they had to put a tube through my nose to get the blood out of my stomach. After that they started giving me medicine...."
>
> So it took one month and two days of me spitting up blood before they gave me real medicine."[17]

Women often do not receive regular Gynecological and obstetric care. One BTC detainee first brought her symptoms to the attention of the medical staff on December 18, 2003. Although she had the classic symptoms of an ectopic pregnancy, a painful and potentially fatal condition, her concerns were ignored. On several occasions, she was simply given Tylenol and told her pain was normal. When she began to bleed profusely, the medical staff still did not take her complaints seriously. On January 4, 2004, when she was finally seen by a doctor, she was immediately taken to the hospital for surgery, resulting in both the loss of her child and the removal of her fallopian tube.[18] She told FIAC:

> "I think it was around December 18, 2003 that I realized I did not get my period... I started to get worried because I am usually on time and also because I started to experience some pain in my lower stomach.
>
> I put in a written medical request to go to the clinic at BTC. The nurse saw me and I explained my problem. I was told that this was not uncommon. Also that several other women missed their period for two or three months due to stress and not to worry about it. At that visit, I was given about 20 packets of Ibuprofen for the pain. There are two Ibuprofen pills in each packet.
>
> ...By January 1, 2004 the pain was getting much worse... [T]he teacher who speaks Kreyol, helped me make a medical request that day because I was in too much pain. After being told again that this was due to stress I was given Tylenol and Ibuprofen and asked to go back to bed.
>
> When I went to bed the pain was so bad that I was moaning and the officers came. They went downstairs to get a nurse but no one is in the

[17] FIAC interview, April 6, 2001.

[18] FIAC and the Women's Commission wrote DHS to request an investigation into this case and another case involving a pregnant woman at BTC. An investigation was conducted, but FIAC was advised that the results could not be forwarded.

> clinic at night. The officers thought it might be a stomach problem so they gave me antacid and soda…
>
> When I woke up there was blood everywhere. I was bleeding heavily. The officers wrote the request for me to go to the clinic that morning, on January 2, 2004. I was given more Tylenol and Ibuprofen and asked to go back to bed again. I insisted that it was not normal for me not to get my period and was finally given a pregnancy test. The test revealed that I was pregnant… But the pain continued to get worse and I kept bleeding.
>
> On January 3, 2004, I went to the clinic again… They kept giving me more Tylenol and Ibuprofen and sending me back to bed. They always use a telephonic interpreter service at the clinic with me…
>
> On January 4, 2004 the pain was severe. My roommate… helped me get to the clinic. They [clinic employees] wanted to send me back to my room again but my roommate said no. She told them how much I was suffering and said she would not take me back to my room in that condition.
>
> Finally, they brought me back to a room with a table in the clinic and told me to lie down on the table. A male doctor was there. I was in so much pain I was screaming. All he did was touch my stomach and then he said they had to take me to the emergency room immediately. They took me out in a wheelchair.
>
> I was taken to the Broward Medical Center and was told by the Doctor there that it was too late and they needed to operate because I had an infection. He said it was an ectopic pregnancy. I had surgery on January 5, 2004. I was told afterwards that one of my tubes had to be removed. I was devastated by the news because not only had I lost the baby but also because now it would be much more difficult for me to have a baby….I spent three days at the hospital and all the time that I was there, even though there was a phone in my room, the guard that stayed with me did not allow me to use the phone to contact my relatives and let them know what had happened… I was not able to get any special visit with my family either…. I will never be able to forget all that I went through since I've been here."[19]

Another woman who had not had her period since arriving at TGK and was having lower abdominal pain said she made numerous requests to see a physician, beginning in March 2001. In late June she was informed that a referral had been made for her to be seen at Jackson Memorial Hospital, but not until August. A detainee suffering from a gynecological condition who was scheduled for surgery on her uterus had the surgery canceled on the evening before it was to take place. She was never notified of the reason.

[19] Statement of Haitian woman at the Broward Transitional Center (February 4, 2004). See also letter from Kerline Phelizor (April 27, 2003).

A female detainee who miscarried while in immigration custody at TGK described her failed efforts to get medical attention:

> "When I was brought to this jail facility I was placed in the intake holding cell. The room I was locked in for hours had feces smeared on the walls and floor. I thought well maybe it was just that room, however I was moved to another one and that too had feces smeared on the walls and the rooms where absolutely filthy disgusting.... I was six weeks pregnant when I came into this place.
>
> I have been so distraught about the physical conditions and cleanliness of this place. On 7/12/04 I put in a written request to see the facility psychiatrist as I felt these above conditions were not viable to my pregnancy. I wanted to document the stress this facility is causing me. My written request went ignored and on 7/15/04 I miscarried. I was taken to Jackson Memorial Hospital in shackles and handcuffs. I sat in the waiting room amongst other pregnant women who wore looks of concern sitting next to what looked like a criminal. I was wearing bright orange jail uniform and in shackles and handcuffs with two guards at all times. I waited for three hours at which point I started to visibly hemorrhage and only at this point did the medical staff attend to me. I was supposed to go back to the hospital for a follow up, however I was not going back through that humiliation and violation of my human rights unless my life depended on it. To date my request to see the facility psychiatrist has still gone ignored and I have been unable to tell anyone of the upset and emotional stress I have gone through losing my child in a place like this. This jail is not set up to handle real medical emergencies."[20]

All the women in ICE custody at TGK were moved to a Monroe County jail in September 2004 on the basis that TGK could not meet the agency's detention standards,[21] something immigration officials had repeatedly denied.[22] FIAC learned in January 2006, in response to a Freedom of Information Act request, that an ICE annual detention review of TGK in March 2004 assigned a final rating of "At-Risk" regarding detainees' access to medical care. They concluded that "the overwhelming lack for health and safety found at TGK is disturbing."[23]

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[20] Letter from detainee to FIAC, July 28, 2004.

[21] Alfonso Chardy, "Immigration agency moves 45 female detainees to Keys," *The Miami Herald*, September 18, 2004. FIAC believes the Monroe County jail also clearly failed to meet the Immigration Standards, including access to adequate medical care, and detailed complaints from FIAC were repeatedly ignored by ICE and jail staff.

[22] In a letter to TGK officials, thanking them for their efforts to comply with the Detention Standards, an immigration official asked the jail staff not to meet with FIAC, "in particular Ms. Little,' without approval from ICE. (Letter to Lois Spears, Miami-Dade County of Corrections, from Kim Boulia, Immigration and Naturalization Service, Office of the District Director, March 27, 2001) Meetings with TGK staff that had resulted in some improvement in medical care for detainees came to an abrupt end.

[23] DHS, USICE TGK Correctional Center Annual Detention Review, April 5, 2004.

Obtaining mammograms can also be difficult. FIAC attorneys represented a female detainee who was transferred to several facilities. Despite her repeated requests, she was unable to obtain a mammogram in either jail even though she had suffered recurrent bouts with breast cancer, underwent a mastectomy, and had been instructed to undergo regular mammograms. Ft. Lauderdale City Jail medical personnel requested that the detainee be transferred to a facility where she could obtain counseling and Immigration officials transferred her to the Monroe County Detention Center, where she still could not obtain a mammogram. In a December 8, 1996 written response to one of her repeated requests for a mammogram, she was told "reg. mammograms – supposed to have one ever 6 mths – last one was 9/95 – explained WE DON'T DO mammograms."

This detainee did not receive a mammogram until months after the Krome administrator claimed he had ordered one be provided at the Monroe County Detention, months after the mammogram should have been done.[24]

Officers personal beliefs can also interfere with their ability to provide an effective and safe environment for female detainees. For example, FIAC documented the case of an African-born asylum seeker who learned that she was pregnant while in custody. The pregnancy was the result of a politically motivated gang rape in her home country which compelled her flight to the United States to seek asylum. When the BTC staff learned that the pregnancy was unwanted, they purposefully delayed the women's release and pressured her to carry the baby to term. Only after FIAC took her case was she informed that she could get an abortion at her own expense while in custody. This woman was later released and miscarried.

Even children have been deprived of adequate medical care in ICE custody. On April 10, 2003, FIAC staff observed Lormise Guilaume carrying her 2-year-old son, Jordan, who was visibly ill. FIAC requested immediate assistance and officers called 911. Jordan was rushed to the emergency room of a local hospital. His health had been deteriorating for some time and medical attention repeatedly requested was inexcusably delayed.[25] On April 3, 2003, a week before Jordan was rushed to the hospital, Lormise told FIAC:

> "I am very worried about my son here at the hotel. We never go outside. Recreation does not exist for us, we only see the outside world through the glass window; we cannot breathe the air. It's very difficult for my little

[24] A number of women have reported that sanitary napkins were sometimes not available, at times when clean underwear was also unavailable. One asylum seeker reported that a woman who was menstruating was forced to go without any protection at all. When the women were moved from Krome to TGK, TGK officers reported that it was the responsibility of the Immigration and Naturalization Service (INS) to provide toiletries. Women reported that when they asked the INS officer on site about this, she responded: "It's in the contract. TGK is supposed to provide these things. You should tell the TGK officer." Women's Commission interview, June 2001.

[25] See e.g., Letter to Deportation Officer Morales from Charu Newhouse al-Sahli, FIAC (April 11, 2003); Letter to Deportation Officer Morales from Jack Wallace, FIAC (April 9, 2003); Letter to Marion Dillis from Jack Wallace, FIAC (March 31, 2003); and Letter to Marion Dillis from Charu Newhouse al-Sahli, FIAC (March 7, 2003).

> boy. Sometimes he wakes up screaming in the middle of the night, banging his head on the bed and the walls…
>
> My body aches all over from not moving about. I know it's even worse for Jordan. He was much healthier before we came here.
>
> My son has been sick for weeks. A doctor finally did come and see us here at the hotel and prescribed him some medicine, but the medicine has not worked and it's been well over a week since he saw the doctor. The problem was that I don't speak English and the doctor didn't speak Creole. He did not use an interpreter, so I couldn't tell the doctor about all of my son's symptoms…. I'm very worried about his health…
>
> I never imagined the United States would treat us like this."[26]

At times the treatment provided detainees seems unnecessarily harsh. FIAC assisted a 54 year old Swiss woman with a history of repeated episodes of blood clots in the veins of her legs. Her condition had been treated for years with blood thinners. She also had suffered from a triple fracture to her left ankle in September 2006 that required surgery. When she was detained by ICE in January 2007, she repeatedly told the officer who handcuffed and shackled her that her ankle was not completely healed. She was nonetheless forced to board the ICE bus wearing shackles. She tripped and fell while trying to board the bus, suffering further injury. An officer who observed her said "I think I'm looking at a broken ankle." While this detainee was given ACE bandages and ibuprofen for pain, she said she did not receive any medical attention for several weeks.

A detainee with an infected toe reported the following:

> "Since I been detained, I never got to have a nail clippers. So my big toe nail started growing in the skin. I finally got help for my infected toe, they did surgery on it, which was butchering procedure with a sharp knife going under the nail to cut it out. This was done without any local anesthesia. I almost broke my teeth grinding them from the pain."

Last year, FIAC interviewed a Haitian detainee at Wakulla County Jail who had a swollen abscess on his neck. He says that the jail's medical staff did not explain anything about his condition to him when he was taken to the jails' medical clinic, that he was simply told to lie down and was then held down by a physician, nurse and jail sergeant. Then the doctor, without his consent and without anesthesia, "came at [me] with a knife" and sliced open the abscess. He was escorted back to his pod and administered pain medication after the incident.

A detainee who slit her wrist couldn't get proper medical attention to clean it for several days and had to soak a sock in bleach to make a makeshift bandage for her

[26] Statement of Lormise Guillaume, April 3, 2003.

wound. Following this incident the detainee was locked down and reprimanded by an officer:

> "When I returned from the hospital I needed something to cover my wrist because it was bleeding and I need[ed] butterfly stitches. I asked [a TGK Corporal] and she asked me to let her see. That's when she stated that I really didn't want to kill myself. Because if I did I would have cut my arm the long way across. I told her thank-you, I had never known how [to go] about going to kill myself but now I know how to the next time the right way.[27]

The grave consequences of inadequate medical care are all too clear. Eighty-one year old Joseph Dantica, a Baptist minister who fled Haiti seeking asylum, was detained by DHS at Miami's airport for more than 12 hours and was not permitted to leave the airport with his family even though he had a valid visa to enter the United States. He was taken to Krome and died five days later, on October 28, 2005. A medic at Krome suggested that Dantica was faking his illness and reluctantly agreed to take him to Krome's medical clinic. According to John Pratt, Reverend Dantica's attorney:

> "During the entire time the medic and other Krome officials were in the Asylum Unit, when I was there, *no medical treatment at all was provided to Reverend Dantica.* No one checked his vital signs or did anything at all to determine the state of his medical condition. No one ever wiped the vomit off his face and clothes. Eventually, about 25-30 minutes after he suffered the attack, the medic, officer and/or other detainees brought a stretcher and moved Reverend Dantica from the asylum unit to the medical facility."[28]

Later that day Reverend Dantica was transferred to Miami's Jackson Memorial Hospital (JMH), Ward D, the hospital's prison ward, where he died. Dantica's lawyers and family have serious questions about the adequacy of medical care provided him while in ICE custody, including at JMH.

FIAC also believes the investigation conducted by the Office of Investigator General into Reverend Dantica's death was a whitewash and wrote a detailed letter of complaint.[29] Congressman Kendrick Meek (D-FL) asked the DHS Inspector General to "review and evaluate the claims raised by FIAC."[30]

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[27] Detainee affidavit, March 14, 2001.
[28] Declaration of John Pratt, Esq., January 14, 2005.
[29] FIAC wrote the OIG Inspector General with its concerns that in far too many instances the findings in these reports were either based upon alarmingly insufficient evidence or clearly erroneous. See letter to Honorable Richard L. Skinner, DHS Inspector General, from FIAC Executive Director Cheryl Little, November 23, 2005, attached.
[30] Press Release, "Meek Asks DHS Inspector General to Consider New and Conflicting Information in Investigating of Detainee Treatment," December 9, 2005.

In November 2001, 28-year-old Jean Jude Andre, a Haitian national, died after collapsing in a Krome bathroom. A preliminary autopsy report indicated an abnormal heart probably caused his death. According to his family and other Krome detainees, however, Andre's death might have been prevented had he received proper medical care while in immigration custody.[31] As one detainee wrote following Andre's death:

> "I… watched the Nigerian who died on the soccer field on January 1st. We were playing soccer and… he fell down. When that happened, a detainee from Israel and some of us tried to resuscitate him because he was not breathing….About three INS officers were there [on the soccer field] but…for about thirty minutes no one [from INS or PHS] help[ed]. When the doctor finally came, he came with empty hands, nothing to help the detainee. So I think he died because he didn't have medical help in time…. They don't care here…. So we got scared for ourselves. With that, we Nigerians here, we feel very troubled."

In 1999, 46- year-old Ashley Anderson died after being transferred from Krome to Larkin Community Hospital in South Miami. Before his death, Anderson had repeatedly complained to the Miami Herald about neglect and inadequate medical treatment at Krome.[32]

Detainees at the Bay County Jail in Panama City, Florida believe that inadequate care led to the death of another detainee:

> …[O]ver here in Panama City there was an old man by the name of_____. He told the medical department that he was feeling sick, all they gave him was aspirin, and they waited until he got really sick to take him to the hospital where he died. He was here in my dorm.[33]

In late July 2007, detainees wrote FIAC about their concern that a female Haitian detainee at the Glades County Jail in Moore Haven, Florida "may have died" following her collapse. They said she had congealed blood for an hour and pleaded for medical attention and she had no pulse when taken to the medical unit. They hadn't seen her since.[34]

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[31] FIAC and Human Rights Watch wrote immigration officials to express concern over Andre's death. See e.g. letter to John Bulger, Acting INS District Director, November 14, 2001; letter to Wesley Lee, Krome Officer-in-Charge, from FIAC, November 14, 2001.

[32] In September 1998, a Krome Public Health Service worker described to The Herald clinic deficiencies so extensive that "the whole system needs to be closed down and the patients evacuated." Although many improvements have since been made, and Krome's medical center now has state-of the-art equipment, other problems described to The Herald by clinic workers clearly have not been addressed. Among these are accusations that "the majority of the staff" at Krome is insensitive: "They view the people in there as criminals, and they are not treated with simple human dignity," another Krome worker told The Herald. "Staff gets the attitude that no one is really sick. They treat people like everyone is faking it."

[33] Answer to questionnaire by Cuban Detainee in Bay County Jail Annex.

[34] Letter to Mr. Zale Koot from Hamza Al Ksahif, July 24, 2007.

One has to wonder how many detainees have lost their lives behind closed doors, removed from the public eye.

Language Barriers

ICE detainees face unique obstacles in accessing medical and mental health care. Medical screenings are often conducted in English. Detainees consistently report that their health issues are more likely to be ignored, misdiagnosed and/or mistreated if they do not speak English. Non-English speaking detainees are extremely frustrated with their inability to communicate with medical staff have resorted to sign language.

Jail staff often require detainees to submit a written request for medical care, which may be impossible for detainees who are illiterate and/or do not speak or write English. Jails typically rely on other detainees to translate even the most private and confidential details of health matters. Even in facilities housing only ICE detainees, such as the Broward Transitional Center (BTC) in Pompano Beach, Florida, the medical staff typically resort to telephonic interpretation, a source of frustration for detainees.

Detainees like Ming Xu, who was detained at the Wakulla County Jail during a recent FIAC visit, could not write a medical request in English. Other detainees there were illiterate and the written request system makes medical care inaccessible to them. A nurse at the jail told FIAC that the ICE office is right next door to the medical unit and if someone at the jail speaks Spanish, she asks an ICE officer to interpret. Detainees speaking Creole, Mandarin or other less commonly spoken languages in Florida have an especially difficult time. As one Haitian asylum seeker said:

> The language is a huge problem. Sometimes they've had an officer who speaks Creole help me because of my medical problem. But not always. The other day at the clinic the nurse asked me something I didn't understand. I asked for a Creole officer but there was no one. They say we can complain if we want to.... We can't communicate in English so there are a lot of things we can't complain about."[35]

Inability to communicate with medical staff affects not only the extent and quality of the medical care detainees receive, it may also prevent confidentiality between the medical staff and detainees. For example, a Spanish-speaking asylum seeker with a urinary tract infection was forced to explain her problem through the interpretation of a male inmate who was also at the clinic. This detainee was in tears as she told FIAC, "The male inmate asked me when the last time I had sex was."

A Colombian woman with gastrointestinal problems had difficulty explaining her symptoms in detail because the doctor did not speak Spanish. No translation was provided, even telephonically. On her third visit to the doctor, the doctor asked a detainee who was incarcerated to translate, and then asked about her symptoms in front of several others, including officers and other detainees.

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[35] Detainee Statement, April 22, 2002.

Physically Disabled Patients

The neglect of disabled detainees is not an isolated concern. One detainee who suffered from illnesses which prevented her from full use of her legs was not given a wheelchair or the daily care she required at TGK. Instead, officers relied on other detainees assisting her with her daily activities including showering, eating, combing her hair and using the bathroom:

> "Lise [INS detainee] did everything for me except eat, go to the bathroom and sleep… She helped me get from one place to another. She did my housekeeping and my clothes. She washed my hair and bathed me. She got a plastic chair so I could bathe. She combed my hair, cut my nails, put cream on me. She had to help me get off the toilet because it wasn't handicapped accessible for me. Everything you do to yourself everyday, she did for me. I use diaper pads, but they didn't have those there. They put me in regular diapers. I had continuous seizures… So afterwards I'd need to be cleaned-up… the guards would yell across the pod, 'Hey Lise, your baby needs her diaper changed.' After the end of a bad night it still went back to Lise getting up to clean me up, clean my room (get the urine up, change my sheets) washing me all of that. The nurses flat out said Lise was needed to take care of me [although there were] times when they didn't want to give Lise plastic gloves to help when she cleaned me up but she'd clean me anyway.[36]

This detainee had a wheelchair at Krome that was taken from her upon her transfer to TGK. Only after she suffered a bad fall and injured herself at TGK was she provided with a wheelchair:

> "The first few days of April 2001 is when they put in a handicap shower. That was in the week before I left. I slipped coming out and messed my knee up real bad. They didn't take me to the hospital until the next day. Next day I ended up in a stretcher in an ambulance. At the hospital they said I had to have a wheelchair."[37]

Detainees at Krome have reported similar problems. J. had three heart by-pass surgeries and other serious medical problems, including ulcers on his legs. J. complained that three days after he got to Krome, the doctor took his wheelchair away claiming he didn't need it:

> "From the time I was without the [chair] and have been force[d] to walk. My legs and feet have swelen extremely and I am in severe pain. And have not receive[d] any other medical treatmon in this institution."

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[36] Detainee statement, October 5, 2001.
[37] Id.

Complaints have also included inadequate assistance for disabled detainees in showering, going to the bathroom or washing their underwear and the postponement of outside medical appointments because there wasn't adequate transportation available for someone in a wheelchair.

Access to Mental Health Care

Oftentimes detainees with mental health issues receive little, if any, treatment. A Jamaican woman in ICE custody recently reported to FIAC that she was hearing voices, feeling anxious and depressed. She said she put in at least three medical requests since her arrival at the Wakulla jail a few weeks earlier. She told FIAC, "the nurse told me it will take too long to get the records so I can get treatment. About a week and a half ago the nurse told me I'm leaving soon. They say I won't get to see a doctor in time and if I start medication I'll be deported so it won't work. But I can't take it anymore… I hear voices. It's getting worse and I can't sleep. I'm up all night. Please help me."

FIAC observed a young Ethiopian detainee in Port Manatee who had been eating soap, putting Bengay on his genitals, and babbling incoherently. Jail personnel stood by and did nothing when FIAC was there.

One asylum seeker who seemed perfectly healthy upon arrival in the United States apparently suffered a psychotic break shortly after her asylum interview at TGK. She was stripped naked and sent to the Women's Detention Center ("Annex") in July 2001, in Miami where her condition worsened. Her cousin, a psychiatric nurse, was given permission to visit the detainee after contacting a local Congresswoman. The cousin described the conditions of detention at WDC:

> "The condition in which I saw [her] was extremely disturbing. She was completely naked lying on a bare narrow cot secured in a cell next to a security guard. Her lips were dried, chapped and cracked. She appeared to be extremely dehydrated. She expressed a desire for some water. I requested a cup of water from the security guard on duty. The guard directed me to a dirty empty milk carton which I used to secure water from the tap in the cell. She drank four cartons of water. [The next day] I revisited [her]. I saw her lying naked on the cot in a worse condition that the day before. When an attempt was made to get her up, she collapsed. At that point, I was asked to leave."[38]

This detainee was eventually transferred to the Palmetto Mental Health Center, in Florida, where her relatives were not allowed to see her for several days. She was heavily medicated with such drugs as Haldol, Ativan, Syroquil and Cogentin. The family, concerned about the amount and kind of drugs being prescribed for her, only consented to this after they were told that if they did not sign and agree, a court order would be obtained. The family claims the medications were changed without their

[38] Letter from cousin of Guyanan asylum seeker, August 6, 2001.

knowledge and/or permission. A FIAC staff person accompanied the young woman's relatives to the Palmetto Mental Health Center where they initially encountered her incoherent and lying on the floor.

Although this asylum seeker was eventually released, her relatives had much difficulty in obtaining her medical records. Several months after her release, she was still unable to discuss what had caused her psychotic break.

Following the transfer of female detainees from Krome to TGK, TGK officials determined that many were over-medicated at Krome (e.g. given too many psychotropic drugs). Abrupt changes in their medication were made and TGK officials claimed the detainees were suicidal, which resulted in about eight or nine of the women being temporarily transferred to the psychiatric ward of Palmetto Hospital in Miami. (At the Palmetto Hospital, detainees themselves had to try to help another detainee with AIDS who was having multiple seizures). The women claim they were depressed but not suicidal and that the depression resulted from drastic changes in their medication:

> "When I was transferred from Krome to TGK on 12-13-00 I did not receive any of my psych meds for almost a week… Many officers and supervisors tried to see if there was any way they could help me get my meds. But, because of the transfers there was a lot of confusion and miscommunication between INS and TGK staff. On two occasions Cpl. ---- and Cpl. ----took me down to the clinic to see if anything could be done about my meds. Once I was down in the clinic one of the nurses asked me if I wanted to go to the mental hospital to get my meds straightened out because there was nothing they could do in the clinic. I told her I knew these things took time and I was going to try to give them a couple of days. When I was brought back to the unit, as I was entering my room, I passed out… Once Nurse ----seen it was me he made a smart remark stating I was faking to go to the (Psych ward) at Palmetto hospital. He was not there when 15 minutes prior I was offered to go to the Palmetto hospital and had refused. He also stated if I wanted to go suicidal I would be going to the Annex."[39]

TGK officials acknowledged that when a detainee appeared to be suffering from depression, she was stripped naked and sent to the Annex. As one detainee said: "They take detainees to the Annex saying that they are crazy – no they are just depress and hate this place. I wonder if INS knows this."

Many detainees are afraid to seek treatment for depression or other medical problems due to threats of transfer or lockdowns if they do:

> "I was on psych medication but I'm afraid to say it because they've made so many other mistakes with my medication. I need some therapy, I'm just trying to hang in there. The girls here are too scared to tell anybody

[39] Detainee statement, January 19, 2001.

> now because they might ship us to the Annex and say we're crazy… There are women here that need to see a psychiatrist but if they admit what they're going through, they're afraid the doctor will prescribe something for them that's off the wall."[40]

An openly gay female detainee at the Ft. Lauderdale jail claimed said she was mistakenly labeled "crazy":

> "I was kept in a cell by myself. I started my menstruation and kept asking the officers for maxi pads, but they wouldn't give me any. They would laugh at me and ignore me. I begged them to please give me one because I was bleeding on myself….
>
> I was put in the single cell but I still didn't get any pads. The kept saying bad things about immigrants. That immigrants should stay out of America….
>
> I didn't know what to do. I felt desperate. All I wanted was a maxi pad. So I took some of my own blood and I wrote the word HELP on the wall using my blood. The officers took pictures of me and took pictures of the wall. They started making fun of me, telling me I was crazy….
>
> I finally got two pads. But two were not enough for me. I needed more, so I asked for more when those ran out. Instead of getting more pads, they put me in the black chair. The black restraining chair. I was strapped down in the chair and handcuffed for sixteen hours. I was put there during one shift and stayed there for an entire shift after that. I wasn't allowed to use the bathroom or get a pad. I was kept dirty. I went to the bathroom on myself and was bleeding on my clothes."[41]

Children in immigration custody have been especially vulnerable. Like adults, their detention can adversely affect their mental health. Some children have been kept in adult detention facilities, and therefore are far less likely to be released, because they have been subjected to unreliable forensic tests (e.g. dental, bone examinations) to determine their age.

Ernso Joseph was fifteen when he arrived on the October 2002 boat in Key Biscayne, Florida. Shortly after being handcuffed and placed in immigration custody, immigration officials subjected him to dental and wrist x-rays and determined he was an adult.[42] He

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[40] Detainee statement, June 2, 2001.

[41] Detainee statement, June 13, 2001. This detainee was subsequently forcibly drugged and deported to St. Kitts.

[42] As an orphan in Haiti, Ernso has never been sure of his true date of birth. However, DHS officials decided he was 18 shortly after he arrived, relying primarily on a dental test, and locked him up with adults at the Krome detention center. In October 2003, his attorneys submitted authenticated official Haitian documents showing Ernso to be 16 years old, and establishing his eligibility for a Special Immigrant

was placed in an adult detention center. Despite being granted asylum in 2003, Ernso was kept in detention while government attorneys appealed the judge's decision.[43] He was only released to his uncle in South Florida on June 12, 2003 after he was diagnosed with Post Traumatic Stress Disorder, clinical anxiety and extreme depression by both a government and an independent trauma specialist.[44] A few months later, the government appeal was upheld and Ernso was ordered to report for deportation. Ernso was ordered to report for deportation. He spent the next several months in detention and was a virtual prisoner in his hotel room. His mental health rapidly deteriorated and he received no psychological counseling.[45]

In November, 2003, after visiting Ernesto in detention, Congressman Kendrick Meek wrote DHS Secretary of Homeland Security Thomas Ridge to ask for his immediate intervention in the case. Meek wrote:

> "I was a Captain in the Florida Highway Patrol, and I can tell you from personal experience that we treat hardened criminals in this country better than we are treating Ernesto Joseph. It is not an exaggeration to say that dogs in kennels receive more humane treatment and have more attentive and kinder human contact than this Haitian teenager has received at the hands of the federal government."[46]

In January 2004, DHS finally granted Ernso permission to take his case to state juvenile court and the judge ruled in his favor.[47] But the Miami District Director denied Ernso a visa, arguing he was not a minor even though the Florida court determined he was. FIAC appealed this decision and the Administrative Appeals office reversed the denial of Ernso's application for relief from deportation.

In July 2005, a few days before his eighteenth birthday, Ernso's application for a green card was approved by the same immigration judge who a year and a half earlier had

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Juvenile Status (SIJS) visa as an abused, abandoned or neglected child in whose best interest it is not to be returned to Haiti.

[43] See e.g., Amnesty International, "Haitian Teenager Granted Asylum Is Still in Detention," Refugee Action, March 14, 2003; Teresa Descilo, Psychological Evaluation of Ernesto "Ernso" Joseph, May 2, 2003; Tanya Weinberg, "Advocates Blast Teen's Detention," *South Florida Sun-Sentinel*, May 23, 2003; "Free Ernesto Joseph," LIRS Urgent Action, Newsletter of the Forgotten Refugees Campaign; and FIAC Urgent Action, "Free Ernesto Joseph Now," February 26, 2003.

[44] FIAC spent weeks getting permission for an independent Trauma Specialist to meet with Ernso. Following her report that Ernso was suffering from PTSD and extreme depression, a government official came to the same conclusion.

[45] Letter to Cheryl Little, FIAC, from Teresa Descilo, Executive Director, Victim Services Center, October 22, 2003.

[46] Letter to Thomas Ridge, Secretary Department of Homeland Security, from Congressman Kendrick Meek, November 12, 2003.

[47] Congress passed Special Immigrant Juvenile (SIJ) status into law in 1990 in order to protect abused, abandoned and neglected immigrant children. Eligible immigrant children are granted SIJ status and ultimately permanent residence. To be eligible, an immigrant child must be (1) found dependent on a juvenile court; (2) a victim of abuse, neglect and abandonment; (3) found eligible for long-term foster care because family reunification is not a viable option, and (4) determined it is not in the child's best interests to be returned to her native country but rather in her best interest to remain in the U.S..

granted him asylum. He was finally able to attempt to recover from the trauma he had suffered in Haiti as well as the trauma he experienced while in ICE custody in the United States.

Many detainees come to the United States to seek asylum after suffering grievous harm in their own country. Such abuses include torture, rape, female genital mutilation, sexual slavery, forced marriages, and trafficking. Yet despite these traumatic experiences, detainees can be held for prolonged periods in harsh conditions that cause them further trauma and hardship. Detainees have sometimes become so depressed by their long detention that they are unable to properly articulate their story to a judge or asylum officer.

Many of the asylum seekers FIAC has represented are Haitians who legitimately fear for their own lives if deported, and for the lives of family and friends who have been deported and disappeared. Yet Haitian asylum seekers and others are generally not offered meaningful mental health services or orientation before being deported. In fact, such deportations are often carried out without notice in the middle of the night.

Some detainees have even been brought to court heavily drugged. In late 1992, the INS mistakenly advised a Chinese detainee that he was going to be deported the next day, which was the day his asylum hearing was scheduled. As a result, he tried to commit suicide. Public Health Service (PHS) personnel injected him with Thorazine and Benadryl, put him on suicide watch, and tied him to his bed. They woke him up after he had been sleeping for 24 hours and sent him off to his asylum hearing.

Neither PHS nor the Immigration officials told the detainee's lawyer nor the Immigration Judge about the previous day's events. The Immigration Judge denied the detainee's asylum application, ruling that he had not presented a coherent claim for asylum. In April 1993, a federal judge set aside the deportation order, finding that the detainee had been denied the opportunity for a full and fair hearing. The judge found discrepancies between the treating physician's report of the detainee's treatment and INS and PHS records.

Failure to properly care for detainees with mental health issues can pose a danger both to detainees and to others housed with them. During a visit to the Wakulla County Jail in January 2007, a number of male detainees expressed concern about a Mexican detainee whom they believe had severe mental health issues. Detainees said that this detainee would sometimes rant, scream, and fight with someone who was not there, causing detainees to fear for their own safety. Detainees said his behavior was unpredictable and frightening. When the detainee would have a severe episode, the guards would simply lock down everyone in the pod except for the detainee-in-question, who would then "break down" in the main pod area. When FIAC spoke with nurses at the jail, their response was that the detainee is schizophrenic and receiving medication, and that he was going to be deported the following day.

An April 4, 1999 Miami Herald article described a number of incidents at Krome's health clinic in which mentally ill detainees "terrorized or assaulted other patients, officers and medical staff."[48]

Access to Medications

Detainees report serious problems in obtaining proper medications, including medications given at improper times or no medications even after ordered. One detainee told FIAC: "I begged them for my medicine practically in tears but they never listened to me. My mouth was full of herpes…but they gave me pills that weren't for the herpes because they insisted it was a fungus." A Krome detainee who was HIV positive went days without his medication, following a dorm shakedown in July 2006. Medical staff told him they had forgotten to refill his prescription and subsequently were giving him less than half his prescribed dosage.

Detainees also complain that often they don't know what drugs they are taking, or why. Detainees in one Florida facility, outside of Sarasota, called the doctor "Dr. No-touch" because he prescribed medication without seeing them.

Detainees have also complained that they were given expired medication or medication that is different from their prescription. One detainee reported, "[T]he nurses often get the medications mixed up. If they don't have what they need, they'll sometimes get pills from another detainee."

Detainees have had to buy their own over-the-counter medications from the commissary, including aspirin, at inflated prices. Detainees at the Bay County Jail Annex told FIAC that if detainees need over-the-counter medications, such as Tylenol, Sudafed, or Zantax, they must either buy them from the jail commissary or obtain a prescription from the medical department. However, commissary orders may be placed only twice a week. If a detainee is indigent and cannot buy medication from the commissary, he or she may wait several days before eligibility for free medication is established.

A female detainee who suffered from epilepsy said she was given the wrong medication: "When I started convulsing due to the new medication, I was transferred to Palmetto as suicidal. I wasn't suicidal, I was on the wrong medication. {And then they] kept messing up my levels of medication at TGK and I [had] seizures coming and going all the time."[49]

Another detainee reported that her yeast infection went untreated for two and one half months. She was prescribed medication by an ob-gyn at TGK three times over the course of two months. The nurses at TGK, however, failed to dispense her medication despite multiple calls to the clinic by on-duty TGK unit officers and multiple detainee sick-call requests.

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[48] Andres Viglucci, "Krome clinic under fire," *The Miami Herald*, April 4, 1999.
[49] Detainee statement, January 4 and 9, 2001.

Medications improperly dispensed can have serious consequences. As one TGK detainee reported: "I only have one functioning kidney and now they are giving me high dosages of Motrin which can cause kidney problems. I take the Motrin but by fixing one problem, they're creating another."

Detainees who have attempted to correct nurses' mistakes in dispersing their medications have been criticized.

Dental and Eye Care

An initial dental screening exam should be performed within 14 days of the detainee's arrival. However, for the first six months of detention, treatment provided is rudimentary and on an emergency basis. Even after six months, dental care is generally limited to extractions, and treatment of painful dental and gum conditions is delayed or denied altogether. Dentures are not provided, and broken dentures are rarely fixed. One Krome detainee who wrote FIAC in late September 2006 summed up the frustration of his fellow detainees: "It's either pull the tooth out or nothing. Fal[se] teeth services is not provided, although it is indicated in the detainees' handbook." Detainees may not even use their own money to secure dental care.

Eyeglasses are not a covered benefit except when detainees are taken into ICE custody with eyeglasses and the glasses break while they are in custody. Eyeglasses are not replaced if they were left behind or lost at a previous detention facility.

Unhealthy Living Conditions

Detainees complain about unhealthy, unsafe conditions, including filthy jails and overcrowding. Overcrowding can lead to serious health consequences for those detained.

While Krome's medical clinic has been greatly improved over the years and in many ways is now state-of-the art, detainees continue to complain that their complaints aren't taken seriously and often complain of overcrowding.

Overcrowding at Krome has been a long-time concern. In 2006, the population there skyrocketed to well over 1000, although the stated capacity is about 580. There were reports that detainees waiting to be processed were sleeping in the halls and medical area, sometimes near toilets. Detainees wrote FIAC:

> "The campus is over crowded like Sardines with full bunk-beds plus 58+ average (army cots & boat beds), average 1300, plus 250+ non processed detainees, which is causing lots of tension that leads to confrontations, unsanitary dorm, showers, and clogged toilets (5 toilets per 120+ detainees) with low water pressure, flies, shortage of hygiene items.... The A.C. read 79-80 degree and the exhaust fan never on for circulation of the

> air, dirty air is making detainees sick specially breathing on one another while sleeping with 1 foot distance to each other."[50]

On September 20, 2006 there were 1,054 persons detained at Krome, which is nearly double the stated capacity of 580.[51] A detainee aptly described detainees frustrations: "We're living like boil spaghetti. Me, myself I end up have a detainee so close to my bunk it seems like we're sleeping together."

Another detainee from Nairobi was so troubled about overcrowded conditions at Krome in 2006 that he wrote an article that was posted on the East Africa Standard website on April 5, 2007. His op-ed noted:

> "In the months of October, November and December, many times this limit was grossly overlooked with detainees reaching numbers f up to 1,100 at one time. There are no open windows and everyone is consistently sick with one strain of something or another. The clinic is ill equipped to deal with the situation and going to it only guarantees that you are going to sit in a cell for five or more hours only to get aspirins to deal with whichever ailment you have. Rooms built to house 50 people often hold up to 120 people. The filth, congestion and mucky air, with people literally walking over each other's toes, make sure that there were fights almost every day. Although newspapers like Miami Herald had on several occasions asked to get permission to tour the facility, they were always turned down. As of this writing, it has been seven months since the last request was placed for permission to tour the facility, with nothing forthcoming.
>
> On January 8, 2007, my building – Building 11 – had 164 detainees instead of the required 100. On that day, the excess 64 detainees sleeping on the floor in contraptions called boat bunks were taken and distributed evenly among the other buildings so that the overcrowding wouldn't be as pronounced. This was possible because on the same day, tens of detainees were picked up and transferred to other facilities, some in Florida and some outside. We didn't know what was going on until the next day when we saw people, who we could only assume to be auditors, walking around the facility. This is a game that ICE plays all the time. Every time there is too much public outcry, they move some people around to reduce the congestion. After a week or so, everything is right back to normal. The immigration department picks up so many people that it has no resources left to minister to them. Rarely will you have soap, you are forced to wash your whole body with tiny sachets of hair shampoo, go without toothpaste

[50] Signed letter from Krome detainees, September 20, 2006.
[51] Letter to John Stevenson, Acting Officer-In-Charge, ICE, from FIAC, September 28, 2006.

> and other personal products. I can only imagine the anguish of the female detainees in their facilities."[52]

Last year when Krome was terribly overcrowded, ICE refused to provide actual population numbers or acknowledge the serious problem overcrowding was creating. Nor did ICE approve a Miami Herald request for a tour of Krome until months afterward, when the population had significantly decreased.[53]

In June 1995, Dr. Ada Rivera, then chief of the Public Health Service Clinic at Krome, sent a memorandum to Miami District management, warning of the "serious health consequences" of overcrowded conditions at Krome and advising that she intended to suspend the medical clinic's normal functions to "prevent any potential epidemics."[54] Valerie Blake, the Deputy District Director, found Krome "out of control." Despite the clear warning, INS took no action except to advise Dr. Rivera to improve the quality of her paperwork.[55]

Access to Medical Records

It can be extremely difficult for detainees to access their own medical records, and can even take months for FIAC or other lawyers to access records on clients' behalf. Last year FIAC spent months getting a client's medical records and test results. The woman who was detained at BTC first found a lump in her breast in May 2006 that was documented as growing and increasingly painful. She was denied access to her own medical records for months. She eventually received a biopsy in November 2006 but neither she nor her attorney were informed for weeks of the results, which fortunately revealed the lump was benign.

The process for requesting records is different at each facility where immigrants are detained, but is consistently riddled with bureaucratic red tape. Medical files are often imperative not only to help ensure that a detainee is receiving proper treatment but also for political asylum and torture convention court cases.

Sometimes requests for medical records can be made directly to the jail, but records may be held off-site. BTC officials claim that all requests must be approved by the detainee's Deportation Officer first. At TGK every time a detainee asked how she could obtain a

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[52] "Horror of Being Held in Immigrants' Deportation Cell," Opinion, *East African Standard* (Nairobi), August 5, 2007.

[53] "An overcrowded Krome, again," Editorial, *The Miami Herald*, July 7, 2006.

[54] On June 8, 1995 PHS Director Dr. Ada Rivera reported: "We would like to take this opportunity to reiterate our findings during our environmental health inspections for the last couple of months. The overcrowding poses a health problem due to the lack of cleanliness and appropriate air circulation. We have noticed an increased in respiratory and skin conditions. These issues must be urgently addressed to prevent any potential epidemics."

[55] According to an Office of Inspector General (OIG) report, INS officials in Miami tried to deceive the task force about overcrowded conditions at Krome by releasing dozens of detainees, without medical screening, and by sending dozens others (19 of whom were returned to Krome several days later) to a county jail in northwestern Florida or to an INS facility in New Orleans. Even after the OIG investigation was undertaken, Krome's population remained high and the facility overcrowded.

copy of her medical records the answer seemed different. Detainees were routinely told by TGK medical staff that they needed a "court order" to get their records and were unaware of any form for requesting records.[56] According to the Dade Corrections Health Service, the cost to obtain medical records is $1 per page, even for detainees.

With transfers of detainees from one facility to another becoming more and more routine, it can take months to gather a detainee's medical records. Transfers routinely interrupt medical care. Detainees' medical records are not always transferred promptly, in complete form, or in some cases, at all. Medications provided in one facility are frequently not provided for weeks following transfers.

When there is a death, such as in Reverend Joseph Dantica's case, it's even more difficult to obtain medical records. FIAC had to sue in federal court to get Reverend Dantica's medical records. The medical records finally obtained contained 31 redacted pages on the basis of privacy, despite the fact that the family had requested them.[57]

Forcible Drugging to Deport

While DHS officials deny that such drugs are used simply to carry out deportations, immigration employees privately have conceded the opposite.[58]

Earlier this year the Los Angeles Daily Journal reported that federal immigration agents at a Lose Angeles detention center forcibly drugged two immigrants while attempting to deport them.[59] The paper claims it obtained medical records confirming that both men who reportedly had no history of mental illness or violence, were drugged against their will. Airline officials refused to let them board the plane.

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[56] Attorneys had to request TGK detainees' files through Miami-Dade Corrections Health Services. Typically, TGK was without the file for one-two weeks, after the file was sent from TGK to the Miami-Dade staff.

[57] FIAC filed its first request for Reverend Dantica's medical records on December 3, 2004, asking for all of his records and any investigative reports on his illness and death. The request was filed with the DHS's Miami office because the records being sought were held at Krome. After hearing nothing for more than a month, FIAC inquired about the status of its request on January 10, 2005. A Krome staffer said that she had not seen the request and that the request had not been sent to Krome from DHS's Miami office. A staffer at DHS's Miami office told FIAC that it had not even begun to process the request because the entire office was behind on Freedom of Information Act requests since some of its staff had been reassigned to another unit. FIAC faxed the request to the Miami office again on January 11. In a letter to FIAC on January 11, U.S. Citizenship and Immigration Services District Director John M. Bulger said that the Dantica request had been placed on the "complex track" and not processed as quickly as simple requests. Bulger's letter suggested that the FIAC "simplify" its request to get faster service.
FIAC responded that its expedited request was very short and very specific, requesting only the medical records of one person who was in DHS custody for five days. FIAC followed up with a call to Krome on January 26, 2005 and a detention center staffer said that they had still not received orders to process the request from DHS's central office. In response to FIAC's January 20th letter, DHS sent a letter, dated January 26, suggesting that the records request be redirected to the Immigration and Customs Enforcement Office of Investigations in Washington, D.C. FIAC contends that Immigration's Miami office was the correct venue for making the request, citing the department's own policy.

[58] William Booth, "U.S. Accused of Sedating Deportees," The Washington Post, October 7, 1993.

[59] Sandra Hernandez, "U.S. Agents Forcibly Drug Immigrants to Deport," *Los Angeles Daily Journal*, May 8, 2007.

In June 2001, FIAC received a call from a former detainee following her deportation:

> "A nurse woke me up to give me a shot… I was taken to the airport and boarded a plane. I fell asleep again. I don't remember anything about that morning after I got the shot. When I got to St. Kitts… I started feeling really sick. I felt weak and dizzy. I could barely walk or talk. I had to call a cab to take me to the hospital… My speech was slurred… I never felt like that before and I haven't felt like that again."

In October 1991, Krome's medical staff injected a detainee with extremely large doses of powerful anti-psychotic drugs to carry out his deportation, although he was not diagnosed as mentally ill. Tony Ebibillo Eplcen had applied for asylum but was denied. He believed that his return to Nigeria was tantamount to a death sentence and resisted deportation on three occasions. An attempt to deport him in December 2001 failed. Tony's medical records indicated that he had been given heavy doses of Thorazine and was placed in 4-point restraints.[60] When he briefly regained consciousness in the INS van, he was handcuffed, shackled, and straitjacketed. His mouth was taped shut.

American Airlines officials refused to transport him. A flight superintendent said that since the authorities refused to ungag or unstrap Tony, she and the plane's captain were worried that during the course of the nine hour trip he wouldn't be able to go to the bathroom or even drink water.[61]

Detainees Treated Like Criminals

According to detainees, some officers have an anti-immigrant bias that can affect their access to medical care. Officers frequently view ICE detainees as criminals, even when they have no criminal history. At times they too readily assume the detainees are faking their illness.

Moreover, ICE detainees who are not serving criminal sentences are nonetheless handcuffed and/or shackled when transported to outside hospitals for medical care and even when in their hospital ward. In the summer of 2004 a very ill, pregnant ICE detainee held at a local Miami jail was taken to Jackson Memorial Hospital in shackles and handcuffs and not seen by doctors until she began to hemorrhage. Reverend Dantica, an 81-year old Baptist minister with no criminal history, was transported to Jackson Memorial Hospital with leg restraints and relatives who requested to see him were turned away.

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[60] Doses of Benadryl and Thorazine were administered on December 6, 1991, the day before his scheduled deportation. Doses were repeated every few hours for twelve and a half hours and resumed at 6:30 the next morning. At 2:55 p.m. the next day, he was given more Benadryl and Thorazine and Ativin.

[61] Mark Dow, "American Gulag, Inside U.S. Immigration Prisons," pp. 69-84, University of California Press, Berkeley.

Even children sent to the hospital have been denied permission to see their relatives. The sister of an unaccompanied minor in Immigration custody was denied permission to visit her brother at the hospital shortly after he arrived in October 2002, and burst into tears when forced to leave the hospital:

> "I called Haiti and found out that Jimmy, my 16-year-old brother, came to Miami on the October 29, 2002 boat. I found out that he was taken to Jackson Hospital. When I went to the hospital and into his room, there was an immigration Officer there. I was about to go in to hug my brother and see how he was doing, but the officer would not let me in. I tried to plead with the officer and begged him to let me see my brother, but he started screaming at me and did not let me in the room. It had been six years since I had seen my brother. I had to leave the hospital in tears without being able to talk to him and see how he was doing."[62]

Because the sister spoke to the press about her concerns, her brother was advised while at Boystown that he could be deported because his sister was "making problems."[63] Jimmy was finally released on Christmas Eve, 2002.[64]

A Colombian woman who was meeting with a doctor at TGK said he advised her during her first visit to wait until she was deported to Colombia, and then she could get medical care. During her third visit, she said the doctor told her: "You should be happy. I understand that you are about to be deported."[65]

The condescending nature of the treatment at times received by female asylum seekers is sometimes manifested in staff culture and training. For example, in 2004 FIAC saw the BTC Detention Manual given to detainees to help them navigate the correctional institute, which included a section on "social tips." This section reminds detainees not to spit or blow their nose on the floor, wall or in the sink; that when speaking to Americans, detainees should stand an arms length away and speak in a low even tone, rather than a loud rapid manner; and that Americans are very conscious of personal hygiene and therefore detainees should shower, brush their teeth and change their undergarments everyday. Underlying these "tips' is the assumption that foreign-born women engage in socially unacceptable behavior.

A Haitian detainee who had been in ICE custody for about two years had renal failure while in jail in Bradenton, Florida and had to be hospitalized. This detainee was released after winning his immigration case. FIAC was not contacted when he was about to be released, which had been requested due to his serious medical condition. Following his release at night, this detainee ended up sitting on a bench outside the jail, without any

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[62] Statement of Chimene Noel, December 3, 2002; see also Jacqueline Charles, "Haitians struggle to unite families," *The Miami Herald,* December 12, 2002.
[63] See Letter to Carmel Clay Thompson from Cheryl Little, March 17, 2003.
[64] "Christmas Present for Noel," *Washington Post*, December 26, 2002; Alfonso Chardy, "Young Haitian migrant released," *The Miami Herald*, December 25, 2002.
[65] Women's Commission interview, June 2001.

money or belongings. The next morning when the immigration court judge was going to work she saw him and contacted FIAC. After FIAC picked this client up, he passed out and was taken to a local hospital. He later had to go on dialysis and died a year following his release.

Until July 1998, Immigration officials used the Jackson County Correctional Facility to house its detainees. Following complaints that officers sometimes used an electric shock shield to punish detainees, including detainees who needed medical treatment, immigration officials quickly removed the detainees. Detainees described the shield as a curved, four-foot high piece of a Plexiglass-like material, with two handles in the middle. The detainees hands and legs were handcuffed to a concrete bed and the shield placed over the detainee's body.[66]

Numerous detainees told FIAC and Miami Herald staff about the electric shield. One detainee reported: "the first time I saw this (use of electronic shock shield) an inmate had epileptic seizures, he kept begging for some medication, banging on the glass window. Then four or five officers came in with the electric shield, handcuffed him after they threw him to the floor and handcuffed his hands behind his back, and then they put the shield on him and they hit him....He had plenty of seizures at Jackson. Many times his head would be banging against the wall with the seizures and the officers would say, 'don't touch him.' And [the officer and the nurses] would always tell the guy, 'there is nothing wrong with you, stop faking it.' And the poor man was having seizures back to back. He really needed help."[67]

In June 2006 a detainee from Trinidad was taken to the Wakulla County jail's medical unit after being tasered in his neck and abdomen, falling to the floor and hitting his head. This detainee was tasered even though he had done nothing wrong and was never written up by officers. On the contrary, he was a victim of abuse by another detainee.

One anonymous medical worker told the Miami Herald in the fall of 1998 that "the majority of the staff there right now is insensitive. They view the people in there as criminals, and they are not treated with simple human dignity. They just totally ignore them. Staff gets the attitude that no one is really sick. They treat people like everyone is faking it."[68] Unfortunately, this view remains all too pervasive even today in detention facilities across Florida and elsewhere.

Retaliation

Fear of retaliation frequently prevents detainees from seeking appropriate medical care. Sometimes detainees who attempted to get proper medical care were placed in lockdown.

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[66] See e.g. Andres Viglucci, "Immigrants allege abuse at jail in N. Florida," *The Miami Herald*, July 30, 1998; "Brutality at county jails?," Editorial, *The Miami Herald*, July 31, 1998; Andres Viglucci, "Immigrants' claims of torture stir probe," *The Miami Herald*, July 31, 1998; and Teresa Mears, " A Shock to the System," *Miami New Times*, July 30-August 5, 1998.
[67] Affidavit, July 28, 1998.
[68] Andres Viglucci, "Critics of clinic paint a tarnished Krome," *The Miami Herald*, September 21, 1998.

Detainees also say they have been threatened with transfers, and in some cases transferred, after complaining about adequate access to medical care.

Conclusions/Recommendations

ICE detainees are routinely subjected to poor, and sometimes appalling, medical care. They are especially vulnerable because they are truly at the mercy of DHS officials. Because they are detained they are not permitted to get treatment from outside doctors – even at their own expense. FIAC's attempts to obtain adequate medical treatment for clients and to call attention to serious medical issues have repeatedly been ignored.

Understandably, some overwhelmed health care employees may be suffering from compassion fatigue, but denying that problems exist can place at risk detainees in dire need of medical care. While some detainees may exaggerate the problems they face in getting proper medical attention, press reports and statements from medical staff themselves make clear that detainees' complaints are often legitimate.

Standards promulgated by the American Correctional Association (ACA) provide useful information for those running these facilities, however they were designed for a criminal population and do not take into account that detainees in ICE custody are there on the basis of civil violations only and are not serving criminal sentences or awaiting trial. They have special needs that are not applicable to those accused or convicted of criminal violations.

The current detention policy is overly broad and inhumane. Notwithstanding ICE officials best efforts, they must work within the system and the system is fundamentally flawed. Those who are neither dangerous nor likely to abscond should be fairly considered for parole.

There is a serious lack of oversight regarding the adequacy of medical care provided to ICE detainees. It is ICE's responsibility to ensure the adequacy of medical care provided to its detainees, regardless of where they are housed or who the medical providers are, because it is ICE that holds them prisoner.

ICE has abdicated this responsibility by failing to oversee the provision of such care. ICE Standards adopted in 2000 designed to ensure the safe and secure treatment of detainees in immigration custody are not being implemented, despite assurances to the contrary. These Standards are not binding and routinely ignored. Only outside, independent scrutiny of detainees' medical care will ensure that DHS carries out its moral and legal responsibility to provide for the health and safety of detainees entrusted to its care. Given the dramatic increase in the use of INS detention, the need for proper scrutiny of medical care is more critical now than ever.

FIAC recommends that the following steps be taken immediately:

- ICE must ensure that all detainees in ICE-run facilities, contract facilities or county jails receive adequate medical care.

- ICE must ensure that medical facilities are clean and properly staffed, maintained and equipped.
- ICE must ensure that detainees are properly and consistently referred to competent health care providers both within the facility in which they are detained and outside.
- ICE must discontinue arbitrary rules such as the refusal to provide dental care until the detainee has been in custody for at least six months.
- ICE must ensure that detainees may seek medical care without threat they will be transferred or punished if they do so.
- ICE must ensure that detainees' medical records and medications accompany them upon transfer so that medical treatment is not interrupted.
- Women detainees must be provided with regular gynecological care and mammograms.
- ICE must take detainees' medical conditions and the adequacy of available medical care into consideration in determining whether a detainee should be released or transferred.
- ICE must ensure that adequate translation services exist at every facility where its detainees are held so that they may effectively communicate their medical needs.
- ICE must ensure that detainees in county jails are not required to buy over-the-counter medications.

ATTACHMENT

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November 23, 2005

The Honorable Richard L. Skinner
Inspector General
United States Department of Homeland Security
Attn: Office of Inspector General
Washington, DC 20528

Re: In re: Death of Reverend Joseph Dantica -- Objections to Findings Set Forth in OIG Documents: *Report of Investigation* (March 21, 2005) and *Response to Recent Press Reports* (July 18, 2005) -- OIG Case No. I05-BICE-MIA-01646

Dear Inspector General Skinner:

On November 3, 2004, Reverend Joseph Nozius Dantica -- devoted father, uncle, and public servant -- died while in U.S. Immigration and Customs Enforcement (ICE) custody. On that day, Reverend Dantica's family, friends, and parishioners suffered a profound loss from which they have yet to recover. Nevertheless, on November 18, 2004, their spirits were buoyed by the announcement that the Office of the Inspector General (OIG) was initiating an investigation into the circumstances surrounding Reverend Dantica's death. Reverend Dantica's loved ones placed their faith in your office's pledge to conduct a thorough investigation that would report the facts regarding Reverend Dantica's inhumane treatment at Krome Service Processing Center (Krome) and Jackson Memorial Hospital (JMH).

After reviewing the findings contained in your *Report of Investigation*, dated March 21, 2005, and your *Response to Recent Press Reports*, dated July 18, 2005, Reverend Dantica's family, friends, and parishioners are deeply saddened that, in far too many instances, the findings in these reports are either based upon alarmingly insufficient evidence or are clearly erroneous.

In particular, we unequivocally object to the following findings contained in OIG's *Report of Investigation* and *Response to Recent Press Reports*:

I. **Errors Contained in the *Report of Investigation***

A. OIG's *Report* is so Vague and Imprecise that it Fails to Address the Critical Question Which Prompted the Investigation

OIG correctly stated that its "investigation was initiated to determine whether the death of 81-year-old Haitian National Joseph Nozius Dantica on November 3, 2004, while in U.S. Immigration and Customs Enforcement (ICE) custody, was the result of any improper actions by ICE or other personnel." (Report p. 1). Nevertheless, for thirteen out of the fifteen pages of OIG's *Report*, OIG simply regurgitated the testimony of all of the persons contacted during the investigation without any attempt to analyze the evidence or to make findings of fact.

The only conclusion OIG reached in its entire report is that "[t]here was no evidence of mistreatment of malfeasance by any CPB *[sic]* or JMH employees." (Report p. 2). Even though OIG stated that it was commissioned to investigate whether Reverend Dantica's death was "the result of any improper actions by ***ICE or other personnel***," it apparently restricted its conclusion to the actions of employees of U.S. Customs and Border Protection (CBP) and JMH. OIG's language is important, as the majority of employees at Krome are employed by U.S. Immigration and Customs Enforcement (ICE) and not CBP.

The conclusion reached in OIG's *Report* may only be explained in one of two ways: either the language used in describing those employees under whose care Reverend Dantica was placed was alarmingly imprecise and actually intended to encompass "ICE [and] other personnel," or OIG's conclusion deliberately sought to exclude ICE, PHS, KSPC, and other personnel from its finding of no mistreatment or malfeasance. Perhaps OIG's focus on CBP personnel was simple carelessness (OIG even misspelled CBP as "CPB") (Report p. 2). Conversely, given the ample record evidence of mistreatment and malfeasance on the part of various DHS employees, it is also possible that OIG knowingly excluded all non-CBP employees from its finding of no malfeasance.

In either case, no reasonable reader of OIG's *Report* can help but be troubled by OIG's cavalier response to the mistreatment that Reverend Dantica experienced at the hands of DHS employees prior to his death. By failing to precisely answer the key question it plainly admits it was commissioned to investigate -- whether Reverend Dantica's death "was the result of any improper actions by ICE or other personnel" -- OIG's report trivialized the loss suffered by Reverend Dantica's loved ones and squandered an important opportunity to instill a process whereby DHS employees are required to account for their improper actions.

The remainder of this letter operates under the assumption that OIG intended to include all DHS, KSPC, PHS, and other personnel in its conclusion that "there was no evidence of mistreatment of malfeasance by any CBP or JMH employees."

B. OIG's Report Erroneously Concluded that "There was *no* Evidence of Mistreatment or Malfeasance by any CBP Employees." (Report p. 2)

1. OIG's Report Ignored Substantial Record Evidence that Several Public Health Service (PHS) Employees Incorrectly and Insensitively Stated that Reverend Dantica was Deliberately not Cooperating with PHS Employees and Suggested that He was Faking His Illness.

Around 9:00 am on November 2, 2004, Reverend Dantica was taken to Krome's Asylum Office for his "credible fear" interview. (Report p. 1). Shortly after the interview began, the

telephonically contracted interpreter had trouble hearing Reverend Dantica and "asked him to come closer to the phone to improve reception." (Report Ex. 9) When Reverend Dantica leaned forward he became critically ill and began vomiting severely. *Id.* Despite this unmistakable indicia of severe illness, several PHS employees at Krome accused Reverend Dantica of failing to cooperate with medical staff and, even more distressingly, of faking his own illness. Nevertheless, OIG ignored the plain record evidence before the agency and concluded that there was ***no*** evidence of mistreatment or malfeasance.

Specifically, OIG ignored testimony from three Krome officials that, even as Reverend Dantica leaned back in his wheelchair nearly unconscious and completely covered in his own vomit, "PHS employees made reference to the fact that Dantica was not being cooperative." (Report Exs. 10, 15, 16). For example, the physician's assistant called to respond to Reverend Dantica's illness "informed Pratt [Reverend Dantica's attorney] that [s/he] felt that Dantica could have been more cooperative with the PHS response team." (Report Ex. 16). Pratt, who works at the law firm of Kurzban, Kurzban, Weinger and Tetzeli, himself stated that a PHS employee told him that Reverend Dantica was "not cooperating." (Report p. 6).

Additionally, Reverend Dantica's son Maxo testified that a PHS employee informed him "that he felt that Dantica was faking his illness." (Report p. 7). Maxo's testimony is confirmed by Reverend Dantica's Asylum Pre-Screening Officer's testimony that "PHS employees . . . interacted with Pratt and discussed the ***validity and severity*** of Dantica's illness." (Report Ex. 9).

OIG's *Report* also failed to give appropriate weight to the critical fact that Reverend Dantica could not respond to PHS employees because "[Reverend] Dantica's own vomit had rendered [his] electronic voice box inoperable." (Report p. 6). Only after Reverend Dantica was taken to the PHS Urgent Response Unit did PHS officials finally attempt to clean Reverend Dantica and change his Krome uniform "because it was soiled with vomit." (Report Ex. 18).

OIG was aware as well that a Security Officer in the Asylum Office had to be asked on two separate occasions to call for help from PHS. (Report p. 5 and Ex. 9). Reverend Dantica's attorney stated that he and an Asylum Officer "insisted that a medic immediately attend to Reverend Dantica. (Response Ex. 7). After begging security to contact medical assistance, a security officer informed Pratt that "we are on a lockdown," and a doctor could not be summoned at that time. (Report p. 6 and Ex. 11). Pratt subsequently demanded that a stretcher be brought to move Reverend Dantica to the medical unit because his client "looked almost comatose to me at the time [and] seemed somewhat unconscious and couldn't move." (Response Ex. 7).

Rather than assigning appropriate weight to the testimony of four of DHS' own employees, Mr. Pratt, and Maxo, OIG simply ignored their recollection of the November 2nd events and unequivocally concluded that there was "***no*** evidence of mistreatment or malfeasance." Had OIG chosen to conclude that there was some dispute as to a finding of no mistreatment or malfeasance, one might conclude that OIG made a conscientious judgment in this regard. OIG's conclusion, however, of no wrongdoing whatsoever, failed to give ***any***

credence to the compelling evidence cited above. Accordingly, OIG should vacate this finding as it is clearly erroneous and not based upon the record evidence before the agency.

2. OIG Erroneously Concluded that, When Summoned to Aid his Father to Communicate with PHS Employees, Maxo "was visibly upset and was not cooperating with the PHS employees to provide translation services." (Report p. 5)

OIG's conclusion completely ignored the record testimony of PHS employees, Mr. Pratt, and Maxo. (Report p. 7). Krome's own medical records stated that "when his son arrived he started communicating [with Reverend Dantica] and finally we established communication [with] them." (Krome Chronological Record of Medical Care – Emergency Note 11/2/04). Additionally, a PHS physician's assistant testified that "once Osnac (Maxo) arrived, Dantica responded to him and pointed to his stomach as a source of pain." (Report Ex. 16). Additionally, Pratt told the OIG that Maxo was helpful in trying to assist Reverend Dantica to communicate with PHS employees, but that communication was hindered because Maxo was not allowed to clean the vomit off of his father's face and, thus, his father's voice box was rendered non-operational. (Report p. 6, 7) Maxo said that his efforts to communicate with his father were also hindered because his father was unable to hold the voicebox to his larynx. (Report p. 7). Pratt stated that Maxo was escorted out of the Asylum Office because PHS employees said he was not cooperating. (Report Ex. 11). According to Maxo, this was the last time he saw his father. (Report p. 7).

Accusations by officials at Krome that Maxo was "visibly upset" and therefore failed to cooperate also incomprehensibly fail to take into account how traumatic it must have been for Maxo to suddenly see his father listless and utterly helpless, in a wheelchair and "covered in vomit." (Report pp. 5, 9). This was especially so since PHS officials "would not allow [Maxo] to wash Dantica's face." (Report p. 7). Pratt pointed out that "Maxo was upset that [officials] didn't want him to stay with his father **because he was worried about him**." (Response Ex. 7). The OIG report itself notes that Maxo said "he pleaded [with authorities] to remain with [Reverend] Dantica." (Report p. 7).

It is worth noting that Mr. Pratt was the one who insisted that Maxo be summoned to communicate with his father and to provide information about his father's medical history. (Response Ex. 7). Another Haitian detainee had initially been brought to the Asylum Office to attempt to communicate with Reverend Dantica because Krome Officers hadn't been able to locate Maxo, who had been attending a Krome program he had signed up for.

By erroneously stating that Maxo did not cooperate with PHS employees to provide translation services, OIG neglected to consider substantial testimony from several eyewitnesses stating otherwise. OIG's conclusion demeans the value of Maxo's corroborated testimony and displays an appalling lack of sensitivity to his loss. By concluding that Maxo was not cooperative in aiding DHS officials to save his own father, OIG concluded that Maxo saw his father dying and nonetheless chose not to cooperate. This conclusion, like the conclusion that Reverend Dantica himself seemed uncooperative, unfairly blames the victim. It is not credible and should immediately be retracted by your office.

3. OIG Incorrectly Stated that "Dantica received medical attention in the asylum office and was transferred to the Public Health Service (PHS) unit at [the Krome Service Processing Center] where he was placed under the care of a physician." (Report p. 1).

This finding squarely conflicts with the testimony of Reverend Dantica's attorney. Specifically, Mr. Pratt declared that:

> During the entire time the medic and other Krome officials were in the Asylum Unit, when I was there, ***no medical treatment at all was provided to Reverend Dantica***. No one checked his vital signs or did anything at all to determine the state of his medical condition. No one ever wiped the vomit off his face and clothes. Eventually, about 25-30 minutes after he suffered the attack, the medic, officer and/or other detainees brought a stretcher and moved Reverend Dantica from the asylum unit to the medical facility. (Response Ex. 7).

Mr. Pratt is a well-respected immigration attorney who has been practicing in Florida for nearly ten years. As an immigration attorney, it is critical that Mr. Pratt maintain a positive working relationship with DHS as the fate of his clients often depends upon the exercise of discretion by DHS employees. Accordingly, Mr. Pratt has absolutely no incentive to make statements that cast ICE officials in a negative light. Nevertheless, OIG completely ignored Mr. Pratt's unbiased account of the events surrounding Reverend Dantica's asylum interview and failed to note the discrepancy as to whether Reverend Dantica received adequate medical attention at the Asylum Office. We request that OIG issue a statement noting this fact.

4. OIG's Report Concluded that "Dantica's death was the result of an illness that likely pre-existed his entry into the United States five days earlier." (Report p. 2). This Conclusion Conflicts with Evidence that Reverend Dantica's Medical Examination at Krome did not Reveal any Pre-Existing Conditions Associated with Acute and Chronic Pancreatitis.

OIG's conclusion that Reverend Dantica died from a pre-existing condition of acute and chronic pancreatitis is inconsistent with evidence submitted to OIG during its investigation. Specifically, OIG received a November 4, 2004 memo from a DHS employee stating that, upon Reverend Dantica's arrival at the Miami International Airport, "I did not see any reason to be concerned about his health. In fact, one of the Officers present when he was being interviewed said he was cheerful and seemed to be joking around." Reverend Dantica also informed DHS officials at the Miami airport that his health was "not bad." (Report p. 3).

Further, on October 29, 2004, Reverend Dantica was provided with a medical screening upon admission to Krome. Reverend Dantica's physical examination form listed him as being in "normal" condition with the exception of having hypertension, arthritis, and an enlarged prostate. The "screening did not indicate that Reverend Dantica was suffering from pancreatitis" or any symptoms commonly associated with pancreatitis. (Report p. 4). Nothing in Reverend Dantica's medical history as noted by medical officials at Krome indicated that he had ever suffered from

pancreatitis in the past, that he had symptoms suggestive of pancreatitis, such as recurrent abdominal pain, or that his personal habits indicated risk factors for pancreatitis such as excessive alcoholic consumption.

Accordingly, either Krome's physicians and DHS employees failed to detect and diagnose Reverend Dantica's pancreatitis or OIG's report is erroneous. If the former is correct, Reverend Dantica's family are owed an explanation as to whether Krome's physicians should have diagnosed his pancreatitis earlier and whether it was possible to have intervened to prevent Reverend Dantica's death. If the latter is correct, OIG's report must be vacated and amended to correct this erroneous conclusion. Regardless, OIG's failure to address this critical inconsistency in its report has resulted in unnecessary and disheartening confusion with regard to the preventability and cause of Reverend Dantica's death.

5. OIG Cavalierly Concluded that "there was *no* evidence of mistreatment or malfeasance by any JMH employees" without Conducting a Good-Faith Investigation as to the Veracity of this Conclusion.

By concluding that there was no evidence of mistreatment or malfeasance by any JMH employees, OIG's report ran afoul of its own characterization as to the scope of its investigation. In OIG's *Response to Recent Press Reports*, OIG explicitly stated that "OIG did not address the issues relating to Mr. Dantica's medical care at JMH because they were considered ***outside the scope of the OIG's review***." (Response p. 6).

If Mr. Dantica's medical care at JMH was considered "outside the scope" of OIG's review, how can OIG ethically justify its conclusion that there was no evidence of mistreatment or malfeasance by any JMH employees? It is axiomatic that one cannot find evidence of medical wrongdoing if one does not investigate treatment at the site where wrongdoing is alleged to have occurred. Accordingly, OIG must retract its conclusion that there was no evidence of mistreatment or malfeasance by any JMH employees since, by its own admission, it made no good-faith attempt to investigate any mistreatment or malfeasance by JMH employees.

Moreover, because Reverend Dantica was in DHS custody while being treated at JMH, OIG had a duty to investigate the treatment Reverend Dantica received there. As DHS documents make clear, when detainees are taken to outside facilities for medical care, "ICE retains the authority to make administrative decisions affecting the detainee (visitors, movement, authorizing/limiting services, etc)." (Report Ex. 20). Given that JMH served as DHS' agent by treating Reverend Dantica in the emergency room and in Ward D of its facility, OIG was required to conduct a comprehensive investigation as to whether JMH's medical staff could have acted to save Reverend Dantica's life.

Additionally, there is ample evidence that, given Reverend Dantica's symptoms, JMH staff failed to perform appropriate tests upon his admission that would have rapidly detected the alleged cause of his death (Acute and Chronic Pancreatitis) and given JMH physicians an opportunity to save Reverend Dantica's life. If indeed Reverend Dantica suffered from pancreatitis, JMH staff clearly missed this important diagnosis which could have – and should

have – been quickly and easily made. It was the Medical Examiner who made the diagnosis as to the apparent cause of Reverend Dantica's death.

The overwhelming evidence before the OIG also indicates that no medical staffperson was checking Reverend Dantica's vital signs on a regular basis, despite the fact that he was admitted to JMH on an emergency basis. Earlier in the day of Reverend Dantica's death, a DHS guard had advised OIG that Reverend Dantica was "noticeably uncomfortable," so he notified a nurse and Reverend Dantica's vital signs were then checked. (Report p. 11). And it was a DHS guard who upon returning from his break noticed that Reverend Dantica was "unresponsive" and immediately notified medical staff of Reverend Dantica's condition. Unfortunately, JMH attempts at that point to provide emergency resuscitation failed and Reverend Dantica was pronounced dead at 8:46 pm on November 3, 2004. (Report p. 11 and Ex. 22). Rather than constantly monitoring Reverend Dantica's rapidly deteriorating health in an intensive care setting, DHS and JMH left Reverend Dantica under the watch of a guard who was on a scheduled break during the most critical moments of Reverend Dantica's hospitalization at JMH.

Rather than conducting a thorough investigation into these incidents, OIG simply concluded that there was no malfeasance at JMH based upon an admitted lack of record evidence to support this conclusion. Therefore, this conclusion must immediately be retracted by the agency.

II. Errors Contained in the Response to Recent Press Reports

A. OIG Erroneously Concluded that "our inquiry did not substantiate reports that ICE officials denied Dantica's son's or niece's requests to visit Dantica, either before or after his death." (Response p.2).

OIG concluded that visitation was not denied to Reverend Dantica's family members because "according to all of the ICE personnel interviewed that were assigned to guard Dantica while he was housed at Jackson Memorial Hospital, their supervisors, and the custody log book maintained by ICE, no one attempted to visit Dantica prior to his death." (Response p. 3). This conclusion completely ignores the fundamental fact that no one attempted to visit Reverend Dantica because they were specifically told that they were not allowed to visit him.

According to Mr. Pratt, he "asked Officer Mead if Reverend Dantica's family could visit him at the hospital. Officer Mead stated that the decision would have to be made by Lt. Morris. Upon speaking to Lt. Morris, [he] was informed that no one could visit Reverend Dantica at the hospital for 'security reasons,' not even me, his lawyer." (Response Ex. 7). Moreover, Pratt stated that he "repeatedly explained that having family members around him would be reassuring for Reverend Dantica, especially if his condition was serious." *Id.* Nevertheless, he was told that visitation "was not a possibility due to security reasons." *Id.*

Additionally, during the entirety of November 2, 2004, Mr. Pratt was not even able to confirm that Reverend Dantica was being treated at JMH. He was simply told that Reverend Dantica was being treated in the Miami area and was being held overnight for "observation." *Id.* Finally, OIG

ignored record evidence that Krome's official policy is that "Friends, family and civilian visitation is not allowed unless authorized by the OIC of Krome SPC." (Report Ex. 6).

Given Mr. Pratt's statement and Krome's clear visitation rules, OIG had no basis for concluding that it could not substantiate reports that Reverend Dantica's relatives were denied visitation during the final stages of his life. Despite Mr. Pratt's unbiased testimony and the testimony given by several of Reverend Dantica's family members -- including his niece Edwidge Danticat -- OIG's report erroneously concluded that Reverend Dantica could have been visited by his family members had they simply chosen to notify hospital officials of their intent to visit.

This conclusion is completely demeaning to the members of Reverend Dantica's family who pleaded for the right to visit him prior to his death, and to his attorney who vigorously fought to secure visitation rights for Reverend Dantica's family. OIG must immediately retract this erroneous conclusion as it is based upon the utterly offensive premise that no relatives sought to visit Reverend Dantica during the final days of his life.

Furthermore, it is both incorrect and demeaning to Reverend Dantica's family that OIG's *Response* suggested that the family was uncooperative with the investigation. (Response p. 4). OIG first attempted to contact Maxo by having an inspector leave his card at his cousin Edwidge Danticat's house in Miami. Edwidge was in New York at the time, attending Reverend Dantica's funeral. When considering the trauma attendant to Maxo's loss, and the necessity of obtaining counsel and a translator to assist him in meeting with OIG, Maxo cooperated as diligently as possible with OIG's investigation. Moreover, Maxo met not once, but twice with OIG officials. The second appointment was scheduled soon after Maxo's return from his uncle's funeral in New York. Additionally, the OIG did not request to meet with Edwidge until late May, 2005. At the time this request was made of Cheryl Little, Edwidge was in New York for her own father's funeral. Shortly upon her return to Miami, on June 5, she met with the OIG.

OIG's conclusion that Maxo refused to provide contact information regarding family members who attempted to visit his father at JMH is terribly misleading. During his second interview with the OIG, Maxo provided the names of relatives he believed had done so and when asked for their contact information he replied that it was increasingly difficult for his family to discuss his father's death, but that he would do what he could. He then showed OIG officials pictures of his father in Haiti and reiterated how painful it was for him to go forward with his second interview with the OIG. It should also be noted that the OIG says Maxo "refused" to sign a release form so that OIG could get Reverend Dantica's medical records from JMH. When this request was made, Maxo actually indicated he wanted to so but his attorney advised him to delay giving his permission until other family members were contacted. Soon thereafter, Little provided the OIG with the JMH records she had only recently received. The family's request that OIG provide them a copy of the Krome medical records which OIG had received was denied on the basis that the OIG did not have the authority to do so.

B. OIG Selectively Concluded that "at no time was Dantica ever chained to a bed, or otherwise physically restrained, while he was a patient at Jackson Memorial

Hospital," and Ignored Testimony from DHS Employees that Reverend Dantica was Shackled while Inside of the Ambulance on his way to Jackson Memorial Hospital.

In concluding that "at no time was Dantica ever chained to a bed, or otherwise physically restrained, while he was a patient at Jackson Memorial Hospital," (Response p.2), OIG ignored unequivocal testimony from an Immigration Enforcement Agent that Reverend Dantica, a gravely ill 81-year old man with no criminal history, was "transported to the Jackson Memorial Hospital with . . . ***leg restraints***." (Response Ex. 4). There was no reason for DHS to place leg shackles on a critically ill elderly Reverend posing absolutely no threat to officers or medical personnel.

Moreover, OIG admitted that Reverend Dantica was placed in Ward D at Jackson Memorial Hospital. Ward D houses Miami-Dade County inmates who are serving criminal sentences and KROME'S policies make clear that officers assigned to Krome detainees hospitalized for medical care are required to ensure that "at least one pair of handcuffs and one leg shackle" is available for each detainee. KROME'S policies further state that "leg shackles shall be applied to a detainee if he/she is allowed to walk around the room, and that detainees will be secured at all times in their rooms, unless injury and/or medical conditions warrant their use." (Response p. 2). It is reasonable to infer that Reverend Dantica was restrained during his detention ***in*** Ward D, given that he was restrained while being transferred ***to*** Ward D and in light of DHS' pattern and practice of restraining patients housed in Ward D. OIG must revise its report to include these essential facts. Persons in Reverend Dantica's position must not be robbed of their basic human dignity during the final moments of their life by being shackled when they pose absolutely no security risk.

C. OIG Incorrectly Found "No Evidence to Suggest that the Medical Care that Dantica Received was Not Timely and Adequate. (Response p. 4).

The OIG states that while at JMH, Dantica "was being actively treated by a physician when he died." (Response p. 4). In fact, JMH records indicate that Reverend Dantica was not seen by a JMH physician until November 3, 2004, a full 24 hours after his admission, despite his being admitted on an emergency basis. Given Reverend Dantica's symptoms, an evaluation by an attending physician should have been done shortly after his arrival at JMH. Additionally, Reverend Dantica's JMH medical records indicate that the history of his illness did not address such important factors as the location of the pain, quality of symptoms or duration of symptoms. The severity of nausea and vomiting also were not noted and there was no repeat of abnormal admission labs. Concerns in this regard are outlined in more detail in Section I (5) of this response, infra.

D. OIG Falsely Stated that Reverend Dantica "did not meet the requirements for a humanitarian parole." (Response p. 5).

OIG's statement that Reverend Dantica did not meet the requirements for a humanitarian parole is patently false and is not based upon any established principle of immigration law. Ira Kurzban, one of the country's most prominent immigration law experts, believed that even

before Reverend Dantica was hospitalized, he was eligible for humanitarian parole. Mr. Pratt stated that Mr. Kurzban attempted to secure Reverend Dantica's release on humanitarian parole on November 1, 2004, which was denied by DHS. (Response Ex. 12). By its own admission, DHS could have released Reverend Dantica on parole at this time, without his having to pass an Asylum Office interview, if it had found "exigent medical circumstances." (Response p. 4). Given that Reverend Dantica was an 81-year-old, non-criminal alien who arrived in the United States on a valid travel visa and upon his arrival at Krome was placed in the medical unit, it is disingenuous to claim that Reverend Dantica could not qualify for humanitarian parole. He was housed in Krome's medical unit because upon admission there he was diagnosed as having uncontrolled hypertension, prostate enlargement, and larynx cancer, which made it difficult for him to communicate.

Additionally, an ICE official told the OIG that DHS "never adjudicated Kurzban's request for a humanitarian parole or a credible fear asylum due to Dantica's death while in custody." (Response Ex. 11). However, the Deputy Officer-in-Charge of Removal at Krome indicated that once Reverend Dantica became sick during his credible fear interview, Krome's Officer-in-Charge approved his humanitarian parole. (Response Ex. 8). Pratt also told the OIG that on November 2, 2004 someone from DHS called him on his cell phone to inform him that a decision had been made to release Reverend Dantica on humanitarian parole, without the need to pass an Asylum Office interview, as soon as his condition stabilized. (Response Ex. 7).

Accordingly, OIG must retract its statement that Revered Dantica was not released on parole because he did not meet the requirements. Reverend Dantica was not released on parole because DHS chose not to release him in a timely manner. OIG's implication that DHS' hands were somehow tied in this matter is not credible. In fact, Reverend Dantica could have been released before ever being taken to Krome. DHS could have admitted him as a tourist, since he arrived with a valid visa, and told him to later decide to apply for asylum. Ironically, had Reverend Dantica not advised CBP officials that he was concerned about returning to Haiti, he would not have been detained. [He was detained at MIA from approximately 3:30 pm on October 29, 2004 until approximately 12:00 pm on October 30, before being taken to Krome].

Most importantly, the OIG report notes that DHS offered Reverend Dantica's attorneys the option to waive the 48 hour delay in scheduling Reverend Dantica's Asylum Office interview and to provide him an expedited "credible fear" interview on November 1, but this offer was declined. (Exh. 11). Pratt, however, informed the OIG that he requested the interview be scheduled for November 1 and that DHS told him it would have to take place on the 2nd (Response Ex. 6). On the morning of November 1, attorney Ira Kurzban also contacted DHS to inquire how he could expedite Reverend Dantica's case (Response Ex. 12).

III. Conclusion

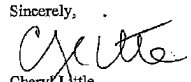
Reverend Dantica's family, friends, and parishioners deserve to be told the truth about what happened to him during November 2004. OIG's *Report* was not a thorough and objective inquiry into the facts of what occurred while Reverend Dantica was in DHS custody. Rather, it was a

cavalierly written report that highlighted evidence casting DHS in a positive light and ignored substantial evidence that Reverend Dantica was mistreated.

The OIG report included a KSPC document, "Detainee Classification System," which notes that "non-criminal aliens and those detainees with minor criminal history must be afforded an environment that is far from harassment and fear." Surely in the case of Reverend Dantica this was not done. The tragic irony is that Reverend Dantica came to the United States in order to save his life and ended up losing it after only about five days in DHS custody. Interestingly, DHS did not immediately request an OIG investigation into Reverend Dantica's death. They told the OIG they did not do so because Reverend Dantica died due to natural causes. (Report p.3). On November 18, 2004 the OIG received a letter from Congressman Kendrick Meek requesting the investigation. *Id.* The investigation was initiated on that date.

It is often said that a society's worth is measured by the way it treats those who cannot look after themselves. If we are ever to become the society that Reverend Dantica dreamed about as he entered the United States, it is incumbent upon OIG to protect the rights of those, like Reverend Dantica, who depended upon DHS to protect their basic human rights and provide basic life-saving medical treatment in their time of need. Accordingly, we respectfully request that OIG reopen its investigation as to the circumstances surrounding Reverend Dantica's unfortunate death while in ICE custody and retract the findings indicated in this letter.

Sincerely,



Cheryl Little
Executive Director

cc: Elizabeth Redman, Assistant Inspector General for Investigations

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Gotardo A. Rodrigues, M.D.
Hematology and Medical Oncology

1313 SW 1st Street
Miami, FL 33135
Tel: (305) 642-6966
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September 27, 2007

Re: Yong Sun (Thompson) Harvill, A35-173-532

To Whom It May Concern:

I am an Oncologist, Hematologist and Internist practicing in Miami-Dade County, Florida. I am Board Certified by the American Board of Internal Medicine in both Medical Oncology and Internal Medicine. I was requested to review medical records of Mrs. Yong Sun Harvill (DOB: 3/6/56) by Mrs. Harvill's attorney, Kelleen Corrigan of the Florida Immigrant Advocacy Center.

On July 10, 2007, I wrote a letter regarding my recommendations for Mrs. Harvill's care after reviewing the then-available medical records. In that letter, I noted that Mrs. Harvill has a history of desmoid tumor (cancer) in her left lower abdomen and her left knee; deep vein thrombosis and cellulitis of the left leg; osteomyiitis of the left femur; recurrent fibromatosis; significant chronic lyphedema and chronic pain; recurrent depression, panic disorder and adjustment disorder; pain and swelling in her left lower extremity; Hepatitis-C; Gastro Esophageal Reflux Disease and Gastritis; recurrent nose bleeds; and other issues.

I also stated in that letter that I believe the consequences of failing to provide proper care to Mrs. Harvill could include "chronic infections, disability, recurrence of tumors that could lead to her death." The evaluations and treatment that I noted Mrs. Harvill should be receiving, in my opinion, included the following:

- evaluation by a Hepatology doctor for her Hepatitis-C;
- recurrent ultrasounds, scans or MRIs of the liver every three months to exclude development of liver tumors;
- periodic evaluation of her liver enzymes, viral loads and tumor proteins;
- treatment by a lymphedema specialist to help preclude infections of the soft tissues, ulcers in the limb and bone infections (lack of treatment could cause a need for prolonged antibiotic therapy and even eventually require debridment surgeries or an amputation)
- MRI studies of her abdomen, pelvis and upper and lower extremities, rather than a regular CT Scan (because where prior surgeries and radiation therapy have been used, the definition of normal, malignant versus scar tissue is fundamental to define best planning of care);
- an oncologist specialized in sarcoma should be evaluating her condition, especially considering the recurring and multifaceted nature of her disease;
- her pain should be evaluated by a pain specialist for proper management and control;
- comprehensive psychologic or psychiatric evaluation and management should be carried out.

I have since reviewed Mrs. Harvill's most recently available medical records from Pinal County Jail in Florence, Arizona and make the following medical comments and recommendations:

1) The CT Scan done on 8/25/07 mentions distended gallbladder with extra hepatic biliary duct dilation. The CT scan is changed from a prior one dated 8/13/07, when these problems were not described. This indicates that the patient could have acute or chronic cholecystitis and need PIPIDA (Nuclear medicine hepatitic-biliary scan). If that is positive for cholecystitis, she will need surgery to remove her gallbladder or she might develop severe pains, nausea, vomiting, jaundice, disseminated infection and even death. A blocked gallbladder becomes distended. Because of the lack of drainage, the bile eventually can get infected with bacterial growth in the bile fluid.

2) The patient also has enlarged lymph nodes in her groin described by CT scan. That could be related to her cancer history. Close follow up for changes in the lymph node size should be performed. She might need a lymph node biopsy or excision to exclude active cancer in the region. Also, given the patient's history of recurrent cancer, she needs additional testing to determine whether she has any other cancer currently.

3) The patient has had rectal bleeding (8/10/07). Mrs. Harvill, especially since she is over the age of 50 and has had cancers in the past, should undergo a Colonoscopy to exclude a colon cancer. She is also on Ibuprofen which could cause bleeding, gastritis, hepatitis and duodenitis (irritation and inflammation of the small intestine).

4) On 5/14/07 she had lab testing blood in her urine. No additional evaluation for that problem was requested. Those could be very important for her health and if abnormal results are found, proper additional testing should be done.

5) At one point, Mrs. Harvill had a liver biopsy scheduled but it was not carried out. A liver biopsy is critical in her case to check for the degree of Hepatitis-C damaging her liver and the possible need for Hepatitis-C therapy. This condition is usually incurable and can cause liver cirrhosis, liver failure, coagulation abnormalities and even hepatic or biliary cancers. She should be evaluated and followed by a Hepatology doctor. Possible treatment options that she might qualify for include Ribavarin, Interferon or PEG INTRON. Those therapies need to be performed by Doctors experienced in the use of those toxic medications. She should have ultrasounds, scans or MRIs of the liver every three months to exclude development of liver tumors. Also, periodic evaluation of her liver enzymes, viral loads and tumor proteins such as Alpha Feto Protein, Carcino Embrionary Antigen and CA-19.9 are to be followed. She was seen twice in the past in a gastro-enterology clinic with only repeat labs being ordered.

6) The patient should have follow-up mammography. The records indicate that her last test was from last year. This is important to ensure that Mrs. Harvill does not require a breast biopsy on any suspicious mass in her breasts. The prior mammography showed suspicious calcifications that are a common finding in breast cancer. Despite the abnormal suspicious reading by a radiologist, another doctor later decided not to proceed with the requested biopsy. If Mrs. Harvill does have a breast cancer, the wasted time can make the difference between more or less serious therapies and a better or much worse prognosis.

7) The patient's abdomen is described as being large and distended. Her legs are also getting more and more swollen. Since the patient also has a history of Hepatitis-C, it is unclear if the abdominal distention is due to cirrhosis with ascitis (free fluid between bowel loops and peritoneal membranes) or to constipation/impaction. A new CT scan or ultrasound should be done to evaluate her condition and the possible need for intervention. She might need drainage of the ascitic fluid if present and she might require

careful diuresis and adjustment of her medications.

8) There is reference to vaginal bleeding. In a post-menopausal woman like Mrs. Harvill, this should be evaluated by a Gynecologist with a PAP smear, vaginal ultrasound and then possibly a curettage (scrapping of the uterus) or even surgery depending on curetage results. In addition, the patient was reported having had heavy gynecological bleeding for several days and she was also very nervous and pale. No blood count, coagulation tests or liver function testing was checked to evaluate the degree of anemia and possible need for transfusion or anemia therapy. (8/24/07).

9) The patient had an episode of diarrhea on 7/06/07 with diaphoresis (heavy sweating) and altered mental status. An order for Imodium 6 tablets now and one after each diarrhea was given. With that high, unusual and unexplained dosage, abdominal pain, distention or discomfort, constipation, drowsiness, dizziness, fatigue, dry mouth, nausea and vomiting, and epigastric pain may occur. It is unclear why the diarrhea, altered mental status and diaphoresis were not at all evaluated.

10) Some older records show the patient was in Lopid in the past, a cholesterol and triglicerides lowering drug. There seems to be no consistent follow up care for that condition in the recent records. Mrs. Harvill also has multiple elevated blood sugar levels, but no evaluation for diabetes mellitus has been done.

11) The patient continues to have a persistent complaint of severe pain, which may be worsening. Her pain is not being properly managed. The records show the patient was on Tylenol #3 and Percocet (Tylenol with Codeine), which are considered only a step above plain Tylenol, Aleve or Motrin. The patient did not receive a stool softener or laxative with it, and noted she had abdominal pain and stool impaction. When that happened, the medical staff stopped her medication abruptly and left her with pain. It is the standard of care to start a laxative at the beginning of an opioid therapy (like Codeine) to prevent constipation and slowing of bowel motility. That was not done until she already developed the complications. One should also not discontinue opioids abruptly after prolonged use. That could cause severe withdraw symptoms including shaking chills, nausea, vomiting, diarrhea, tachycardia and generalized malaise.

    The switch to Ibuprofen could be responsible for Mrs. Harvill's increased bleeding. High doses of Ibuprofen worsen bleeding problems that she was already having and can also cause ulcers, gastritis, and even kidney or liver damage. If her pain was not properly controlled with Percocet, the switch to an even milder analgesic was not adequate. Mrs. Harvill also reports several nose bleeds which were never addressed.

12) Mrs. Harvill has also suffered from an anal area rash. This type of rash is usually fungal ("diaper rash") or genital herpes. The patient has only received Hydrocortisone topically. This treatment could worsen a fungal, bacterial rash or herpes. Specific tests or a dermatology evaluation should be done to achieve the right diagnosis therapy for her condition. On 7/14/07 she is also reported to have a "'small abscess in perianal area." She continued to have severe pain in that area for at least 10 days. A painful abscess in perianal area is usually treated with antibiotics. Some cases will require a minor surgery to drain and expedite recovery. The only treatment she was given was warm compresses.

As I also mentioned in my July 10, 2007 letter, the consequences of continued incomplete and superficial care of Mrs. Harvill may include chronic infections, disability, recurrence and progression of tumors, deteriorating physical and mental health, and other complications that could even lead to her death. In addition, treating those more severe conditions will be much more costly in the end, with a lesser chance of a positive prognosis. I

urge you to get Mrs. Harvill proper care or to release her to a facility that can fully treat both her complex and simple medical conditions as soon as possible.

Sincerely,

Gotardo A. Rodrigues, M.D.

H. LEE MOFFITT Cancer Center & Research Institute
A National Cancer Institute Comprehensive Cancer Center
At the University of South Florida

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Division Chief

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G. Douglas Letson, M.D. (Musculoskeletal Oncology)
David Cheong, M.D. (Musculoskeletal Oncology)
Vernon Sondak, M.D. (Surgical Oncology)
Eric Sommers, M.D. (Thoracic Surgery)
Scott Kelley, M.D. (Surgical Oncology)

Medical Oncology
Samuel Agresta, M.D.
Gina Z. D'Amato, M.D.
Daniel M. Sullivan, M.D.
Charles Williams, M.D.

Radiation Oncology
Randy Haysek, M.D.

Musculoskeletal Radiology
Martin L. Sibbiger, M.D.

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June 26, 2007

Florida Immigrant Advocacy Center
ATT: Emily
Facsimile: 305.576.6273

RE: Yong Harvill
Date of Birth: 3.6.56

To whom it may concern:

Ms. Harvill is a patient the H. Lee Moffitt Cancer Center & Research Institute in Tampa, Florida. She has a history of a desmoid (involving the ligaments) tumor (1996) in the left lower abdominal quadrant complicated by deep vein thrombosis and severe cellulitus (acute inflammation of the deep subcutaneous tissue and muscles) with multiple recurrences. In 2001 the patient had fibromatosis (a large distribution of multiple fibromas) of the left lower extremity and was treated with surgery and radiation (2001, 2004 and 2005) and has suffered from chronic lymph edema (fluid accumulation and may arise from surgery, radiation or the presence of a tumor in the area of the lymph nodes) since that time. Her most recent recurrence was in 2005 with progressive disease to the sacrum and pubis. In addition, Ms. Harvill has been seen consistently for pain management and psychosocial issues. Ms. Hartville's disease is extremely debilitating and painful. She will need continued care at a facility familiar with these types of tumors as they will continue to recur and progress. If not treated properly they can become life-threatening.

Please feel free to contact my office if you need any further information on this patient.

Sincerely,

G. Douglas Letson, M.D.
Program Leader, Sarcoma
H. Lee Moffitt Cancer Center & Research Institute.

bac

Ms. LOFGREN. Thank you to all of the witnesses for your compelling testimony. I will just ask a handful of questions, if I could.

Mr. Castaneda, an incredible story, and I do appreciate that you are here to change things for others and I honor you for that. As I was listening to your story of a situation that got worse and worse and worse, I was trying to put—how many months were you in custody? When you arrived, you had a problem and it got worse and worse. Over what period of time were you in custody?

Mr. CASTANEDA. Over 10 months.

Ms. LOFGREN. It was 10 months. In 10 months' time, it wasn't until you were so sick that they essentially threw you out.

Mr. CASTANEDA. Until they saw I was bleeding and discharging and couldn't stop bleeding, and that is when they released me.

Ms. LOFGREN. Let me ask you, Ms. Danticat, a question. There are a lot of myths about immigration, but as you told your story of your uncle, he had a valid visitor's visa to come into the United States, and he had been here before. I mean, why would an 81-year-old Baptist minister who had a valid visa even be stopped? And how was he treated when he was stopped when he came into the United States just before the detention? Do we know about that?

Ms. DANTICAT. Well, I think the people who detained him would have to answer the why. But as to how he was treated, when he made known his request for asylum he was taken into custody, he was interviewed, and then he was brought to the Krome Detention Center.

Ms. LOFGREN. Ms. Everett, when your sister was at the airport, she already had the fibroid problem and she had scheduled surgery, in fact. Did she tell the ICE agents that she had surgery scheduled, do you know?

Ms. EVERETT. Yes. And we also gave them copies of the appointment card for the people that she was seeing that were preparing her for that, in addition to the appointment card for her surgery.

Ms. LOFGREN. And they simply just ignored it?

Ms. EVERETT. Just ignored it completely.

Ms. LOFGREN. Well, this is a little sideline. California State Prison System Health Care is now being run by Bob Sillen, the guy who used to be in charge for Santa Clara County Jails when I was on the board of supervisors. And this sounds like the sort of situation where either we get our act together, or some Federal judge is going to take somebody like Bob Sillen and say, You are in charge now. And I think those are the two choices. Certainly, we want to get to the bottom of whether there are things that have not been reported. But, obviously, Mr. Castaneda has suffered a tremendous amount and he would not show up in a statistic.

And so I think the suggestions made, Mr. Jawetz, are excellent ones.

Certainly, Ms. Little, the need to make mandatory changes, not just advisory, are obviously important.

And, Dr. Keller, your testimony particularly, I have always thought it was a mistake—and I didn't vote for it when we changed the rules—that the default is that someone seeking freedom in the U.S. is incarcerated.

You know, our policy is that we are the beacon of hope and freedom in the world, and that those people who are fleeing from oppression, from communism can come to this free place and breathe free air. And now our policy is: and then go to jail. So certainly there need to be rules in place so that you have people who show up, who aren't gaming the system. That has happened in some cases. But it is not necessary to incarcerate people in every case. And certainly people who have been traumatized and abused are not going to do well in a custodial setting many, many times.

So I would just like to say that this is, I think, one of the most important hearings that I have had an opportunity to participate in, in the 13 years that I have been in Congress, and I hope that it will be the first step in making necessary changes.

And I appreciate all of you, especially those who have lost a loved one, for sharing a very painful part of your life in an effort to set things right. And I can't promise success, but I can promise efforts that are equal to the sacrifice you have made to be here and to share your thoughts.

So, with that, thank you, on behalf of the Subcommittee, and this hearing is adjourned.

[Whereupon, at 4:23 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE ZOE LOFGREN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRWOMAN, SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW

I would like to welcome the Immigration Subcommittee Members, our witnesses, and members of the public to the Subcommittee's hearing on immigration detainee medical care.

According to the General Accounting Office (GAO), nearly 300,000 men, women, and children were detained by Immigration and Customs Enforcement (ICE) in 2006, triple the amount in 2001 when less than 100,000 were detained.

With the large increase of detainees in ICE custody, it is incumbent upon this Congress to ensure that ICE is properly executing its responsibility of providing safe and humane treatment of detainees in their custody.

Recent reports suggest that ICE is not doing its job.

In just the last few months, there have been several reports of individuals detained by ICE that suggest unsafe and inhumane treatment in ICE or contracted detention facilities. For example, the Boston Globe recently reported the case of a man who died in ICE custody due to epilepsy complications, despite the fact that his sister twice attempted to provide necessary medication to detention officials, according to his family. His sister says she was turned away both times. Another reported case involves Victoria Arellano who was taken off HIV drugs while in custody and subsequently died after serious complications and lack of appropriate medical care for several months. Reports indicate that fellow inmates tended to as much care as they could possibly provide on their own and repeatedly informed detention officials of Arellano's illness.

These and other cases have spawned questions from several Members of Congress, but so far, few answers have been provided.

There are two critical questions I hope we can address today. First, are the medical care standards employed by ICE satisfactory so as to create an environment that supports safe and humaen treatment of individuals in ICE custody? Second, if those standards are adequate, are they being implemented in an appropriate manner?

After a preliminary review of the standards and the various reports on the administration of medical care, it appears we have problems on both levels.

The DIHS Medical Dental Detainee Covered Services Package specifically states that medical care in ICE detention facilities is to be provided primarily for emergency care. Care for "[ac]cidental or traumatic injuries incurred while in the custody . . . and acute illnesses" is not required, but simply "reviewed for appropriate care." Care for other illnesses, including pre-existing illnesses that are serious but not life-threatening, is also not automatic, but simply reviewable for appropriate care. Furthermore, these reviews are conducted in Washington, D.C. by nurses, not physicians, who are away from the patient and simply reviewing paperwork submitted by other health care professionals recommending such care.

With this policy, it is no wonder there are reports of unsafe and inhumane medical treatment in ICE custody. This policy fails to recognize a fundamental principle of medical care in detention—the patient is detained and there is no other option but care authorized by ICE. Yet, the policy only insures emergency care and considers other care, even in serious cases, on a case-by-case basis.

I hope that today's hearing will help us further understand and clarify the problems that exist in providing medical care to those in ICE custody so that we may begin to find solutions to what appears to be a very serious problem.

PREPARED STATEMENT OF THE HONORABLE JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN, AND CHAIRMAN, COMMITTEE ON THE JUDICIARY

I have read reports collected regarding medial care provided to individuals in ICE custody and, frankly, I am very concerned.

There is the case of **Reverand Joseph Nosius Dantica**, *a courageous man who was a minister for decades in Port-a-Prince, Haiti. After watching his neighbors get killed and gang members threatening his life, Rev. Dantica, at the age of 81 and after 50 years of service to his community, fled Haiti to seek safe haven in the United States where he was a frequent visitor for 30 years. When he arrived in the United States, he had a valid passport and visa, but decided that this time he would need to seek asylum. He was immediately arrested and detained and his heart medication was confiscated. He tried and tried to let as many people know about his need for medication to no avail. The problems that followed are more than gruesome. 15 minutes went by before medical care was provided when Rev. Dantica appeared to be having a seizure and vomited. A nurse accused him of faking his illness and there was inadequate care at a hospital hours later. With this lack of medical attention, it wasn't long before Rev. Dantica passed away.*

Then there's the case of **Mr. Abdoullai Sall**, *who, I am told, also died in detention after being denied necessary medication despite several requests by him and his attorney. Mr. Sall eventually collapsed and died in detention without ever receiving his medication. I am told that efforts to investigate the case by the ACLU have been stymied by DHS.*

There's the case of **Victoria Arellano**, *a transgender, HIV-positive individual who was held in ICE custody for two months without medication she was taking prior to detention. Weeks before her death, medical staff told her that her T cells were down and simply prescribed an antibiotic, a drug that doctors say is not the choice for HIV patients. I am told that over the next few days, Arellano began vomiting blood and suffering from diarrhea and fellow detainees took care of her. They lodged numerous complaints about the lack of medical care, and ultimately began chanting "hospital" until she was finally taken to the hospital, where she died on July 20, 2007. Again I am told that DHS has stymied efforts to get answers on this case, including the transfer of two detainees who spoke to the press about also being denied access to their own HIV medications.*

Sadly, the list of horror stories goes on. I want answers to these horrendous cases. How is this possible in American detention centers and what can we do to prevent this?

Testimony of
Immigration Equality, Human Rights Campaign, Gay Men's Health Crisis, Stop Prisoner Rape, Urban Justice Center, National Center for Lesbian Rights, TGI Justice Project.

Testimony Before the
Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law,
Committee on the Judiciary
United States House of Representatives

Madam Chairman Lofgren, Ranking Member King, and members of the Subcommittee:

Thank you for the opportunity to submit testimony to the Subcommittee on health conditions in Immigration and Customs Enforcement ("ICE") detention centers. We, the undersigned organizations have prepared the following testimony to share with you the stories of Victoria Arellano, Amber (not her real name), Fadyar (not his real name), and Christina Madrazo at the hands of ICE. Their names may not be familiar but their stories are unfortunately all-too-common examples of the human rights abuses perpetrated against lesbian, gay, bisexual, transgender ("LGBT") and HIV-positive individuals in immigration custodial authority including harassment, sexual assault, the denial of medical attention, and death. The current system governing the treatment of detainees fails even basic levels of care and decency. These failures amount to human rights abuses and must be treated as serious violations of law.

This testimony is intended to address the specific problems experienced by LGBT and HIV-positive individuals in immigration detention. This testimony will highlight failures in both policy and practice that have led to an unacceptable standard of care which endangers the health and lives of LGBT and HIV-positive detainees. The testimony provided herein argues for increased oversight as well as enforceable regulations on behalf of LGBT and HIV-positive detainees to ensure that facilities that abuse or ignore the regulations are held accountable. Finally, the testimony recommends policy changes to better serve the needs of LGBT and HIV-positive detainees to restore public confidence in DHS's ability to carry out its stated goal of protecting the health of immigrant detainees.

LGBT and HIV-POSITIVE IMMIGRANT DETAINEES' STORIES

On any given day there are nearly 30,000 individuals held in immigration custody. It is not currently known how many of this total number are transgender, lesbian, gay, or HIV-positive. We do know, however, that among these 30,000 individuals LGBT and HIV-positive detainees are among the most vulnerable and ill-treated.

Victoria Arellano

On July 20, 2007 Victoria Arellano, a transgender woman died while under the care of the San Pedro Detention facility. She died shackled to her bed, her body overcome with pneumonia and meningitis which could have been cured in any medical facility in the U.S. with inexpensive and readily available medical assistance. Instead, Victoria was deliberately

denied access to medical attention. When Victoria was taken into ICE custody she was managing her HIV through the use of a common antibiotic dapasone. Victoria notified officials at the San Pedro facility of her need for the medication and was denied proper treatment despite the well-known medical consequences of any lapse in treatment. Her health began to rapidly deteriorate and soon Victoria was so ill that she could not move without screaming in pain. Her condition was so dire that other detainees began advocating on her behalf. "We made requests to the infirmary asking for help because she was so sick. She wasn't eating, she had constant diarrhea, and she was vomiting blood. The nurse who responded was totally inhumane," states fellow detainee at San Pedro, Oscar Santander as reported in an August 9 report in the Daily Journal. "The nurse said, Oh, is that the same person you complained to us about before? The doctor hasn't approved any medication. Just give her Tylenol and water, and it'll go away."

"It" did not go away. Another detainee at the San Pedro Abel Gutierrez told The Daily Journal, "Victoria was so sick and they wouldn't do anything. One night, 80 of [us] defied the order to line up for evening head count, and staged a protest on Arellano's behalf." A week before her death Victoria was finally taken to the hospital but returned to the facility within 24 hours. By the time she was taken to another hospital it was too late and Victoria died shackled to her bed. The men who tried to speak out on Victoria's behalf were transferred in retribution for trying to help her.

It is incomprehensible but sadly not unheard of that trained medical technicians could be so deliberately negligent. Victoria's HIV status and the denial of medical treatment for her condition led to her death, but her identity as a transgender woman raises many questions about the treatment of transgender detainees and the policies governing their care.

Amber (not her real name)

ICE facilities are sex-segregated and individuals are assigned to centers based on their birth-sex or their genitalia. This system places transgender women at extraordinary risk as visible targets for discrimination, physical, and sexual abuse by fellow detainees as well as by ICE employees. Amber (not her real name), recently detained at the Passaic County Jail in Paterson, New Jersey described her recent experience while being detained on immigration violations. "The head officer went ballistic when he saw me. "What is a female doing in here?" The officer said, "She looks female, but she's not."

Amber's experience with her fellow detainees was very different than Victoria's. There were many men in the facility who began taunting and threatening Amber. "Goodbye to the gay man because we're gonna shoot you in the head…I'm gonna kill you." Amber asked to be placed in protective custody and to speak with a mental health professional. She was told if she wanted to be protected she would be put on psychiatric watch, lights on for 24 hours a day and her clothes would be taken from her. After two and a half weeks at the Passaic County facility, Amber was transferred to the Bergen County Jail. Amber was placed with a man who did not care for her. Amber asked to see a medical professional and to be put in protective custody. Amber, who was receiving hormone therapy was told by a nurse that her medical records had not arrived. The same nurse later denied Amber's hormone request saying, "this facility does not care to treat this." Instead of giving Amber her own cell (there were many empty cells) she was moved to solitary confinement under 23-hour-a-day lockdown.

Fadjar (Not his real name)
In addition to the neglectful treatment described above, LGBT immigration detainees are often the victims of guards and employees who display predatory and criminal behavior. Fadjar (not his real name), a gay Indonesian man was sexually harassed during his detention at the El Paso Service Processing Center in El Paso, Texas while awaiting a decision on his pending asylum claim. Fadjar was told by officers at the Center to "walk straight" because, "this is not a beauty salon, but a jail." On multiple occasions officers called Fadjar, "puto" a pejorative term similar to the English "slut" but when said to another man, similar to "faggot." On one occasion Fadjar was walking to his sleeping quarters when an officer, one Pedro Rodriguez said, "Hey puto, how much for a blow job?"

Christina Madrazo
At the Krome Detention Center in Miami, Florida a transgender woman named Christina Madrazo was twice raped by a guard. The officer who raped Christina was responsible for bringing her meals and watching over her cell-block.

Christina was placed in solitary confinement when she arrived at the Krome Center because officials were unsure whether she should be housed with an all male or all female population. The officer, Lemar Smith, attacked Christina while she was in solitary confinement, attempting to force her to perform oral sex on him. He then sodomized her until he heard another individual approaching.

After speaking with a mental health professional at the center and a visitor from the Mexican Consulate, Christina decided to file a report of the incident. After filing the report, Officer Smith was allowed back in Christina's cell where he later raped her a second time.

Christina Madrazo was eventually released from custody. One month after her release, Officer Smith was indicted on two counts of rape and two counts of sex with a ward. He was sentenced to eight months in jail and one year of probation.

Lesbian, gay, bisexual, transgender and HIV-positive immigrant detainees are among the most vulnerable of all incarcerated populations. The LGBT and HIV/AIDS communities are concerned about the general level of health care immigrant detainees receive and the deaths of nearly 65 individuals in DHS custodial care since 2004. Similarly, the organizations signed to this document fear that without a major overhaul of the current guidelines for immigrant detainee health care that the low quality of services and medical attention will persist at a substandard and unacceptable level.

KEY ISSUES FOR LGBT and HIV-POSITIVE DETAINEES

Policies and Practices that Support a Zero-Tolerance Approach to Sexual Violence Must be Adopted
Sexual violence in immigration detention facilities constitutes a serious human rights crisis that has had a disproportionate impact on LGBT detainees. LGBT detainees have endured sexual abuse both at the hands of immigration officials and by other detainees with the acquiescence of officials. Survivors of this form of abuse are left beaten and bloodied, contract HIV and other sexually transmitted diseases, and suffer severe emotional harm.

LGBT detainees are uniquely vulnerable to sexual assault due to their perceived or actual sexual orientation and/or gender identity.

The Detention Operations Manual ("DOM") represents a distressing example of institutional indifference toward the potential for sexual misconduct and abuse. The manual does not deal with sexual assault in a comprehensive and substantive manner. Existing language is unfocused and out-of-date, contributing to a policy document that treats sexual assault as an afterthought in the context of ICE detention.

Immigration facilities fall within the purview of the Prison Rape Elimination Act (PREA) of 2003 and, as such, ICE should develop policies in accordance with the federal law. The DOM must include a zero-tolerance approach to sexual violence with sound policies and practices that adequately protect detainees from this type of abuse.

The DOM must also provide for an appropriate response in the aftermath of a sexual assault. Taking action in a timely and professional manner is an essential component in minimizing the harmful consequences of sexual abuse in detention. Detainees should have multiple avenues for failing a complaint of sexual abuse, so that no one is required to report grievances to an abusive staff member or to one who will not take action.

All detainees must have access to acute-trauma care, including treatment of injuries, medical examination, STD testing and prophylaxis, and emergency mental health counseling. Detainees who have been victimized should further receive appropriate physical and mental health care follow-up and confidential counseling for post-traumatic stress disorder and other mental health problems. This follow-up must also include access to confidential, voluntary testing, treatment, and counseling for HIV/AIDS and other STDs.

When a complaint of sexual abuse is lodged, evidence must be collected as soon as possible, including through the completion of a rape kit whenever possible. Detainees who report sexual assault must not be punished for filing a complaint, and non-punitive measures should be taken to protect detainees who report abuse. For example, the sexual assault survivor should have the option of being placed in administrative segregation that does not result in the loss of privileges and programs available in general population. If a complaint is lodged against an employee of the detention facility, such employee must be removed from a supervisory post, and not permitted to interact with detainees, pending an investigation. If an official is found to have sexually abused a detainee, his or her employment must be terminated.

Mental Health Care Must Be Provided

Concerning the mental health needs of immigrant detainees the DOM currently states:

> Every facility will provide its detainee population with initial medical screening, cost-effective primary medical care, and emergency care. The OIC will also arrange for specialized health care, **mental heath care** [emphasis added], and hospitalization within the local community. Mental health providers must be available, on-site, at every facility.

The harsh circumstances experienced while in detention affect individuals in many different ways and can have serious psychological implications. For LGBT individuals, the isolation

of detention coupled with situations that may threaten a person's health or safety can have disastrous effects including suicidal thoughts and self-inflicted harm.

As discussed above, victims of sexual assault should be treated both for physical and mental health conditions following assaults. They should have access to confidential counseling by a professional who has been trained in responding to rape trauma syndrome, and is sensitive to the needs of all survivors, regardless of sexual orientation or gender identity. Proper records of mental health therapy must be kept and upon release these records must be provided to the detainee along with a referral to local and low-cost community health resources.

Suicide is also a serious issue that must be better addressed. The DOM provides guidelines for suicidal diagnostics and for those deemed suicidal. They follow:

> If danger to life or property appears imminent, the medical staff has the authority, with written documentation, to segregate the detainee from the general population. A detainee segregated for this reason requires close supervision in a setting that minimizes opportunities for self-harm. The detainee may be placed in a special isolation room designed for evaluation and treatment. The isolation room will be free of objects or structural elements that could facilitate a suicide attempt. If necessary, the detainee may be placed in the Special Management Unit, provided space has been approved for this purpose by the medical staff.

Suicidal segregation must be considered administrative segregation and a detainee who is segregated for risk of suicide must be treated by a mental health professional. The guidelines currently do not mandate such intervention, but clinical intervention from mental health professionals is essential. Detention centers must also take steps to intervene with at-risk populations by providing mental health therapy including the notification of mental health officials when a detainee has become a victim of violence.

Effective Health Care Must Include Comprehensive Care

There are many procedural barriers to providing proper health care to LGBT and HIV-positive immigrant detainees. Among the most challenging are providing comprehensive and ongoing health care to individuals who require daily or frequent medical attention as well as the management of persons and records when detainees are transferred from one facility to another. DHS is currently failing its own standards of providing medical care.

The Detentions and Operation Manual ("DOM") provides policy guidelines for ICE detention facilities. The DOM currently states:

> Every facility will provide its detainee population with initial medical screening, cost-effective primary medical care, and emergency care. The OIC will also arrange for specialized health care, mental health care, and hospitalization within the local community.

There is substantial documented evidence that the violations of this policy presented in the stories above represent more than isolated and idiosyncratic derelictions. The medical care of HIV-positive detainees is routinely treated with neglect and a haphazardness that puts the long-term well-being of the detainee at high risk. It is documented medical fact that lapses or gaps in medical treatment for HIV-positive individuals can seriously compromise the

immune system and lead to drug-resistant strains of illnesses that can be simply and effectively treated with proper care. The current DOM guidelines address emergency treatment of HIV/AIDS but fail to address accepted practice for the daily management required to provide effective HIV care.

HIV infection must be managed with regard to specific medications taken at the prescribed times and often at multiple intervals throughout the course of the day. With regard to the distribution of prescribed medication the DOM clearly states:

> Distribution of medication will be according to the specific instructions and procedures established by the health care provider. Officers will keep written records of all medication given to detainees.

Furthermore, the Division of Immigration Health Services commonly used drugs formulary states that "all Antiretroviral drugs are on the formulary."

Despite the clear language of the DOM and the categorical formulary listing of all antiretrovirals, many detainees report being told by doctors at immigration detention centers that they do not have the proper medications available to continue their drug therapy. Detainees further report that when the proper medication regimens are available, the medications are handed-out arbitrarily, or according to the facilities' availability and willingness without any regard for what is medically expedient. This malfeasance puts the health of detainees at extreme risk for infection and increased drug resistance. Current practice also leads to additional and unnecessary costs associated with emergency medical care.

HIV-positive individuals have complex medical needs. Drugs considered to be interchangeable for most healthy individuals will detriment the health of a person with HIV if paired incorrectly with antiretrovirals. HIV-positive individuals have multiple chronic conditions and complex medication regimens that must be carefully balanced and maintained, especially as patient needs change over time. Protocols around HIV drug interactions are frequently adjusted as new information becomes available. Intimate knowledge of a patient's needs, and the ability to access the right drug(s) regardless of cost must be provided at all immigration detention facilities including DHS/ICE facilities, contracted facilities, as well as state and local facilities that house immigrant detainees.

Similarly, transgender detainees undergoing hormone therapy are routinely denied transition related endocrine hormone therapy despite the well-documented and recognized health risks associated with lapses in therapy or the halting of such treatment. The commonly used drugs formulary does not list many of the hormones used in transition related medical care. This routine denial places transgender immigrants at risk for serious medical conditions including cardiovascular illness, diabetes, depression, anxiety, chest and breast pain, high/low blood pressure, and withdrawal symptoms including hot flashes, nausea, and dizziness. These conditions can in turn lead to attempts at self-treatment such as aut-castration, which can cause serious harm and extensive, costly hospitalizations.

It is clear that the current guidelines are insufficient both in policy and in practice. The DHS must take immediate steps to ensure that the guidelines for HIV/AIDS treatment conform

with current medical practices, that proper medications are available, and that detainees have the ability both to request and receive medical attention as according to their medical needs. Properly managing the health needs of detainees will prevent the need for emergency health care and as a result drive down the cost of providing medical care and assistance.

Rules To Provide Emergency Care Must be Transparent and HIV-Sensitive
Emergency medical care must be provided as necessary. The DOM fails to provide proper language concerning the medical needs of immigrant detainees. Further, the guidelines that do exist continue to be ignored and medical professionals fail to provide for the proper health care of detainees. Currently, the DOM provides the following guidelines relating to emergency medical care:

> Detention staff will be trained to respond to health-related emergencies within a 4-minute response time. This training will be provided by a responsible medical authority in cooperation with the OIC and will include the following:
>
> - The recognition of signs of potential health emergencies and the required response;
> - The administration of first aid and cardiopulmonary resuscitation (CPR);
> - The facility plan and its required methods of obtaining emergency medical assistance;
> - The recognition of signs and symptoms of mental illness (including suicide risk) retardation, and chemical dependency; and
> - The facility's established plan and procedures for providing emergency medical care including, when required, the safe and secure transfer of detainees for appropriate hospital or other medical services.

Whenever an officer is unsure whether a detainee requires emergency care by a health care provider, the officer should contact a health care provider or an on-duty supervisor immediately.

These guidelines are insufficient. There is no language in the guidelines that mandates the detainee receive medical attention. The guidelines state that a plan for emergency care must be in place but do not provide appropriate governance regarding medical standards of emergency care. There is no definition on what qualifies as a medical authority or whether such an individual must be licensed or certified. At a minimum the guidelines must provide provisions that mandate treatment in emergency situations and clearly define what constitutes an emergency situation. The DOM must add guidelines as to when emergency medical care is required. Similarly the DOM must add transparent response guidelines for emergency medical care in line with standard medical practice. HIV/AIDS health professionals with knowledge of current HIV/AIDS therapy must establish the guidelines governing the care of HIV-positive detainees. Detainees can only be hospitalized at the order of a physician, but there is no mandate that a physician be staffed at a facility. These gaps in the DOM allow facilities to fail in their responsibilities to the health of detainees and not be held to account.

Proper Medical Records Must Be Kept and Transferred with the Detainee
Detainees often report that they are denied medical requests or access to medication because they have been transferred from one detention facility to another and their records have not yet been received. The DOM conceives of medical transfers for those who require acute medical treatment to another facility or a hospital. Similarly the DOM provides guidelines for the transfer of medical records and medication:

> The facility health care provider will be given advance notice prior to the release, transfer, or removal of a detainee, so that medical staff may determine and provide for any medical needs associated with the transfer or release of a detainee…When a detainee is transferred within the Detainee Immigration Health Service ("DIHS") System, a Transfer Summary and the detainee's official health records will accompany the detainee.

Regarding the medication needs of the transferred detainee the DOM provides that, "Prior to transfer, medical personnel will provide the transporting officers with instructions and, if applicable, medication(s) for the detainee's care in transit."

These guidelines provide helpful language for detainees who require necessary medical assistance but remain inadequate without language necessitating medications accompanying transferees. Individuals who require medication on a daily basis must be provided with adequate dosage regiments to cover any gap in medication dispersion as a result of being transferred from one facility to another and the recipient facility must be notified in advance of the detainees' arrival that medication and medical attention, if necessary, must be provided upon arrival. It is simply insufficient to provide guidelines without mandating the timely dispersal of medication.

Strip Searches Must Not Be Used to Shame or Punish
Immigration detainees frequently report that their privacy is not respected and that as a result they are placed at risk for physical harm, taunting, or punitive retribution. The right to privacy is one of the most fundamental rights in our society. Immigrant detainees do not give up this right despite their incarceration. Of primary concern is the use of strip searches and medical confidentiality. LGBT individuals and gender non-conforming individuals are at high-risk and tend to be victimized due to their sexuality or their perceived sexuality. Of primary concern is the use of strip searches and breaches of medical confidentiality to victimize LGBT and HIV-positive detainees. The DOM defines a strip search as,

> The removal or rearrangement of some or all of an individual's clothing to enable officers to examine the clothing and surfaces of the detainee's body, including breasts, navel, exterior anal and genital areas, and the inside of the nose, ears, and mouth. To the extent possible, the officers conduct the search visually, without touching the body parts.

The DOM does not make public any language providing for the proper or improper usage of detainee searches within unpublished "Detainee Searches" portion of the guidelines. The secrecy surrounding DIHS policy in this regard does little to provide confidence that detainee searches are conducted with the privacy and rights of the detainee in mind. Detainees have reported that strip searches are used in abusive and inappropriate ways including repeated strip searches for unknown reasons, the use of strip searches to put detainees' bodies on display as a shame tactic or to intimidate and degrade a detainee, and most disturbingly the

use of strip searches and body cavity searches to sexually assault detainees under the cover of appropriate DHS departmental policy. The DOM does not explicitly prohibit sexual contact between ICE staff members and detainees and fails to state that officer-detainee sexual contact is never appropriate, even if considered "consensual." Because the guidelines pertaining to detainee searches are not public it is difficult to ascertain whether there is language explaining what is considered inappropriate uses of strip searches and body cavity searches. If any guidelines exist they should be made public. If the guidelines do not exist they must be written in a manner that respects the privacy of immigrant detainees and provides clear definitions of acceptable and non-acceptable practices as well as clear punishment when violated.

Medical Information Must Be Restricted, Kept Confidential
The DOM provides for the confidentiality of detainees regarding their medical history and medical needs. It states:

> All medical providers shall protect the privacy of detainees' medical information to the extent possible while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well being of detainees. Where a detainee is covered by the Privacy Act, specific legal restrictions govern the release of medical information or records.

These guidelines provide useful language but are undermined by another section of the DOM that allows all staff at detention facilities to have access to the medical records of immigrant detainees. There is no need for all staff members to have access to the medical records of detainees. Access to medical records should be restricted to authorized medical personnel. Detainees often report their HIV status being made public by guards as retribution or to endanger their physical health. Transgender detainees can also be put at high risk of violence when their personal information regarding their gender identity and or history of transgender health care is disclosed. Providing all detention facility staff with access to the private and personal medical records of detainees enables the abuse of medical information.

It is imperative that the medical information of detainees be kept private and confidential. Officers who violate this policy should be made to provide a clear reason why this policy was violated. If no clear justification can be provided the employee must be held accountable and the individual who's privacy was violated must be protected in a manner consistent with non-punitive protective custodial policy.

Protective Custody Must Not Include Punitive Solitary Confinement
The DOM defines "administrative segregation" as a "non-punitive form of separation from the general population used when the continued presence of the detainee in the general population would pose a threat to self, staff, other detainees, property, or the security or orderly operation of the facility." One form of administrative segregation is protective custody that may be used at the request of the detainee or be ordered to protect the detainee from harm.

The manual further requires that detainees in administrative segregation receive "the same general privileges as detainees in the general population," taking into account the resources

and security of the facility. The guideline language is acceptable but in practice is often either ignored or not followed. Too often administrative segregation closely resembles punitive segregation including solitary confinement and loss of privileges. Due to the high-risk situations LGBT detainees often find themselves, it is critical that they be able to request protective custody without the fear of punitive segregation. These requests must be treated seriously and non-punitive segregation must be an available option for detainees who fear for their safety because of their sexual orientation, transgender identity, or perceived gender non-conforming behavior.

It is imperative that administrative segregation be clearly distinguishable from punitive segregation otherwise detainees who are physically abused, threatened, or harassed will not seek protection further endangering their physical safety. Additionally, individuals who are in administrative custody must retain the privileges of the general population including visitation rights, phone privileges, access to resources and library material as well as supervised outdoor activity privileges.

Transfers Must Be Used Cautiously for Detainees With Health Problems
The DOM provides extensive guidelines to govern the transfer of a detainee and outlines the manner in which a detainee should be transferred as well as common reasons for transfer. Detainees are often transferred from one facility to another and the regularity of such transfers make them difficult to regulate. Similarly, the frequency of transfers renders the sustained and managed health care of individuals a particular challenge. The transfer of medical records as well as any required medication must accompany detainees at all times.

Immigration officials use transfers as weapons. Victims of sexual assault have been transferred so they cannot file complaints against immigration authorities. Individuals that cooperate in investigations or speak with the media have also reported being transferred punitively. Transferring individuals with mental and physical health needs including medication and mental health needs can be disruptive to their medical treatment and often prove severely detrimental to their overall health. Individuals should not be transferred unless absolutely necessary and unless their medical needs can be provided for during transfers and at the facility to which the detainee is being transferred.

RECOMMENDATIONS

The undersigned organizations call upon the Department of Homeland Security and Customs and Immigration Enforcement to implement the following set of recommendations:

- Revise the current DOM to include standards that are enforceable and legally binding in all ICE/DHS facilities, regardless of whether said facilities are operated by the federal government, private companies or contractors, or state/county/local governments. Detainees, their families, and their legal representatives must have proper legal recourse when a grievance is registered and when Departmental standards are violated.

- Provide effective internal and external oversight of detention conditions and treatment

of detainees. This would include the establishment of an ombudsman to monitor and inspect facilities and grievances filed against DHS/ICE personnel. The ombudsman will release his/her reports to the public including the U.S. Congress.

- Adhere to international covenants and treaties mandating the humane treatment of all detainees, including the International Covenant on Civil and Political Rights and the Universal Declaration of Human Rights.

- Pursue non-custodial alternatives to detention, particularly for individuals whose personal safety or health needs would be imperiled by detention.

- Conduct a full audit of reports of sexual assault in ICE/DHS as well as privately contracted immigration detention centers including state, county, and local facilities. The results of this audit must be released to the public.

- All detainees must have access to acute-trauma care, including treatment of injuries, medical examination, STD testing and prophylaxis, and emergency mental health counseling. Detainees who have been victimized should further receive appropriate physical and mental health care follow-up and confidential counseling for post-traumatic stress disorder and other mental health problems. This follow-up must also include access to confidential, voluntary testing, treatment, and counseling for HIV/AIDS and other STDs.

- When a complaint of sexual abuse is lodged, evidence must be collected as soon as possible, including through the completion of a rape kit whenever possible. Detainees who report sexual assault must not be punished for filing a complaint, and non-punitive measures should be taken to protect detainees who report abuse.

- Provide mental health officials on-site, at every DHS/ICE facility including privately contracted facilities and state, county, and local facilities.

- Provide, within 24 hours, survivors of sexual assault access to mental health professionals. Survivors of sexual assault must be provided with ongoing therapy during incarceration and must be provided his/her mental health records upon release with a referral to local and low-cost community health resources.

- Align the DOM with current standards of medical care. In particular care and treatment of people with HIV/AIDS must conform to accepted standards of care including uninterrupted and comprehensive medication as well as prompt medical attention by physicians knowledgeable in the field upon request and or when medically necessary.

- Insert and acceptable definition of what constitutes an emergency medical situation. This definition must be clearly understood by all staff, medical and non-medical alike. The DOM must mandate treatment in emergent situations.

- Provide proper dosages of medication for individuals including all drugs as necessary, in addition to antiretrovirals, for HIV-positive individuals.

- The DOM must provide clear direction for providing medication to cover any gap in dispersal either as a result of being transferred from one facility to another or for any other reason. The recipient facility of an individual with medication needs must be notified in advance of the detainees arrival and such medication must be provided upon arrival of the detainee.

- Revise DOM regulations that currently allow all ICE employees access to medical information to restrict such information on a need-to-know basis.

- Make public the guidelines pertaining to strip searches. These guidelines must respect the privacy of immigrant detainees and provide clear definitions of acceptable and non-acceptable practices. Accusations of the strip search violations must be investigated. When violations occur perpetrators must be investigated and if found guilty, must be fired. During an investigation the DHS/ICE official or any other person under investigation must not have access to the individual who filed the complaint.

- Prevent the housing of transgender detainees in situations where they are vulnerable to assault. Transgender detainees should be housed in accordance with their self-identity and individual safety needs taking into account their gender identity. Placements should never be made solely based on genitals. In addition, accommodations for private showers and other measures for improving safety must be made on request for all detainees vulnerable to assault, including transgender detainees.

- Provide clearly defined distinctions between administrative and punitive segregation. Individuals requesting administrative segregation must retain the privileges of the general population including visitation rights, phone privileges, access to resource and library material as well as supervised outdoor activity privileges.

- Provide for community-based training of immigration detention staff on transgender, HIV, and lesbian, gay and bisexual issues.

September 11, 2007

Julie L. Myers
Assistant Secretary
U.S. Immigration and Customs Enforcement
Department of Homeland Security
425 Eye Street, NW
Washington, DC 20536

Re: Victoria (a.k.a. Víctor) Arellano [A: 77991267]

Dear Ms. Myers,

We, the undersigned organizations, representing HIV/AIDS, civil rights, human rights, immigrant justice, and civil liberties advocates and service providers from across the United States, write to you today to express our outrage over the July 20, 2007 death of Victoria (a.k.a. Victor) Arellano in the San Pedro detention center. Victoria's death was excruciating and needless. Her requests for her AIDS medication were deliberately and repeatedly denied, as were her fellow detainees' increasingly desperate pleas to staff to take her to the hospital.

When Victoria was sent to San Pedro in May, she was taking the antibiotic dapsone to prevent pulmonary infections from developing into pneumonia. At San Pedro, she was denied the medication despite the known consequences of discontinuing this antibiotic: the onset of treatment-resistant pneumonia within a few weeks. Indeed, Victoria's health deteriorated rapidly to the point where the pain was so great, she would scream if anyone tried to move her. She complained of severe nausea, headaches, cramps, and back pain. She was vomiting and suffering from diarrhea. Her care was left to the men detained with her. They administered cold compresses to bring down her fever and took turns taking her to the bathroom when she was too weak to get there by herself. Seventy of them signed a petition appealing for medical care for Victoria.

A week before her death she was taken to the infirmary and give amoxicillin. Again, the standard of care for people living with AIDS was ignored. Amoxicillin is ineffective against meningitis and AIDS-related lung infections. When Victoria returned from the infirmary, she began vomiting blood. Once again, her fellow detainees put themselves on the line to demand medical attention for Victoria. She was finally taken to a hospital but was returned to the detention center less than 24 hours later. By the time she was taken to another hospital, it was too late. She died shackled to her bed in the ICU. Her mother reports her body was wracked by pneumonia and meningitis.

With everything to lose – with their own futures uncertain – the men detained with Victoria Arellano met the brutality and the calculated negligence of ICE with profound humanity. They cared for her; they advocated for her; they even consoled her mother when she lost her child. Some of these men have been transferred out of San Pedro,

possibly to prevent them from participating in an investigation and/or in retaliation for their role in trying to save Victoria.

Although she was born male, Victoria had been living and identifying as a woman for years. It is not appropriate to house women, such as Victoria, in a male dormitory. ICE must revise its policies to ensure that transgender women are placed with other women in female facilities. While we are grateful for the care given to her by the men she was housed with, other transgender women have not been so lucky. It is widely known that they are at increased risk of assault when placed with the male population. In Victoria's case, it was the guards who harassed her. Further, another transgender woman testified at the National Prison Rape Elimination Commission in Los Angeles in December 2006 that she had been raped by an official at San Pedro.

Victoria's was not the only foreseeable, preventable death to have occurred in ICE detention. Hers wasn't even the first in San Pedro. Media reports indicate that since 2004, at least 65 people have died in ICE detention. The guidelines for medical care contained in the Department of Homeland Security's *Detention Operations Manual* (DOM) are insufficient and unenforceable. Far from providing a recognized standard of care, ICE fails to meet even its own standards of providing "primary medical care, and emergency care." Facilities the size of San Pedro are required to make medical personnel available to see detainees who request medical services in a clinical setting at least five days per week. Victoria, like many others, was not given this access and had to wait much too long before she received any care.

The *DOM* further states that following a clinical evaluation, if an HIV-positive person in detention "manifests symptoms requiring treatment beyond the facility's capability, the provider will recommend the detainee be transferred to a hospital, or other appropriate facility for further medical testing, final diagnosis, **and acute treatment as needed...HIV positive detainees should be hospitalized until any acute treatment deemed necessary is completed.**"

In response to the glaring violations of current DHS/ICE guidelines and of Victoria Arellano's human rights, we seek the implementation of new policies that meet appropriate standards of care and that are reviewable and transparent to the public.

We, the undersigned organizations, call on the Department of Homeland Security and Immigration and Customs Enforcement to:

- Implement revised standards that are enforceable and legally binding in all ICE/DHS detention facilities, regardless of whether said facilities are operated by the federal government, private companies, or state/county/local agencies. Detainees, their families, and their representatives must have legal recourse when these standards are violated.

- Provide effective internal and external oversight of detention conditions and treatment of detainees. This would include the establishment of an ombudsman, ongoing monitoring and frequent inspections with subsequent reports released to Congress and made available to the public.

- Immediately rectify any and all breaches of detention standards, including denial of medical care.

- Increase the availability of medical personnel to see detained individuals who are in need of care, regardless of whether or not a detainee has made a formal request for care. Currently, facilities with over 200 detainees are only required to schedule "sick calls" five days a week, while facilities with fewer than 50 detainees need only provide access to medical personnel one day a week. This is grossly insufficient.

- Commission an investigation into the death of Victoria Arellano that is independent and transparent, so that the public may have confidence in the investigation's outcome.

- Strengthen the DHS/ICE national detention standards to comply with human rights principles.

- Ensure that treatment regimens, including medication for HIV/AIDS and related infections and hormone therapy for transgender detainees are not interrupted.

- Adhere to international covenants and treaties mandating the humane treatment of all detainees, including the International Covenant on Civil and Political Rights and the Universal Declaration of Human Rights.

- Pursue non-custodial alternatives (e.g., parole, supervised release to family members, regular reporting requirements, bond options) for immigration detainees, particularly for those individuals whose health or personal safety would be imperiled by detention.

- End the practice of prolonged and indefinite detention, which is a violation of both international and U.S. law.

- Publicly report all deaths that occur in ICE custody, refer them immediately to the Office of the Inspector General for investigation, and make the results of each inquiry available to the public as soon as it is complete.

- End the practice of placing immigration detainees with the general inmate population.

- Ensure that the safety of detainees, particularly transgender detainees is the paramount consideration when deciding whether to place an individual with the male or female population. Solitary confinement must not be considered a viable option.

- Grant transgender detainees the right to choose to be housed in a facility that corresponds with their gender identity, regardless of which sex is listed on their legal documents and/or regardless of their birth-sex.

- Revise the DOM to address the particular needs of gay men, lesbians, bisexuals, and transgender men and women, including health and safety issues.

- Train all staff in all facilities where ICE detainees are held to comply with these standards and safeguard the inherent dignity of all persons.

We are bringing this matter to the attention of our elected officials and we urge you to take prompt and necessary action to prevent further threats to health and loss of life among immigrants in ICE detention.

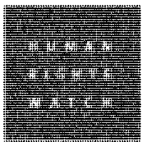
Sincerely,

African American Hispanic Health Education Resource Center
African Services Committee
AIDS Action Council
ACT UP Philadelphia
AIDS Foundation of Chicago
The AIDS Institute
AIDS Legal Council of Chicago
AIDS Project Los Angeles
Ali Forney Center
American Academy of HIV Medicine
American Civil Liberties Union
amfAR
Artists for a New South Africa
API Equality-LA
Asian American Institute
Asian American Justice Center
Asian Law Caucus
Asian Pacific AIDS Intervention Team
Asian and Pacific Islander American Health Forum
Astraea Lesbian Foundation for Justice
The Audre Lorde Project
Bienestar

East Bay Community Law Center
Empire Justice Center
Episcopal Migration Ministries
Casa de Esperanza
Center for Constitutional Rights
Community HIV/AIDS Mobilization Project (CHAMP)
Gay & Lesbian Advocates & Defenders
Gay Men's Health Crisis
Fundación Latino Americana Contra El SIDA, Inc.
Health Global Access Project (Health Gap)
Housing Works
Hudson Pride Connections
Human Rights Campaign
Immigration Equality
International AIDS Empowerment
International Federation of Black Prides, Inc./IFBP Fund for Leadership, Inc.
International Gay and Lesbian Human Rights Commission
Intersect Worldwide
Jews for Racial and Economic Justice (JFREJ)
Kentucky Coalition for Immigrant and Refugee Rights
Koreatown Immigrant Workers Alliance of Southern CA (KIWA)
L.A. Gay & Lesbian Center
Las Americas Immigrant Advocacy Center (El Paso)
Latino Commission on AIDS
The Lesbian, Gay, Bisexual & Transgender Community Center (New York)
Less AIDS Lesotho
Mexicanos Sin Fronteras
National Association of Lesbian, Gay, Bisexual & Transgender Community Centers
National Association of People with AIDS
National Center for Lesbian Rights
National Gay and Lesbian Task Force
National Immigrant Solidarity Network
National Immigration Project of the National Lawyers Guild
National Minority AIDS Council
National Network for Immigrant and Refugee Rights
Neighborhood Legal Services, Inc.
New York AIDS Coalition
NYC AIDS Housing Network (NYCAHN)
New York Immigration Coalition
Nicaragua Solidarity Fair Trade Resource
Political Asylum Project of Austin (PAPA)
Prostitutes of New York (PONY)
Rocky Mountain Survivors Center
Search for a Cure
STOP AIDS Project
Stop Prisoner Rape

Sylvia Rivera Law Project
Transgender Law Center
Treatment Action Group
Triangle Foundation
Unitarian Universalist Association of Congregations

Cc: Secretary Michael Chertoff
Director John P. Torres
Dr. Timothy T. Shack
Ambassador Mark Dybul
Warden Rudolph Garcia
Senate Majority Leader Harry Reid
Speaker Nancy Pelosi
Senator Barbara Boxer
Senator Hillary Clinton
Senator Dianne Feinstein
Senator Patrick Leahy
Senator Joseph Lieberman
Senator Charles Schumer
Representative Tammy Baldwin
Representative Xavier Becerra
Representative Howard Berman
Representative John Conyers, Jr.
Representative Barney Frank
Representative Charlie Gonzalez
Representative Raul Grijalva
Representative Luis Gutierrez
Representative Barbara Lee
Representative Zoe Lofgren
Representative Jerry Nadler
Representative Ileana Ros-Lehtinen
Representative Lucille Royball-Allard
Representative Linda Sanchez
Representative Hilda Solis
Representative Bennie G. Thompson
Representative Nydia Velázquez
Representative Maxine Waters
Representative Henry Waxman



HIV/AIDS Services for Immigrants Detained by the United States

Submitted by
Human Rights Watch
HIV/AIDS and Human Rights Program
October 3, 2007

Human Rights Watch respectfully submits this testimony to the House Judiciary Committee Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law as it examines the issue of medical care for immigration detainees. Human Rights Watch, an independent non-governmental organization founded in 1978, has documented human rights abuses around the world. We are the largest human rights organization in the United States, and regularly report on US criminal justice issues including prison conditions, prison medical care, and conditions of confinement for immigration detainees.[1] Our HIV/AIDS and Human Rights Program identifies human rights violations that fuel the HIV epidemic and impede access to life-saving treatment, both in the United States and around the world.[2] Services for immigration detainees with HIV/AIDS in the United States is the subject of a forthcoming report. Copies of our reports are available at www.hrw.org.

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[1] *See*, e.g. Human Rights Watch and ACLU,, *Custody and Control: Conditions of Confinement in New York's Juvenile Prisons for Girls* (New York: September 2006); Human Rights Watch, *So Long As They Die: Lethal Injections in the United States* (New York: April 2006); Human Rights Watch, *Locked Away: Immigration Detainees in Jails in the United States* (New York: September 1998)

[2] See, e.g., Human Rights Watch, *LifeDoesn't Wait: Romania's Failure to Protect and Support Children and Youth Living with HIV* (New York: August 2006); Human Rights Watch, *Injecting Reason: Human Rights and HIV Prevention for Injection Drug Users* (New York: September 2003).

HIV/AIDS Services for Detained Immigrants in the United States

Summary

An estimated 30,000 immigrants are held in administrative custody in the United States. These detainees are held in detention centers operated by the Immigration and Customs Enforcement agency (ICE), centers owned by private corporations, and in more than 300 local and county jails. A small number of immigrants are also held in federal facilities operated by the US Bureau of Prisons. U.S. and international legal standards require, at a minimum, that administrative detainees receive HIV/AIDS prevention, care, and treatment services equivalent to those provided in the general community. The US has no uniform national standard that meets this test; and the standards that do exist do not protect the majority of immigrant detainees, who are housed in local jails and contract detention facilities. Government failure to collect data on detainees living with HIV/AIDS and to adequately supervise medical care provided in its "outsource" facilities further undermine its obligation to ensure that proper and appropriate medical care is provided to immigrants. These failures violate immigrant detainees' fundamental right to health protected under US and international law.

Legal Standards

In the United States, courts have consistently held that administrative detainees must be held in non-punitive conditions.[3] Detainees are entitled to "reasonable" medical care which courts

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[3] *Wong Wing v. United States*, 163 U.S. 228, 237 (1896); *Jones v. Blanas*, 393 F.3d 918 (9th Cir. 2004); *Haitian Centers Council, Inc. v. Sale*, 823 F. Supp. 1028 (EDNY, 1993).

have found to be a "demonstrably higher" standard than the Eighth Amendment prohibition on cruel and unusual punishment.[4] The definition of "reasonable" medical care has not been articulated by the judiciary, but national correctional health standards have adopted as policy the "equivalence standard," requiring that prisoners receive medical care at least equivalent to that provided in the general community.[5]

Key international instruments establish that all persons have a right to health. The International Covenant on Economic, Social and Cultural Rights (ICESCR) , which the US has signed, confers an explicit right to "the highest attainable standard of health." [6] The US is a party to the International Covenant on Civil and Political Rights (ICCPR) which incorporates several rights directly and indirectly linked to the right to health, including the right to life, the right to be free from cruel, degrading or inhumane treatment or punishment, the right to be free from discrimination, and the right to privacy. These rights are not forfeited upon incarceration. On the contrary, Article 10 of the ICCPR specifically requires that all persons deprived of their liberty be treated with humanity and respect for their inherent dignity. [7] International guidelines for the treatment of prisoners require that incarcerated persons receive medical care equivalent to that provided in the general community.[8] Standards

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[4] *Haitian Centers, supra*, at 1043.

[5] National Commission on Correctional Health Care (NCCHC), Position Statement, "Administrative Management of HIV in Corrections", October 19, 2002, p. 1; American Public Health Association (APHA), Standards for Health Care in Correctional Institutions, (2003) p. 2.

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

[7] 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, 1192, arts. 6,7 10(1).

[8] United Nations Standard Minimum Rules for the Treatment of Prisoners, May 13, 1977, Economic and Social Council Res., 2076 (LXII); Basic Principles for the Treatment of Prisoners, UN General

established by the World Health Organization, UNAIDS and other international health organizations require that HIV/AIDS prevention, care and treatment services in correctional settings be equivalent to that afforded in the community.[9]

These standards, based on human rights obligations in both domestic and international law, are applicable to all immigrants detained in the United States, for whom Department of Homeland Security and its enforcement agency, Immigration Customs and Enforcement are ultimately responsible. These obligations may not be delegated or evaded by contracting with third party detention facilities. [10]

The ICE Detention Standard for HIV/AIDS Fails to Meet US and International Legal Standards

ICE has adopted a Detention Operations Manual (DOM) that sets forth 38 standards for conditions in immigration detention. The "Medical Care" standard set forth in the DOM contains a specific section addressing the treatment of detainees with HIV/AIDS.[11] However, the HIV/AIDS provisions fail to establish an acceptable standard of care, in line with national and international criteria and recommended practice. This "standard" makes no reference to counseling, current clinical guidelines (such as those set by the Centers for Disease Control or the American Medical Association), confidentiality, or access to specialty care, as it should according to

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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).

[9] WHO Guidelines on HIV Infection and AIDS in Prisons (1999); UNAIDS International Guidelines on HIV/AIDS and Human Rights (2006); UNODC (With WHO/UNAIDS), HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for Effective National Response (2006).

[10] *See, Roman v. Ashcroft*, 340 F3d 314, 320 (6th Cir. 2003).

[11] Department of Homeland Security, Detention Operations Manual, 2006, "Medical Care", para. K, www.ice.gov/partners/dro/opsmanual/index.htm, accessed July 20, 2007.

National Commission on Correctional Health, American Public Health Association, World Health Organization and UNAIDS guidelines.[12] The standard also fails to establish a voluntary testing and counseling program for immigrants with HIV/AIDS, stating that in some cases an immigrant's request for a test may be denied. As a result of these omissions the HIV/AIDS provisions fail to meet community standards of care and fall below national and international recommended standards for the treatment of HIV/AIDS in correctional settings.

Further, the Medical Care standard applies in its entirety only to Service Processing Centers (SPC) operated by ICE or official Contract Detention Facilities (CDF) owned by private corporations; many of its provisions apply only as "guidelines" for the hundreds of local jails and other facilities contracting with ICE. The ICE Detention Standards do not apply to immigrants detained by the US Bureau of Prisons. The Bureau of Prisons policy for medical care expressly adopts the "equivalence" standard requiring that medical care in its facilities, including those for prisoners with HIV/AIDS, shall reflect medical care standards in the community.[13] Consequently, the current US government system lacks uniformity and consistency, creating three distinct populations of immigrant detainees depending in whose custody they are, each subject to and with access to differing standards of medical care.

Finally, because the detention standards set forth in the DOM are not formal administrative regulations, they are not enforceable in a court of law. This "voluntary" status leaves immigrants without legal recourse when the standards are violated.

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[12] See, e.g. NCCHC Position Statement, *supra*, pp1-3; APHA Standards, *supra*, , section V; and UNODC, *supra*, pp 10-21.

[13] Bureau of Prisons Policy 6010.03, www.bop.gov/datasource/execute/dspolicyloc, accessed October 2, 2007.

ICE Failure to Identify or Monitor Detainees with HIV/AIDS Impedes its Ability to Meet its Obligations to Protect Immigrants' Right to Health

Human Rights Watch filed a Freedom of Information Act request seeking statistical information about immigrants with HIV/AIDS in immigration custody, including the number of detainees tested, diagnosed and treated for HIV/AIDS in the last five years. [14] The documents received from ICE in response to this request indicate that the agency largely fails to track this information, or that the information tracked is incomplete, failing to account for the hundreds of facilities throughout the country contracting with ICE to hold detainees.

ICE responded "not tracked" to the following questions:

- The number of detainees receiving treatment for HIV/AIDS
- The number of detainees tested for HIV
- The number of HIV cases reported to federal, state, county or municipal public health agencies
- The number of detainees receiving off site specialty HIV/AIDS care
- The number of detainees with HIV/AIDS ordered deported or removed
- The number of detainees reported or removed with a supply of HIV/AIDS medication

[14] Letter from Human Rights Watch to ICE FOIA Office dated April 4, 2007.

ICE reported that "*the numbers below reflect all reported HIV cases to the DIHS Epidemiology Unit including those diagnosed per(sic) - ICE custody*":

- *2002- not tracked*
- *2003- 30*
- *2004- 42*
- *2005- 40*
- *2006- 54*
- *2007 (through April 2007) 47*

ICE also reported the number of on-site "clinic visits" related to HIV/AIDS:

- *FY 2003- 1162 (12 sites)*
- *FY 2004- 2577 (13 sites)*
- *FY 2005- 1125 (14 sites)*
- *FT 2006- 478 (14 sites)*
- *FY 2007 (October 2006 through April 2007) 233 (20 sites)*

The relationship, if any, between these two categories of statistics (cases reported to the Epidemiology Unit and on-site clinic visits) is unclear. Nor is it clear which facilities report, or are obligated to report, to the DIHS Epidemiology Unit (the Detention Standards contain no such reporting requirement.) [15] The limitation of the clinic visit statistic to between 12 and 20 sites suggests that the HIV/AIDS cases reported to the Epidemiology Unit originate from a limited number of sites, probably the Service Processing Centers and the Contract Detention Facilities. It is unlikely that these statistics reflect HIV/AIDS cases among detainees at the more than 300 jails and regional detention centers throughout the country. Human Rights

[15] The DIHS Epidemiology Unit declined Human Rights Watch's request for an interview.

Watch asked officials at jails in Alabama, Virginia and New Jersey if they reported detainee HIV/AIDS cases to ICE; they did not. [16]

ICE's response to the Human Rights Watch FOIA request indicates that it has limited and incomplete information regarding how many immigrants in its custody have been tested, diagnosed or treated for HIV/AIDS. The failure to collect and analyze this vital information undermines ICE's ability to meet its obligation to ensure appropriate medical care for this very vulnerable population.

ICE Fails to Provide Adequate Oversight of Medical Care in Detention

ICE's current mechanism for ensuring compliance with the National Detention Standards consists of one site visit per year to each of the 300 facilities housing immigrants in the United States. [17] Inspections are conducted by the Detention Standards Compliance Unit, which employs 8 inspectors and three support staff. [18] Inspections typically last 3 days and cover all 38 detention standards. [19] Recent audits of detention centers by the Department of Homeland Security Office of Inspector General (OIG) and the US General Accounting Service (GAO) criticized the ICE inspection system as inadequate, finding that it had failed to identify violations of the detention standards discovered in these audits.

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[16] HRW interview with Warden David Streiff, Perry County Correctional Facility 5/3/07; HRW interview with Superintendent Lewis W. Barlowe, Piedmont Regional Jail 6/20/07; HRW interview with Lt. James Howell, Monmouth County Correctional Institution 5/1/07.

[17] "Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities, December 2006, (OIG Report).

[18] General Accounting Office Report GAO-07-875 (GAO Report): Alien Detention Standards, July 2007.

[19] Ibid; Human Rights Watch interview with Warden David Streiff, *supra*.

The Detention Standard for Medical Care does not require that facilities contracting with ICE be accredited by correctional health organizations; rather, the standard recommends that contracting facilities be "accredited or accreditation-worthy." Numerous prisons and jails contracting with ICE for immigration detention are accredited by the National Commission on Correctional Health Care (NCCHC) or the American Correctional Association (ACA). Neither NCCHC nor ACA, however, requires on-site inspections of accredited facilities on either an annual or a semi-annual basis. Once accreditation is achieved (requiring an initial on-site visit), it can be maintained by submitting documentation of existing policies and procedures.[20] Thus for many facilities housing immigration detainees, a 3 day visit from ICE that includes medical care among 37 other issues will be the only means of determining whether detainees with HIV/AIDS are receiving reasonable care.

Detainees are often not informed of their right to complain to ICE, the Department of Justice or other government agencies. The GAO report found that although some facilities posted a "hotline" number for complaints to the Office of the Inspector General, the number was non-functional from many facilities. Detainee complaints that were received were not processed or analyzed by DHS in any coherent manner.

Conclusion

The current system of "standards" for medical care in detention lacks clarity, uniformity and consistency, creating three different groups of immigration detainees, distinguished simply by reference

[20] *See,* Accreditation Procedures" at www.ncchc.org and www.aca.org, accessed October 2, 2007.

to whose custody they happen to be in, each subject to and with access to differing standards. The ICE detention standards for the treatment of HIV/AIDS fail to meet national and international standards requiring that prison health care be equivalent to that provided in the community. The standards are voluntary and unenforceable, leaving immigrant detainees without legal recourse when the standards are violated.

ICE willfully ignores the incidence of HIV/AIDS among immigration detainees by failing to require programs for voluntary testing, counseling, and education that would identify cases of HIV/AIDS. Treatment may not be required, or appropriate, in every case, but identification and diagnosis would provide potentially life-saving information to individuals seeking that information and would facilitate appropriate medical response and planning. ICE further fails to monitor the testing, diagnosis or treatment of HIV/AIDS that is occurring in the majority of its detention facilities. The ICE inspection system is currently inadequate to ensure appropriate medical care in the hundreds of facilities utilized to hold detainees.

Providing only emergency and short term medical care may be more convenient for ICE and more profitable for county jails, but immigrants with HIV/AIDS, often for procedural reasons, may spend longer in detention than other immigrants and require more complex levels of care.[21] Providing medical care equivalent to that in the community to detainees with HIV/AIDS is a matter of public health, a requirement of federal law, and a fundamental principle of human rights.

On Independence Day 2007, John P. Torres, Director of ICE Detention and Removal Operations published a letter in the *New*

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[21] Human Rights Watch research indicates that immigrant detainees with HIV/AIDS in comparison to other detainees, may seek to challenge their deportation on health grounds, entailing a prolonged process and detention, while their claims are adjudicated.

York Times acknowledging ICE's "moral obligation" to provide medical care for immigrant detainees, "which we uphold each and every day in a manner of which the American people can be proud." ICE's obligation to provide adequate medical care, however, is a legal one. And the US government must take serious steps to address the shortcomings in its policies and procedures relating to immigrant health care before it can claim any pride in them on the part of the American people.

Accordingly, Human Rights Watch recommends that the United States government increase executive and legislative branch oversight of conditions of detention for immigrants, including:

- The General Accounting Office should follow up on its recent report to ensure that ICE has taken appropriate action in response to its recommendations.

- Congress should establish a monitoring body independent of the Department of Homeland Security with the responsibility and the expertise to ensure that each facility housing immigration detainees complies with national correctional health care standards by providing medical care equivalent to that afforded in the community.

- The detention standards should conform to national and international standards and should be converted to enforceable administrative regulations.

September 11, 2007

Julie L. Myers
Assistant Secretary
U.S. Immigration and Customs Enforcement
Department of Homeland Security
425 Eye Street, NW
Washington, DC 20536

Re: Victoria (a.k.a. Víctor) Arellano [A: 77991267]

Dear Ms. Myers,

We, the undersigned organizations, representing HIV/AIDS, civil rights, human rights, immigrant justice, and civil liberties advocates and service providers from across the United States, write to you today to express our outrage over the July 20, 2007 death of Victoria (a.k.a. Víctor) Arellano in the San Pedro detention center. Victoria's death was excruciating and needless. Her requests for her AIDS medication were deliberately and repeatedly denied, as were her fellow detainees' increasingly desperate pleas to staff to take her to the hospital.

When Victoria was sent to San Pedro in May, she was taking the antibiotic dapsone to prevent pulmonary infections from developing into pneumonia. At San Pedro, she was denied the medication despite the known consequences of discontinuing this antibiotic: the onset of treatment-resistant pneumonia within a few weeks. Indeed, Victoria's health deteriorated rapidly to the point where the pain was so great, she would scream if anyone tried to move her. She complained of severe nausea, headaches, cramps, and back pain. She was vomiting and suffering from diarrhea. Her care was left to the men detained with her. They administered cold compresses to bring down her fever and took turns taking her to the bathroom when she was too weak to get there by herself. Seventy of them signed a petition appealing for medical care for Victoria.

A week before her death she was taken to the infirmary and give amoxicillin. Again, the standard of care for people living with AIDS was ignored. Amoxicillin is ineffective against meningitis and AIDS-related lung infections. When Victoria returned from the infirmary, she began vomiting blood. Once again, her fellow detainees put themselves on the line to demand medical attention for Victoria. She was finally taken to a hospital but was returned to the detention center less than 24 hours later. By the time she was taken to another hospital, it was too late. She died shackled to her bed in the ICU. Her mother reports her body was wracked by pneumonia and meningitis.

With everything to lose – with their own futures uncertain – the men detained with Victoria Arellano met the brutality and the calculated negligence of ICE with profound humanity. They cared for her; they advocated for her; they even consoled her mother when she lost her child. Some of these men have been transferred out of San Pedro,

possibly to prevent them from participating in an investigation and/or in retaliation for their role in trying to save Victoria.

Although she was born male, Victoria had been living and identifying as a woman for years. It is not appropriate to house women, such as Victoria, in a male dormitory. ICE must revise its policies to ensure that transgender women are placed with other women in female facilities. While we are grateful for the care given to her by the men she was housed with, other transgender women have not been so lucky. It is widely known that they are at increased risk of assault when placed with the male population. In Victoria's case, it was the guards who harassed her. Further, another transgender woman testified at the National Prison Rape Elimination Commission in Los Angeles in December 2006 that she had been raped by an official at San Pedro.

Victoria's was not the only foreseeable, preventable death to have occurred in ICE detention. Hers wasn't even the first in San Pedro. Media reports indicate that since 2004, at least 65 people have died in ICE detention. The guidelines for medical care contained in the Department of Homeland Security's *Detention Operations Manual* (DOM) are insufficient and unenforceable. Far from providing a recognized standard of care, ICE fails to meet even its own standards of providing "primary medical care, and emergency care." Facilities the size of San Pedro are required to make medical personnel available to see detainees who request medical services in a clinical setting at least five days per week. Victoria, like many others, was not given this access and had to wait much too long before she received any care.

The *DOM* further states that following a clinical evaluation, if an HIV-positive person in detention "manifests symptoms requiring treatment beyond the facility's capability, the provider will recommend the detainee be transferred to a hospital, or other appropriate facility for further medical testing, final diagnosis, **and acute treatment as needed…HIV positive detainees should be hospitalized until any acute treatment deemed necessary is completed**."

In response to the glaring violations of current DHS/ICE guidelines and of Victoria Arellano's human rights, we seek the implementation of new policies that meet appropriate standards of care and that are reviewable and transparent to the public.

We, the undersigned organizations, call on the Department of Homeland Security and Immigration and Customs Enforcement to:

- Implement revised standards that are enforceable and legally binding in all ICE/DHS detention facilities, regardless of whether said facilities are operated by the federal government, private companies, or state/county/local agencies. Detainees, their families, and their representatives must have legal recourse when these standards are violated.

- Provide effective internal and external oversight of detention conditions and treatment of detainees. This would include the establishment of an ombudsman, ongoing monitoring and frequent inspections with subsequent reports released to Congress and made available to the public.

- Immediately rectify any and all breaches of detention standards, including denial of medical care.

- Increase the availability of medical personnel to see detained individuals who are in need of care, regardless of whether or not a detainee has made a formal request for care. Currently, facilities with over 200 detainees are only required to schedule "sick calls" five days a week, while facilities with fewer than 50 detainees need only provide access to medical personnel one day a week. This is grossly insufficient.

- Commission an investigation into the death of Victoria Arellano that is independent and transparent, so that the public may have confidence in the investigation's outcome.

- Strengthen the DHS/ICE national detention standards to comply with human rights principles.

- Ensure that treatment regimens, including medication for HIV/AIDS and related infections and hormone therapy for transgender detainees are not interrupted.

- Adhere to international covenants and treaties mandating the humane treatment of all detainees, including the International Covenant on Civil and Political Rights and the Universal Declaration of Human Rights.

- Pursue non-custodial alternatives (e.g., parole, supervised release to family members, regular reporting requirements, bond options) for immigration detainees, particularly for those individuals whose health or personal safety would be imperiled by detention.

- End the practice of prolonged and indefinite detention, which is a violation of both international and U.S. law.

- Publicly report all deaths that occur in ICE custody, refer them immediately to the Office of the Inspector General for investigation, and make the results of each inquiry available to the public as soon as it is complete.

- End the practice of placing immigration detainees with the general inmate population.

- Ensure that the safety of detainees, particularly transgender detainees is the paramount consideration when deciding whether to place an individual with the male or female population. Solitary confinement must not be considered a viable option.

- Grant transgender detainees the right to choose to be housed in a facility that corresponds with their gender identity, regardless of which sex is listed on their legal documents and/or regardless of their birth-sex.

- Revise the DOM to address the particular needs of gay men, lesbians, bisexuals, and transgender men and women, including health and safety issues.

- Train all staff in all facilities where ICE detainees are held to comply with these standards and safeguard the inherent dignity of all persons.

We are bringing this matter to the attention of our elected officials and we urge you to take prompt and necessary action to prevent further threats to health and loss of life among immigrants in ICE detention.

Sincerely,

African American Hispanic Health Education Resource Center
African Services Committee
AIDS Action Council
ACT UP Philadelphia
AIDS Foundation of Chicago
The AIDS Institute
AIDS Legal Council of Chicago
AIDS Project Los Angeles
Ali Forney Center
American Academy of HIV Medicine
American Civil Liberties Union
amfAR
Artists for a New South Africa
API Equality-LA
Asian American Institute
Asian American Justice Center
Asian Law Caucus
Asian Pacific AIDS Intervention Team
Asian and Pacific Islander American Health Forum
Astraea Lesbian Foundation for Justice
The Audre Lorde Project
Bienestar

East Bay Community Law Center
Empire Justice Center
Episcopal Migration Ministries
Casa de Esperanza
Center for Constitutional Rights
Community HIV/AIDS Mobilization Project (CHAMP)
Gay & Lesbian Advocates & Defenders
Gay Men's Health Crisis
Fundación Latino Americana Contra El SIDA, Inc.
Health Global Access Project (Health Gap)
Housing Works
Hudson Pride Connections
Human Rights Campaign
Immigration Equality
International AIDS Empowerment
International Federation of Black Prides, Inc./IFBP Fund for Leadership, Inc.
International Gay and Lesbian Human Rights Commission
Intersect Worldwide
Jews for Racial and Economic Justice (JFREJ)
Kentucky Coalition for Immigrant and Refugee Rights
Koreatown Immigrant Workers Alliance of Southern CA (KIWA)
L.A. Gay & Lesbian Center
Las Americas Immigrant Advocacy Center (El Paso)
Latino Commission on AIDS
The Lesbian, Gay, Bisexual & Transgender Community Center (New York)
Less AIDS Lesotho
Mexicanos Sin Fronteras
National Association of Lesbian, Gay, Bisexual & Transgender Community Centers
National Association of People with AIDS
National Center for Lesbian Rights
National Gay and Lesbian Task Force
National Immigrant Solidarity Network
National Immigration Project of the National Lawyers Guild
National Minority AIDS Council
National Network for Immigrant and Refugee Rights
Neighborhood Legal Services, Inc.
New York AIDS Coalition
NYC AIDS Housing Network (NYCAHN)
New York Immigration Coalition
Nicaragua Solidarity Fair Trade Resource
Political Asylum Project of Austin (PAPA)
Prostitutes of New York (PONY)
Rocky Mountain Survivors Center
Search for a Cure
STOP AIDS Project
Stop Prisoner Rape

Sylvia Rivera Law Project
Transgender Law Center
Treatment Action Group
Triangle Foundation
Unitarian Universalist Association of Congregations

Cc: Secretary Michael Chertoff
Director John P. Torres
Dr. Timothy T. Shack
Ambassador Mark Dybul
Warden Rndolph Garcia
Senate Majority Leader Harry Reid
Speaker Nancy Pelosi
Senator Barbara Boxer
Senator Hillary Clinton
Senator Dianne Feinstein
Senator Patrick Leahy
Senator Joseph Lieberman
Senator Charles Schumer
Representative Tammy Baldwin
Representative Xavier Becerra
Representative Howard Berman
Representative John Conyers, Jr.
Representative Barney Frank
Representative Charlie Gonzalez
Representative Raul Grijalva
Representative Luis Gutierrez
Representative Barbara Lee
Representative Zoe Lofgren
Representative Jerry Nadler
Representative Ileana Ros-Lehtinen
Representative Lucille Royball-Allard
Representative Linda Sanchez
Representative Hilda Solis
Representative Bennie G. Thompson
Representative Nydia Velázquez
Representative Maxine Waters
Representative Henry Waxman

Interfaith Statement on Medial Care in Detention Facilities

The Honorable Zoe Lofgren
Chair, House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law

Dear Chairwoman Lofgren,

We, the undersigned faith-based organizations, submit this joint statement to the House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law of the Committee on the Judiciary for the October 4, 2007 hearing on "Detention and Removal: Immigration Detainee Medical Care."

We join together to condemn the inhumane conditions and treatment of asylum seekers and other immigrants in detention facilities throughout the nation. We are particularly outraged by the lack of adequate medical treatment provided detainees, which has resulted in serious harm and even death in several cases. We call upon Congress and the Administration to work together immediately to reform these conditions, improve treatment, and provide stricter oversight of both privately and publicly operated detention centers across the country.

Our faith traditions instruct us to welcome the stranger and provide comfort to those who suffer. Thus, we strongly believe that the United States should welcome all newcomers to our country by treating them with dignity and respect. Many members of our organizations and congregations provide comfort, friendship, and religious services to men, women, and children who are often denied adequate medical care and other basic human rights in detention facilities. Faith-based groups administer religious services in Arizona, California, Florida, New Jersey, New York, Texas, Puerto Rico, and other regions.

Our members have been shocked by the suffering they have witnessed. They have seen pregnant mothers go without prenatal care, children vomiting with stomach pain or suffering from a toothache who must wait days to receive any medical attention, cancer patients denied life-saving chemotherapy in detention, critical AIDS patients left to the care and mercy of their fellow detainees, and others with serious illnesses made gravely worse by lack of medical treatment. In congregations, youth and adult ministry groups, and people's homes, our communities are asking how such conditions can exist in facilities operating under the purview of the United States government.

Several government and independent reports* have verified that these firsthand accounts are not merely anecdotal: they are a systemic problem. These reports have documented the exceptionally poor conditions and treatment that have resulted in chronic disease, serious injuries, untreated infections, and death due to a lack of medical attention and available personnel. These tragedies,

*Conditions of Confinement in Immigration Detention Facilities. The American Civil Liberties Union. June 2007.
Detention Watch Network: multiple case studies <http://www.detentionwatchnetwork.org/taxonomy/term/30>.
Locking Up Family Values: The Detention of Immigrant Families. Lutheran Immigration and Refugee Service and Women's Commission for Refugee Women and Children. February 2007.
Report on Asylum Seekers in Expedited Removal. United States Commission on International Religious Freedom. February 2005.
Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities. Office of Inspector General, U.S. Department of Homeland Security. December 2006.
"United States: Immigration/Treatment on Non-Citizens." Human Rights Watch. (multiple case studies 2004-2007)

along with the denial of referrals prescribed by medical personnel and the lengthy, bureaucratic process through which detainees must apply for medical care, are of great concern to the faith-based community. Federal guidelines for treatment in detention are currently not legally binding. Conditions are even worse in detention facilities operated by private contractors, which are neither legally bound or required to adopt such federal detention standards in regard to hygiene, exercise, nutrition, religious services, or medical attention.

We thank the members of the Subcommittee for holding this hearing regarding the inadequacy of medical care within detention centers, and call upon them to:

- Properly fund medical, mental health, dental, and vision care services, as well as translation assistance within all facilities detaining immigrants.
- Mandate the codification of standards governing the conditions and treatment of all immigration detainees, including those held in federal, local, county, state, and privately-contracted facilities.
- Mandate that DHS eliminate the overcrowding of facilities, which produces unsanitary conditions, heightens the risk of acquiring and spreading communicable diseases, and overwhelms sparse medical staff.
- Mandate more rigorous internal quality controls for medical screening and emergency care to prevent misdiagnosis and the exacerbation of critical conditions.
- Provide ongoing annual oversight of the medical, mental health, dental, and vision treatment of all immigrant detainees, including oversight of the Division of Immigration Health Services, which has overruled recommendations of facility medical personnel to the detriment of many patients.
- Mandate emergency medical attention for pregnant women, children, and other critical cases.
- Mandate access to detention facilities for religious and other non-governmental organizations which provide services and care to detainees.
- Call for the nationwide expansion of alternatives to detention, including the expansion of release and parole, to ensure immigrants are detained only when necessary.
- Postpone consideration of any legislation that would increase the use of detention facilities until these reforms and alternatives to detention have been fully implemented.
- Support legislation, such as the "Secure and Safe Detention and Asylum Act", that set legally-binding standards for treatment within detention facilities. The detention of asylum seekers should be abolished in all but the most extraordinary of cases, as being imprisoned has proven to compound the mental anguish and trauma they have previously suffered.

As a community of faith, we deplore the conditions present in detention centers in which asylum seekers and other immigrants are confined. All human beings deserve to have their basic human needs attended to – particularly in the case of medical necessities. We urge Congress and all decision makers to consider how detention conditions harm the physical, psychological, and spiritual needs of detainees. We further urge our nation's leaders to consider the impact that

widespread use of detention has on American communities and our society as a whole. In order to respond to this grievous harm, decision makers must mandate better care and reexamine the necessity of detaining those who seek a better life in the United States.

Sincerely,

Arab American and Chaldean Council

Catholic Charities Office for Social Justice, St. Paul and Minneapolis

Church Communities International

Church World Service, Immigration and Refugee Program

Episcopal Migration Ministries

Franciscan Friars (OFM) Holy Name Province Office for Justice, Peace and Integrity of Creation

Friends Committee on National Legislation

Hebrew Immigrant Aid Society

Hispanic Coalition for Comprehensive Immigration Reform

Immigration Working Group of the Sisters of St. Joseph of Carondelet, St. Paul Province

Jesuit Refugee Service/USA

Jubilee Campaign USA

Lutheran Immigration and Refugee Service

Mennonite Central Committee U.S. Washington Office

National Advocacy Center of the Sisters of the Good Shepherd

National Hispanic Christian Leadership Conference

NETWORK: A National Catholic Social Justice Lobby

Sisters of Mercy of the Americas

Unitarian Universalist Association of Congregations

United Methodist Church, General Board of Church and Society

STATEMENT OF JUDY LONDON

Hearing on Detention and Removal: Immigration Detainee Medical Care

Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law, By Direction of The Chairman

Thursday 10/04/2007 - 1:00 PM

My name is Judy London and I am the Directing Attorney of Public Counsel's Immigrants' Rights Project in Los Angeles, California. This past year, I have visited the San Pedro Processing Center in San Pedro, California on numerous occasions to interview potential clients and in the course of representing clients. My client, whom I will call Jose to protect his privacy, was housed in the same pod as Victoria Arellano, the San Pedro detainee who died in July of this year. Victoria, born Victoria Arellano, was a transgender woman who, prior to detention at the San Pedro facility, was successfully treated for HIV/AIDS through adherence to her managed drug regimen. Once in DHS custody and denied essential medication (including the Dapasone which she had been taking), Victoria's health deteriorated severely. The detention facility, instead of providing Dapasone, prescribed Amoxicillin, a drug which is not effective in treating AIDS patients. While on Amoxicillin, Victoria suffered increasingly severe headaches, back pain, fever, nausea and began vomiting blood. Her care was left to her fellow detainees, as detention staff ignored the detainees' repeated pleas that Victoria be given medical care. On July 20, 2007, Victoria Arellano died at the age of 23, shackled to her hospital bed.

Although I did not know Victoria Arellano, my experience interviewing those detained with her, and specifically, my attempts to secure adequate medical care for my client Jose (housed with Victoria), have convinced me that there will be more needless deaths of detainees if significant changes are not made in the provision of medical care at the San Pedro facility. The system operates with little transparency, and the different institutions present at the detention center are unresponsive to the urgent medical needs of detainees, even when zealous attorneys vigorously advocate for medical treatment.

Jose was detained by DHS in August of 2006. Prior to his DHS detention, Jose had been diagnosed with kidney stones. Once in DHS custody, he was diagnosed with depression and prescribed anti-depressant and anti-psychotic medication. At the merits hearing on his claims for relief, in addition to taking psychiatric medications, Jose was taking Benadryl, also prescribed by the DHS medical providers.

At his immigration merits hearing, Jose has no lawyer. The Immigration Judge found Jose's testimony not credible, and he was denied relief. On appeal, Jose was represented by *pro bono* counsel Sital Kalantry of Cornell Law School. The Board of Immigration Appeals ("BIA"), in May of 2007, reversed the Judge's decision, in part because of the BIA's concern that the Judge never addressed Jose's documented medical conditions which may have impacted his ability to testify.

Throughout March and April of 2007, Jose's lawyer tried desperately to secure medical care for Jose to treat his kidney stones, a growth on his chest, and his psychiatric conditions. DHS transferred Jose from San Pedro to a detention center in Alabama. Despite repeated phone calls and letters from Jose's counsel over a two month period, DHS refused to provide Jose with the requested medical care **and refused to provide Jose's attorneys with his medical records**, making an adequate review of his medical condition impossible.

In or about July of 2007, Jose was transferred from Alabama back to San Pedro for his remanded removal proceedings, and his New York counsel asked Public Counsel to take over Jose's legal representation in California. When I interviewed Jose at the San Pedro facility in early July, he could hardly sit for the hour-long interview with me, he was in so much pain. He reported that he continued to suffer extreme pain from kidney stones, and was in pain from a quarter size growth on his chest.

On July 11, 2007, nine days before Victoria Arellano's death, I appeared in immigration court on Jose's behalf along with *pro bono* co-counsel from the law firm of O'Melveny & Myers LLP. My client remained in extreme pain, and could hardly sit for his hearing. When I raised concerns about my client's medical care before the Immigration Judge, I was chastised for bringing up medical issues, since, as the court explained, the court had nothing to do with medical care. I also brought up my client's medical issues with the attorney from Immigrations and Customs Enforcement ("ICE") representing the government, and was told that there was little ICE could do to assist with medical care issues. The ICE attorney explained that only the deportation staff running the San Pedro facility could make decisions about medical care. Unfortunately, over the past year, the facility's staff had proven completely unwilling to respond to Jose's medical needs.

Because of concerns of our clients' deteriorating health, we recruited a surgeon from Cedars Sinai Hospital in Los Angeles, California to examine Jose on a *pro bono* basis. We wanted an expert's opinion on our client's health needs. Equally important, we needed a surgeon to document our client's scars caused by torture in a Guatemalan military camp. I requested permission from the DHS Officer-in-Charge for the surgeon to examine Jose, at our expense. The Officer-in-Charge told me explicitly that our surgeon would be allowed to visit with Jose only if I guaranteed that the sole purpose of the surgeon's visit was to document scars for evidence supporting Jose's claims relating to the torture he suffered as a child in Guatemala. Under no circumstances would the Officer-in-Charge agree to allow our surgeon to examine Jose *to assess his medical needs*.

By August of 2007, our Los Angeles and New York legal teams had sent multiple letters demanding medical care for Jose and made numerous telephone calls to DHS detention staff. All of these demands were met either with no response or denials. Shortly after the death of Victoria Arellano became public, DHS changed its position dramatically in respect to our request for medical care, and agreed to provide Jose with the specific care we had been demanding for so many months. Before DHS completed Jose's medical evaluation, the government granted him relief based on the torture he had endured as a child in Guatemala and released him from detention.

I have asked for your consideration of my testimony today because my client Jose's story, while lacking the tragic ending of Victoria Arellano's story, is illustrative of the inability of detainees to secure adequate medical care. Unlike the Arellano case, Jose was represented by counsel. For the last six months of his detention, six attorneys worked tirelessly to secure for him the medical attention he so desperately needed. Our legal team made no progress whatsoever until the tragic death of Victoria Arellano. In addition to the inability to meaningfully challenge the detention center's refusal to provide adequate care, our legal team could not even obtain authorization to have our own doctor examine our client (except for the purpose of documenting his scars).

The aftermath of the Victoria Arellano's death has had a profound chilling effect on the willingness of immigration attorneys and detainees to publicly discuss other cases involving medical care issues. I personally interviewed witnesses about Victoria Arellano's death. The witnesses I spoke with were extremely afraid that they would be retaliated against if they spoke publicly about the death. The detainees' fears proved to be well-founded. In August of 2007, only weeks after Arellano's death, many of the witnesses who were housed with Arellano were transferred from San Pedro to Texas while arrangements were being made to set up interviews of these witnesses with representatives of Human Rights Watch. At least one of these detainees was represented by pro bono counsel in Los Angeles. In transferring him to Texas, he was effectively denied the right to meaningfully prepare his case with counsel.

As a result of the transfers of detainees who are witnesses in the Arellano case, both detainees and lawyers fear that "going public" with complaints about detention conditions will lead to retaliation by DHS, including but not limited to the transfer of detainees to remote locations. The chilling effect of these transfers has troubling implications. The conditions of DHS detention must be transparent. If accurate information about conditions in detention centers is kept from ever reaching the public, there will be no ability to insure humane conditions of detention. In the United States, we are taught not to fear the truth but to stand up for it. It is therefore crucial that detainees are allowed and encouraged to speak the truth here and elsewhere without threat of retaliation.

Thank you for considering my testimony today.

Dated: _____

Executed under penalty of perjury by: _____
Judy London, Directing Attorney
Public Counsel's Immigrants' Rights Project

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Theodore A. Levine
President

Steven Banks
Attorney-in-Chief

Adriene L. Holder
Attorney -in-Charge

October 4, 2007

Re: Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law Hearing on Detention and Removal: Immigration Detainee Medical Care
Thursday 10/04/2007 - 1:00 PM

Dear Subcommittee Members:

The Legal Aid Society ("the Society") thanks the members of the Subcommittee for holding this critical hearing on deaths in detention and the provision of medical care to immigration detainees. The Society is writing to provide accounts of the complaints received by the Society's attorneys from New Yorkers detained in New Jersey jails and offer several recommendations to improve the provision of medical care and strengthen oversight.

The Legal Aid Society the oldest and largest not-for-profit law firm in the nation was founded in 1876 to serve New York's immigrant community. For more than 130 years, the Society has not wavered in its commitment to serve low income immigrants. The Legal Aid Society is organized into three practice areas; Civil, Juvenile Rights, and Criminal Defense. Each year the Society's staff provides free legal services in more than 275,000cases involving indigent families and individuals in New York City. The Society's Immigration Law Unit is the only legal service agency in New York City that specializes in removal defense for migrants with criminal convictions. The Unit is the only regular source of free lawyers for detained individuals facing removal. Since 2002, the Society has conducted regular group legal orientation presentations at various county jails in New Jersey where Immigration and Customs Enforcement (ICE) detains roughly 350-400 New York migrants. The Legal Aid Society also operates a weekly Detention Hotline where families of detainees and detainees may call for free legal advise and case screening.

Background

In 1996, Congress passed the Illegal Immigrant Reform and Immigrant Responsibility Act which, among other measures, increased the negative consequences of criminal convictions and instituted the current mandatory detention regime for large classes of non-citizens.[1] Despite the passage of these draconian laws, the former Immigration and Naturalization Service (INS) did not institute the new detention measures quickly.[2] Following September 11, 2001 and the creation of the Immigration and Customs

[1] Illegal Immigrant Reform and Immigrant Responsibility Act, Pub.L. No 104-208, 110 Stat 3009(1996)); *See* 8 U.S.C. §1226(c)(pertaining to mandatory detention of aliens pending resolution of their removal proceedings); 8 U.S.C. §1231(pertaining to mandatory detention of aliens ordered removed).

[2] Anticipating "custody space and personnel deficiencies" Congress provided the attorney General a two year grace period before the new mandatory detention provisions were to come into affect. *See* P.L. 104-302 Section

Enforcement (ICE), the enforcement arm of the Department of Homeland Security, there has been aggressive enforcement of these draconian laws and a rapid expansion of detention as an enforcement tool. As a result, the population of persons detained by immigration authorities has gone from 5,000 on any given day pre-1996 to 27,500 on any given day.[3] In fact, immigration detention is the fastest growing segment of the nation's corrections population.[4] Since 1996, the priority has been in meeting detention mandates, not assuring humane conditions.

The Immigration and Customs Enforcement's lack of experience in the practice of detention has led to serious problems. The former-INS issued Detention Standards in 2000, through the Detention Operations Manual, as guidelines for the treatment and care of non-citizens in detention. Unfortunately, the standards are not legally binding and are merely suggestions for the hundreds of county jails with which ICE currently contracts. The Department of Homeland Security has opposed advocates request to codify the detention standards into formalized regulations. Immigration detainees from New York who are housed in New Jersey county jails have regularly and repeatedly reported to the Legal Aid Society incidents of physical and verbal abuse, deprivation of medical care, overcrowding, interference with religious practices, lack of access to legal materials, and overcrowding in the jails used by ICE in New Jersey.

New York City Residents Detained in New Jersey Jails

Currently, non-citizens from New York City are detained in three New Jersey county jails—Bergen County Jail, Monmouth County Correctional Institute, and Sussex County jail—through Intergovernmental Service Agreements ("IGSA") with ICE. The New York ICE District Office estimates approximately 150 non-citizens are detained each week from just one place, New York City's jail, Rikers Island. But with only a few hundred rented beds in New Jersey jails, ICE transfers most of these New Yorkers around the United States, to detention facilities in New Mexico, Arizona, Alabama, Texas, and Louisiana. Non-citizens with recent offenses triggering removal are detained for months and even years in these jails while fighting the government's efforts to permanently expel the individual from the United States. Attorneys from the Society have observed detainees drop meritorious, even strong, claims for relief from removal due to poor health care while in detention.

In the course of advising or representing hundreds of detained non-citizens each year, the Legal Aid Society has observed several problems with the provision of medical care to detainees. Namely, inconsistent intake medical exams/screening, untimely responses to sick call requests, lack of appropriate medical follow-up, and some irregular medication dispensation. Further, mass transfers of migrants from the New York area to detention centers in other parts of the country exacerbate our concerns regarding continuation of medical care, discharge planning, and the inability for family members to advocate with jail medical providers. It has been difficult to investigate, substantiate, or address these claims. Nonetheless, the frequency and regularity of complaints as well as the similarity of complaints at different times from different detainees at different jails, indicates that there is reason to believe that there is a serious institutional failure in ICE's ability to maintain a safe and humane immigration detention system and a resounding lack of effective oversight. Due to the lack of meaningful oversight, detainees, their families, and other agencies have no where to report such problems.

309(b)(2).

[3] U.S. Immigration and Customs Enforcement, *Fact Sheet: Detainee Health Care*, June 26, 2007, available at http://www.ice.gov/pi/news/factsheets/detaineehealthcare.htm.

[4] Michael Welch, *Detained: Immigration Laws and the Expanding I.N.S. Jail Complex*, Temple University Press, 2002, at 151.

Detention Conditions: Violations of the National Detention Standards and Community Standards of Care

In the course of our representation and provision of legal services, the Society has received information from detainees relevant to the medical care services provided in the jails. For example:

- Earlier this year, the Legal Aid Society received telephone calls and written correspondence from detainees at the New Jersey Bergen County Jail regarding a detainee suicide some believe was preventable. Nery Romero, a 22-year-old El Salvadoran hung himself in his jail cell following days of unanswered cries for his prescription pain medication required following a then-recent leg surgery.[5]

- The Legal Aid Society interviewed a mentally ill HIV positive Haitian detainee at the Monmouth County Correctional Institute in Freehold, New Jersey. Before we were able to obtain his court documents to determine whether we would represent him, he was transferred to a jail in rural Alabama, hundreds of miles from his family in New York and our office. Local attorneys confirmed he was placed in solitary confinement at the Alabama jail for over 30 days as a result of a staph infection, despite the jail's knowledge that his mental illness may be exacerbated by the enclosed confinement. He also reported discriminatory treatment by officers due to his medical condition and failure to administer his mental health and HIV medications when he was first transferred. He is now released and seeking medical and mental health care.

- In February, a woman detained at the Bergen County Jail stated that she needed mental health medications and "just wanted to talk to someone about her fears," but was unwilling to seek medical care for fear of being placed in segregation.[6] The Legal Aid Society has heard of similar complaints at other jails. Detainees are often unable to access psychiatric care without a family or legal representative advocating for such care, even when detainees have histories of depression or other mental illnesses. Some detainees fear being placed on suicide watch if they seek mental health care.

- An HIV positive client detained at the Passaic County Jail reported that he suffered from violent diarrhea and painful anal fissures. For all this, he claimed, he was given Motrin. Despite repeated written and telephonic requests to obtain the client's jail medical records, the Society never received the records. ICE officials blamed the detainees for their illnesses-- stating that detainees were being given their medication but were not taking them in an effort to get so sick as to require their release. The Passaic County Jail stopped housing immigration detainees in 2005 because of frequent complaints.

- A woman deported to the Dominican Republic in April 2007 was involved in an altercation with a non-detainee living in her housing unit at the Monmouth County jail. When attorneys from the Society spoke to her, two weeks after the incident, she still had bruising and redness of her left eye and she reported loss of vision. In addition, she was involved in a van accident when traveling to court. She reported that as a result of the impact to her abdominal region, she was experiencing on-going vaginal bleeding and spotting. The detainee had written 6-8 requests to be seen by a doctor. Twice she was seen by nurses but no tests were conducted on her eye or reproductive region. After nearly two months of advocacy with the jail and ICE by The Legal Aid

[5] Nina Bernstein, "One Immigrant Family's Hopes Lead to a Jail Cell Suicide," *NYTimes*, February 23, 2007 (attached).
[6] Summary of Interview with Detainee at the Bergen County Jail, Hackensack, New Jersey, November 28, 2006 (on file with author).

Society, she was taken to an eye doctor and given an MRI at a hospital. However, she was deported before ever receiving the results.

- Another detainee at the Monmouth County jail was hit with a chair while observing an altercation between two other detainees. He began noticing blood in his urine. Although he filed 2-3 medical requests and was in fact seen by a nurse, he did not receive any medical attention. Three weeks after the incident he showed a nurse his urine, which contained blood, and the nurse finally sent him to a hospital for emergency tests. He was prescribed some medications but the jail failed to dispense them. Although the Legal Aid Society inquired with the medical staff about this individual, he was deported to Jamaica before we were able to confirm whether his medical condition had improved.

When detainees report problems with medical care, the Society's attorneys contact jail medical staff and request the jail to follow-up with the detainees. In general, the jails have been willing to follow-up with the detainees and the problems are resolved. Unfortunately, the Society's attorneys do not come into contact with all detainees and unless the detainees raise medical concerns it goes undetected by the attorneys.

Lack of Effective Oversight

ICE has failed to create meaningful and transparent oversight of detention. The current scheme of detention oversight does not prevent or address systemic failures with the provision of medical care within detention facilities or jails. The government's internal systems of oversight include annual inspections for all ICE detention facilities, contract and intergovernmental service agreement jails and prisons.

In January 2007, the Inspector General of DHS ("OIG") published a report entitled "Treatment of Detainees Housed at Immigration and Customs Enforcement Facilities" following an investigation of five detention facilities. It questioned ICE's annual inspections process. Striking among the OIG's findings were numerous instances of non-compliance with the detention standards that were not reported in the most recent ICE annual inspections of the 5 detention facilities.[7] NGOs have recently learned that ICE in fact fails to inspect each detention facility annually. Perhaps most troubling is that detainees often have no effective mechanism to raise grievances within a facility or directly to ICE. The January OIG report recognized untimely responses to detainee grievances, failure to respond, and problems with effective means to file grievances.[8]

Further, former DHS Undersecretary Asa Hutchinson who previously served as the highest ranking official with responsibility over detention acknowledged gaping holes in detention oversight and accountability at a recent hearing. He observed that "continued oversight is essential to eliminating abuse and violence in the care of immigrant aliens."[9] To achieve oversight, Undersecretary Hutchinson found the agency needed greater transparency in complaints of abuse, investigation, and the outcomes of such investigations. He criticized the current tracking of complaints and their disposition, noting that he was unable to acquire statistics on the instances of sexual abuse in preparation for the hearing.[10]

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[7] Office of Inspector General, *Treatment of Detainees Housed at Immigration Customs Enforcement Facilities*, January 2007, p. 36-37, available at http://www.dhs.gov/xoig/assets/mgmtrpts/OIG_07-01_Dec06.pdf
[8] OIG Report, 20-21.
[9] Testimony of Asa Hutchinson, National Prison Rape Elimination Commission, *Hearing: The Elimination of Prison Rape: Immigration Facilities and Personnel/Staffing/Labor Relations* , December 13, 2006, available at http://www.nprec.us/docs/sxvimmigrdet_d13_persacets_MayraSoto.pdf, at page 38.
[10] *Id.* at 38-39.

In addition, the external oversight process is under-trained and incomplete. The American Bar Association's Commission on Immigration and the United Nations High Commissioner for Refugees ("UNHCR") conducts periodic visits to detention centers to investigate the treatment of detainees, including refugees and asylum seekers. Moreover, various NGOs, legal service providers, and immigrant and human rights groups use media and direct inquiry with the government to create an additional method of oversight. Although the ABA's visits are independent and much needed, they are limited in scope (primarily focusing on access to counsel) and the results are not publicly available. Several regional or state-based immigrant organizations receive complaints regarding detention conditions and raise concerns to the facility, ICE, and the Department of Homeland Security using an administrative complaint process. However, the results are inconsistent, difficult to monitor, and difficult to maintain. In the New Jersey jails where New York immigrants are housed, it should not be the responsibility of legal service providers, such as the Legal Aid Society, to provide oversight for medical care to detainees.

The United States continues to violate the human rights of immigration detainees in jails and detention centers across the country and greater oversight is essential to protect the rights of migrants facing removal. The United States should create strong on-going oversight of detention centers and jails where detainees are held. One expert, Michele Deitch, encourages a "layered approach" where internal and external mechanisms of oversight support the goal of safety and maintaining the human rights of persons in custody. Without multiple systems of transparent oversight, jails and detention centers are literally walled off from public scrutiny, exposing detainees to greater risk of abusive treatment and retaliation by officials for filing complaints.

Recommendations/Conclusion

(1) Create Strong Enforceable Detention Standards in Compliance with Human Rights Principles: The U.S. government should create legally binding human rights standards governing the treatment of immigration detainees in all facilities, regardless of whether they are operated by the federal government, private companies, or county agencies. Affirmative rights to humane treatment should be created through Congressional authority as well as agency binding regulations. Experts, NGOs and directly affected community members should participate in the process of creating minimum standards and regulations through the creation of a Congressional commission. Such standards governing conditions of detention should consider the specialized needs of women, mentally ill, disabled, children, and asylum seekers. Effective independent NGO monitoring of conditions in the jails should be required to prevent the deterioration of conditions and abusive treatment of detainees.

(2) Effective national oversight: U.S. Congress should create a "layered approach" to the monitoring and oversight of conditions for migrants in ICE custody. First, Congress should create an overarching monitoring body, independent from ICE, which monitors every detention center and county jail with which ICE contracts. Monitors with expertise in environmental, health and hygiene, mental health, and security should routinely conduct thorough investigations at each facility. In addition, states or counties should institute facility based inspection teams, independent from jail or county governance, to receive and investigate individual and system-wide allegations of human rights abuses and constitutional violations. Alternatively, Ombudspersons or legislative committees should be created to monitor conditions on an on-going basis. Finally, such oversight institutions should be required to report to the U.S. Congress as well as the public; and all reports and investigations should be publicly available and open to outside scrutiny.

(3) Implement alternatives to detention program for the New York ICE District: Creating a system of supervision of detainees that does not require detention will minimize the number of transfers and allow detainees to seek community health care. These programs, in place in other parts of the United States, will

minimize the arbitrary and prolonged nature of immigration detention and ensure the ability to meaningfully access their rights to make appeals under immigration law. An alternatives to detention program in the NY area is important because of the high number of migrants within this ICE District.

(4) Greater transparency: The United States government should require greater transparency in contracting, oversight, and access to information regarding detention operations. The current process for ICE to contract with a county jail or prison is unknown. Unlike in the Federal Bureau of Prisons method of contracting for jail beds, there is no "Request for Proposals" or publication in the Federal Register. As a result, community groups, legal service providers, and migrants have no involvement in the government's decision to expand the detention system. This hidden process keeps the financial gain derived from ICE contracts a secret. Further, the government should require greater access to federal monitors, investigators, and auditors to permit NGO and detainee involvement in the oversight process. Finally, the U.S. government should create less restrictive policies for access to jail records and detainee medical records to assist with legal representation.

(5) Change Detention Provisions to the Immigration and Nationality Act: Currently, mandatory detention laws require ICE to detain thousands of detainees regardless of mental illnesses, health conditions, length of residence, flight risk or danger to the community. Congress should repeal mandatory detention laws. Instead, the decision to detain a particular non-citizen pending removal should be a discretionary decision in the hands of Immigration Judges.

Thank you for your time and attention to this important issue.

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Statement of Lutheran Immigration and Refugee Service and Bishops of the Evangelical Lutheran Church in America

Submitted to the House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law of the Committee on the Judiciary
October 4, 2007

Lutheran Immigration and Refugee Service (LIRS) and the undersigned bishops of the Evangelical Lutheran Church in America (ELCA) submit this joint statement for the October 4, 2007 hearing on "Detention and Removal: Immigration Detainee Medical Care."

LIRS is the national agency established by Lutheran churches in the United States to carry out the churches' ministry with uprooted people. LIRS is a cooperative agency of the ELCA, the Lutheran Church-Missouri Synod, and the Latvian Evangelical Lutheran Church in America, whose members comprise about 7.5 million congregants nationwide. Founded in 1939, LIRS has assisted and advocated on behalf of refugees, asylum seekers, unaccompanied children, immigrants in detention, families fractured by migration, and other vulnerable populations. With respect to detention of immigrants, LIRS helped start the Detention Watch Network and provides services through 25 grassroots legal service partners. LIRS also serves detained unaccompanied children and has advocated for alternatives to detention and access to legal counsel for detainees through the Legal Orientation Program.

Grossly Substandard Medical Care Puts Immigrants at Extreme Risk

The U.S. Customs and Immigration and Enforcement (ICE) *Detention Operations Manual* states that all individuals in detention "shall have access to medical services that promote detainee health and general well-being," and that facilities should provide both primary and emergency medical and dental care. LIRS research shows that ICE is falling far short of these standards. In February 2007, LIRS and the Women's Commission for Refugee Women and Children released "Locking Up Family Values: The Detention of Immigrant Families," which documented grave problems with the medical services for immigrant families in Department of Homeland Security (DHS) detention. (go to http://www.lirs.org/LockingUpFamilyValues.pdf). In addition, Lutheran volunteers regularly visit detainees in New Jersey facilities and have obtained firsthand knowledge of those facilities' failure to provide adequate health services to detainees. Urgent attention must be paid to the following:

1. **Withholding Medical Care and Pain Relief to Children and Women**
2. **Denying Prenatal Care to Pregnant Women**
3. **Misdiagnosing or Mistreating Serious Health Conditions**

1. Withholding Medical Care and Pain Relief to Children and Women

The "Locking up Family Values" report found that families detained in the T. Don Hutto Residential Treatment Center in Taylor Texas, which has capacity for 512 individuals, often waited several days before receiving medical services after having submitted written requests for such care. Guards frequently told detainees not to bother them with sick requests. New Jersey ELCA congregation members visited with detainees in the Elizabeth and Monmouth, New Jersey facilities and reported that detainees must wait several days before obtaining a health visit of any kind.

> *Rebecca, a detainee in Hutto, reported that her child was suffering from repeated vomiting. When she asked for medical attention, the staff told her that they would need to see the vomit to believe that her son was sick. When the woman's son had a toothache, she submitted a request slip to see the dentist. Her son waited three weeks before seeing the dentist. At that appointment the dentist pulled the rotten tooth without any anesthesia. "My son was in terrible pain," Rebecca said. On another occasion, Rebecca experienced uterine pain and went to see the nurse who said she was not permitted to prescribe medicine. Her condition was not deemed an emergency. As a result, Rebecca waited more than one week before seeing the doctor who was called in on another case at 3:00 a.m. in the morning.*[1]

2. Denying Prenatal Care to Pregnant Women

Several pregnant women provided LIRS with direct accounts of the Hutto facility's failure to provide prenatal care. One pregnant woman recounted that she was given an x-ray to screen for TB without a lead protective cover, even after she told the technician she was five months pregnant. Another woman, Carmen, did not receive her first prenatal exam until she was seven months pregnant:

> *Carmen's pregnancy was confirmed while she was in detention on August 18, 2006. But the Hutto staff gave her no further exam or treatment. On September 23, more than thirty days later, she fainted and was taken to the hospital. She was told that she had a kidney infection and that she should drink lots of water. She was not given any antibiotics for the infection. It was not until October 20 that she received her first prenatal exam. On this occasion she and several other pregnant women were transported by van to a clinic together. By that time she was seven months pregnant, but was given no prognosis of the status of her or the child's health. The Hutto staff did not give her prenatal vitamins or any special diet.*[2]

3. Misdiagnosing or Mistreating Serious Health Conditions

Detainees are sometimes provided medicines and treatments that are inappropriate for their medical needs. Church volunteers at the Elizabeth, NJ facility reported that the medical staff provide only aspirin to address nearly all requests for medical assistance and treatment no matter what is the nature of the condition. Detainees complained of being given only two choices for their ailments: the blue pill or the red pill. Similarly, in "Locking up Family Values," LIRS

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[1] Lutheran Immigration and Refugee Service and the Women's Commission for Refugee Women and Children, *Locking Up Family Values: The Detention of Immigrant Families* (February 2007) p. 22.
[2] *Ibid.*, p. 15.

reported that a young boy who had stomach problems and was vomiting almost every day was given only acetaminophen.

In the Hutto facility, several parents reported that medical personnel provided improper treatment for skin rashes. One mother complained that her children began developing skin rashes.

> *Lily, a five-month-old girl, developed a rash while in Hutto. At first, the facility staff told her mother that Lily's condition was caused by an allergy to an antibiotic that had been prescribed to her at another facility. The staff took the antibiotic away. But the rash only became worse. The staff gave her a cream but the rash continued to worsen. After Lily and her mother were released from custody, a pediatrician told her that the rash was not related to any allergy and prescribed a different medication which resolved the rash.*[3]

The Inhumane Detention of Immigrants Is Contrary to Biblical Instruction
The Bible teaches us to "Welcome one another, just as Christ has welcomed you, to the glory of God" (Romans 15:7). Every human being is a child of God made in God's image and deserving to be treated with dignity and respect. We are deeply concerned that our government's poor treatment of immigrant detainees is eroding our country's values and fundamentally inconsistent with basic Christian values.

From within our congregations, we are receiving an increasing number of inquiries about the government's use of detention. A Lutheran youth group that visited the Elizabeth, NJ facility was shocked to learn that the U.S. government has incarcerated hundreds of people so close to where they live. In 2005, ELCA's New Jersey Synod issued a resolution in response to the harsh treatment of immigrants that parishioners and pastors observed in the detention facilities. (See attached) Now, on a monthly basis, Lutheran church-goers hold a vigil outside the Elizabeth facility standing side-by-side members of other faiths and religions. The interfaith community maintains the vigil on a weekly basis. At just that facility, more than 200 volunteers minister to those in detention.

The Grossly Inadequate Medical Care is a Systemic Problem
The research of LIRS and the Women's Commission and the accounts from congregation members are corroborated by reports from the DHS Office of the Inspector General, the American Bar Association, and Human Rights Watch. Together they are shocking evidence of sub-standard and inhumane conditions and poor medical treatment in federal immigration detention facilities nationwide. We are dismayed that, in our nation's detention facilities, a pregnant mother was given x-rays without a proper lead protection pad; expecting mothers are waiting months before receiving proper prenatal exams; a child with a toothache waited more than a week before seeing a dentist who pulled a tooth without anesthesia; children are being denied treatment or given inappropriate treatment for severe skin rashes that cause bleeding; and most disturbing is the evidence that immigrants have died in detention when such deaths likely could have been avoided with better care.

These gruesome accounts are not exceptions but common occurrences which demonstrate the extremely poor quality of medical care that DHS provides to immigrant detainees. Moreover,

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[3] *Ibid.*, p. 22.

these reports show that the government continues to violate its own detention standards. Finally, they show that the system has failed to protect the health and well-being of families, children, asylum seekers, and other vulnerable populations.

Congress Must Stop the Inhumane Detention of Immigrants
Despite this documentation, Congress appears intent on placing more and more immigrants who pose no threat to the community in jail-like settings. With the exception of the rare hearing, such as this one, Congress has paid scant attention to improving conditions of medical treatment for those detained.

We cannot condone our government's skyrocketing use of detention of immigrants who pose no threat to public safety or flight risk, especially when many have come here seeking asylum and other relief. Such practices cannot continue in the United States, a country founded upon principles that uphold the liberty and fundamental dignity of every human being. Each year, LIRS serves thousands of refugees and asylum seekers, many who have suffered government persecution, including detention by repressive regimes that commit unspeakable human rights atrocities. They have come to our shores seeking protection and freedom from oppression. To subject them to harsh detention without adequate health care services and medical treatment is nothing short of stripping them of their dignity and humanity. Such treatment is little better than that of those countries from which many have fled.

Moreover, such detention is extremely costly, ranging from $100 to $200 dollars per day for each person detained. We wonder why our government is not implementing other alternative methods that are more humane, less costly, and have been proven to be just as effective at ensuring enforcement of our laws and public safety.

Recommendations
In light of these serious systemic problems, we call upon Congress to mandate immediate improvements to the health and medical services in any facilities detaining adult and child immigrants. Until these problems are solved, we urge Congress to suspend consideration of any legislation that would further expand the practice of detention. Moreover, Congress should enact laws that limit the use of detention unless absolutely necessary and mandate the nationwide use of alternatives to detention.

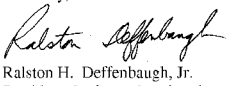
1. Congress should adequately fund health care for immigrant detainees and mandate DHS to make improvements to medical services in detention facilities.
    - Improve access to medical care that includes mandatory screening, primary care, emergency care, and sick call for health, vision, dental, and mental health needs.
    - Strengthen internal quality controls to assure timely and professional provision of health, mental health, and nutrition services to detainees.
    - Offer specialized care and hospitalization as medically necessary.
    - Provide translation assistance to facilitate medical services.
    - Implement vigorous outside review of the DHS health care system by medical experts.

2. Congress should suspend consideration of any legislation that would further expand the practice of detention and enact laws that limit the use of detention to be consistent with international law and standards.
    - Congress should mandate codification of the current ICE detention standards that were drafted in collaboration with the American Bar Association. Only by codifying specific standards will Congress ensure that detention conditions are humane and that individuals have meaningful access to quality medical, legal, social, and pastoral services.
    - Congress should enact laws guaranteeing that immigrants have access to judicial review to consider release on bond, parole, or to an alternative program. Congress should increase the authority of immigration judges to make discretionary decisions regarding detention by narrowing the mandatory detention provisions in the Immigration and Nationality Act (INA), including INA §§ 235 and 236 (8 U.S.C. 1225 and 1226).
    - Congress should establish a process to review ICE parole decisions so that detainees, including asylum seekers, are not unnecessarily held in detention.
    - Congress should provide oversight of DHS's implementation of the August 2007 settlement agreement on the detention of immigrant families at the Hutto facility.

3. Congress should mandate the development and immediate implementation of nationwide use of alternatives to detention. Alternative community-based or monitoring programs have been shown to assure high court appearance rates. These programs are effective because they provide released immigrants with access to vital, emergency services such as housing and legal assistance. These services provide guidance, monitoring and appearance assistance programs for the released individual and instill confidence that the process will be fair thereby dramatically increasing appearance rates. Such alternatives to detention come with a price that is a fraction of the cost of detention. Congress should invest in such programs, which would be more humane for asylum seekers and all immigrants, more cost-effective for U.S. taxpayers, and more consistent with international law regarding the use of detention.

We thank Chairwoman Lofgren and the Subcommittee members for devoting time to this important issue. Any questions regarding this statement may be directed to Gregory Chen, LIRS Director for Legislative Affairs, (202) 626-7933, gchen@lirs.org.

Sincerely,



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LOCKING UP FAMILY VALUES:

The Detention of Immigrant Families

Women's Commission for Refugee Women and Children
Lutheran Immigration and Refugee Service

February 2007

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Mission Statements

Since 1939, **Lutheran Immigration and Refugee Service** has worked with service, advocacy and educational partners nationwide to bring new hope and new life to America's newcomers. LIRS resettles refugees, protects unaccompanied refugee and migrant children, including victims of trafficking, advocates for fair and just treatment of asylum seekers, seeks alternatives to detention for those who are incarcerated during their immigration proceedings and stands for unity for families fractured by unfair laws. LIRS is a cooperative agency of the Evangelical Lutheran Church of America, the Lutheran Church Missouri Synod and the Latvian Evangelical Lutheran Church in America. With initiative and stewardship, LIRS seeks creative solutions for uprooted people regardless of race, ethnicity or religious beliefs.

The **Women's Commission for Refugee Women and Children** works to improve the lives and defend the rights of refugee* women, youth and children. The Women's Commission works in consultation with refugee women, youth and children. Through our advocacy, we ensure that their voices are heard in the halls of power and taken into account in the decision-making process. Our work contributes to long-term solutions, thereby lessening the likelihood of continuing cycles of conflict and displacement. The Women's Commission is legally part of the International Rescue Committee (IRC), a non-profit 501(c)(3) organization. The Women's Commission receives no direct financial support from the IRC.

* The term refugee here includes refugees, internally displaced persons, returnees and asylum seekers.

Cover photos: Left, play area at Hutto. Right, note slipped to a member of our delegation at Hutto.

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Commonly Used Abbreviations

ACA	American Correctional Association
ALDF	Adult Local Detention Facilities
CBP	U.S. Customs and Border Protection
CIS	U.S. Citizenship and Immigration Service
CCA	Corrections Corporation of America
DHS	U.S. Department of Homeland Security
EOIR	Executive Office for Immigration Review
ICE	U.S. Immigration and Customs Enforcement
IGSA	Intergovernmental Service Agreement
IJ	Immigration Judge
INS	Immigration and Naturalization Service
LIRS	Lutheran Immigration and Refugee Service
NCCHC	National Commission on Correctional Health Care
NGO	Nongovernmental Organization
OIG	Office of Inspector General
ORR	Office of Refugee Resettlement
PHS	Public Health Service

Executive Summary

Dominica[1] is a Honduran asylum seeker detained with her two children at the T. Don Hutto Residential Center in Taylor, Texas. Nelly is nine years old and Alice is three. At night they all sleep together in the bottom bunk of their jail cell because they are afraid. Nelly says, "If you are not good, they will take you away from your mom."[2]

Dominica is almost seven months pregnant. The doctor has told her for months that her baby is underweight. He has told her she needs to eat more. But she says she can't. "The food doesn't work here. I cannot eat it." She explains that the food is "difficult to eat" and she doesn't get much time. "There are only a maximum of 20 minutes to eat and I have to feed my children first. They do not eat quickly. You are not allowed to take food out of the cafeteria, even if you haven't had time to finish. Something like bread or an apple…they take it away. It is so sad to throw something like that away because you could not eat fast enough."

Dominica requested parole over two months ago. Her mother is a legal permanent resident and she has passed a credible fear interview. She still has not a received a response to her request. She is afraid that she will have her baby in jail.[3]

Dominica's story is just one of countless tales from detained immigrant families. A small child's note, slipped into the hand of a member of our delegation, sums up their pleas:

"Help us and ask us questions."

On any given day the U.S. government has the capacity to detain over 600 men, women and children apprehended as family units along the U.S. border and within the interior of the country. The detention of families expanded dramatically in 2006 with the opening of the new 512-bed T. Don Hutto Residential Center. Although Hutto has become the centerpiece of a major expansion of immigration detention in America, it builds on and further institutionalizes many of the practices established at the smaller Berks Family Shelter Care Facility in Leesport, Pa., where U.S. Immigration and Customs Enforcement (ICE) has detained a small number of families since 2001.

Prior to the opening of Hutto, detained children were separated from their parents and placed in the custody of the ORR Division for Unaccompanied Children's Services.

The recent increase in family detention represents a major shift in the U.S. government's treatment of families in immigration proceedings. Prior to the opening of Hutto, the majority of families were either released together from detention or separated from each other and detained individually. Children were placed in the custody of the Office of Refugee Resettlement (ORR) Division for Unaccompanied Children's Services, and parents were detained in adult facilities.

Congress discovered this and took immediate action to rectify

[1] All names and some identifying characteristics of detainees and former detainees have been changed throughout this report.
[2] Nelly, interview by Michelle Brané, T. Don Hutto Residential Center, December 4, 2006.
[3] Dominica, interview by Michelle Brané, T. Don Hutto Residential Center, December 4, 2006.

it, in keeping with America's tradition of promoting family values. It directed ICE to stop separating families and either to place them in alternative programs or to detain them together in nonpenal, homelike settings. Such Congressional directives were intended to preserve and protect the role of the family as the fundamental unit in our society. However, ICE chose to develop a penal detention model that is fundamentally anti-family and un-American.

Lutheran Immigration and Refugee Service and the Women's Commission for Refugee Women and Children felt it vital to examine the implications of this expanding penal approach to family detention in order to inform the development of policy and practice that serves the best interests of children and families. To that eud we visited both the T. Don Hutto Residential Center and the Berks Family Shelter Care Facility and talked with detained families as well as former detainees. What we found was disturbing:

- Hutto is a former criminal facility that still looks and feels like a prison, complete with razor wire and prison cells.
- Some families with young children have been detained in these facilities for up to two years.
- The majority of children detained in these facilities appeared to be under the age of 12.
- At night, children as young as six were separated from their parents.
- Separation and threats of separation were used as disciplinary tools.
- People in detention displayed widespread and obvious psychological trauma. Every woman we spoke with in a private setting cried.
- At Hutto pregnant women received inadequate prenatal care.
- Children detained at Hutto received one hour of schooling per day.
- Families in Hutto received no more than twenty minutes to go through the cafeteria line and feed their children and themselves. Children were frequently sick from the food and losing weight.
- Families in Hutto received extremely limited indoor and outdoor recreation time and children did not have any soft toys.

Yet not everything we saw reflected a failure of the system. At the Berks facility:

- The educational system was appropriate to children's developmental needs.
- Families were permitted to participate in field trips.
- Children were able to participate in arts and crafts activities.
- Families enjoyed ample outdoor recreation time in an open, grassy area.

But despite these few positives, the system of family detention is overwhelmingly inappropriate for families.

- Both settings strip parents of their role as arbiter and architect of the family unit.
- Both facilities place families in settings modeled on the criminal justice system.
- There are no licensing requirements for family detention facilities because there is no precedent for family detention in the United States.
- There are no standards for family detention, but both facilities violated various aspects of existing standards for the treatment of unaccompanied children and adults in immigration proceedings.

Neither facility provides an acceptable model for addressing the reality of the presence of families in our immigration system. Although there is precedent in the adult detention system for the use of alternatives to detention and other pre-hearing release systems,[4] ICE has unfortunately made no effort to expand these

[4] See Appendix D, "UNHCR Report on Alternatives to Detention of Asylum Seekers and Refugees."

programs to include families.

Based upon these findings, we recommend the following systemic changes to the U.S. government's treatment of families in immigration proceedings:

- Discontinue the detention of families in prison-like institutions.
- Parole asylum seekers in accordance with international standards and DHS's own policy guidelines
- Expand parole and release options for apprehended families.
- Implement alternatives to detention for families not eligible for parole or release.
- House families not eligible for parole or release in appropriate, nonpenal, homelike facilities.
- Expand public-private partnerships to provide legal information and *pro bono* legal access for all detained families, and to implement alternative programs.

For a full list of recommendations, see page 45.

I. Introduction

As of February 2007, the U.S. government has the capacity to detain over 600 men, women and children apprehended as family units along the U.S. border and within the interior of the country. Family detention space dramatically increased in 2006 with the opening of the T. Don Hutto Residential Center in Taylor, Texas. This facility, a key component in the Department of Homeland Security's (DHS) Secure Border Initiative Family Custody Implementation Plan,[5] represents a major shift in the U.S. government's treatment of families in immigration proceedings from a policy of releasing[6] or separately detaining family members to a policy of family detention.

Consistent with the role of the Women's Commission for Refugee Women and Children and Lutheran Immigration and Refugee Service in advocating for appropriate treatment of immigrant women, children and families, we found it vital to engage in field research and to take an active part in examining this new policy. This report and research builds on our agencies' ongoing work on behalf of children and families in detention. In particular we sought to examine issues of family unity and the provision of legal, medical and psychosocial services to families who are in the custody of DHS.

What follows is our effort to examine the utility and appropriateness of family detention, and to recommend systemic changes that will transform the U.S. government's response to the needs of families in immigration proceedings. We hope that this research will contribute to the development of policy and practice that serves the best interests of children and families and that this report will prove a useful educational resource for policy makers and the public.[7]

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5 U.S. Immigration and Customs Enforcement, letter to Judge John C. Doerfler, April 17, 2006.
6 DHS refers to this practice as "catch and release."
7 For information on methodology refer to Appendix A.

II. Background

Family Detention: Historical Context

The U.S. government has historically struggled with how to administratively handle migrating families apprehended both internally and at the borders. As recently as six years ago the family detention landscape looked very different from what it does today. In 2001 the Immigration and Naturalization Service (INS) began to detain some migrant families in the Berks Facility, a former nursing home. Because there were few detention beds available for family units, a single parent and child would occasionally be detained for short periods of time in hotels contracted for that purpose. However, the majority of families apprehended were released pending a hearing before an Immigration Judge (IJ).

In the wake of the attacks of September 11, 2001, Congress passed the Homeland Security Act, splitting the functions of the INS into three separate agencies, and placing all three agencies under the jurisdiction of the newly created DHS. The act also transferred responsibility for the care and custody of unaccompanied alien children from the INS to the Department of Health and Human Services' Office of Refugee Resettlement (ORR) Division of Unaccompanied Children's Services.

Other post-9/11 changes in immigration law have led to broader enforcement and more restrictive immigration policies, including the expansion of expedited removal.[8]

Past U.S. policy of releasing families apprehended together became problematic in the current climate of increased enforcement. According to DHS assessments, the practice of releasing families encouraged undocumented immigration because prospective migrants would "rent" children to accompany them on the border crossing, thereby ensuring that they would be released on their own recognizance should they be caught.[9] DHS sought to address this problem by detaining both the adults and the children with them. Because of a shortage of detention bed space, the agency began placing children in ORR shelters and holding parents in countless immigration detention centers and state and county jails.[10] In some cases this action protected children from what might have been dangerous smuggling situations, but in other instances it resulted in the forced separation of parents from their children, which unlawfully rendered the children unaccompanied.[11]

Congress discovered the problems and directed DHS to stop separating migrant families. In 2005, the House report accompanying the Department of Homeland Security appropriations bill, 2006, stated:

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8 Expedited removal is a policy that requires immigration authorities to detain all individuals who enter the United States through international airports, land ports and seaports if they are without legal documentation, including many asylum seekers who are unable to obtain travel documents prior to fleeing their country of origin. The practice of expedited removal has been expanded to apply also to individuals arrested without proper documentation within 100 miles of U.S. international borders and within 14 days of their entry into the United States. This second expansion was first piloted in the Tucson, Ariz., and Laredo, Texas, border patrol sectors. Many families now in Hutto were arrested in the Laredo area. For more information see U.S. Commission on International Religious Freedom, *Report on Asylum Seekers in Expedited Removal*, (Washington, D.C., February 8, 2005). See also U.S. Department of Homeland Security, "DHS Expands Expedited Removal Authority Along Southwest Border," news release, September 14, 2005, http://www.dhs.gov/dhspublic/display?content=4816, and U.S. Department of Homeland Security, "DHS Streamlines Removal Process Along Entire U.S. Border," news release, January 30, 2006, http://www.aila.org/content/default.aspx?docid=18404.

9 Department of Homeland Security Immigration and Customs Enforcement, "DHS Closes Loopholes by Expanding Expedited Removal to Cover Illegal Alien Families," news release, May 15, 2006, http://www.ice.gov/pi/news/newsreleases/articles/060516dc.htm.

10 Women's Commission for Refugee Women and Children, *Behind Locked Doors: Abuse of Refugee Women at the Krome Detention Center*, (New York: October 2000).

11 Christopher Nugent, "Whose Children Are These? Towards Ensuring the Best Interests and Empowerment of Unaccompanied Alien Children," *The Boston Public Interest Law Journal*, Spring 2006.
Chad C. Haddal, "Procedural Definition of 'Unaccompanied' for Unauthorized Alien Children," memorandum to House Judiciary Committee, November 1, 2006.

> The Committee is concerned about reports that children apprehended by DHS, even as young as nursing infants, are being separated from their parents and placed in shelters operated by the Office of Refugee Resettlement (ORR) while their parents are in separate adult facilities. Children who are apprehended by DHS while in the company of their parents are not in fact "unaccompanied;" and if their welfare is not at issue, they should not be placed in ORR custody. The Committee expects DHS to release families or use alternatives to detention such as the Intensive Supervised Appearance Program[12] whenever possible. When detention of family units is necessary, the Committee directs DHS to use appropriate detention space to house them together.[13]

In response to Congress's directive, and in keeping with its efforts to ensure court appearance and deter migration, the administration began expanding the practice of detaining families together. DHS opened the T. Don Hutto Residential Center in May 2006. The facility was originally intended to house families apprehended while attempting to cross the U.S.-Mexico border, but families apprehended in the interior are also detained there,[14] including some that are apprehended when parents come to collect children who have been released from ORR custody.

The practice of detaining families in jail-like, criminal settings is contrary to the explicit intent of Congress. Congress clearly reaffirmed its intent in the House report of the Department of Homeland Security appropriations bill, 2007: "The Committee encourages ICE to work with reputable non-profit organizations to consider allowing family units to participate in the Intensive Supervision Appearance Program, where appropriate, or, if detention is necessary, to house these families together in non-penal, homelike environments until the conclusion of their immigration proceedings."[15]

DHS's use of Hutto greatly expands family detention in a way that contravenes Congress's directives and is inconsistent with the United States' international obligation to protect the rights of the most vulnerable migrants. With the opening of Hutto, DHS has dramatically departed from its own less jail-like model, as embodied by the Berks facility. However while the environment at Berks is closer to a nonpenal, homelike model, it still fails to satisfy Congressional intent.

Standards of Care and Custody

Family Detention Standards

To date no family detention standards have been implemented. Since its inception six years ago family detention has been governed by *ad hoc* hybrid policies and procedures that DHS derives from a combination of DHS's *Detention Operations Manual,* described below, and *Flores v. Reno*,[16] a 1993 case that resulted in a settlement stipulating that children in immigration proceedings be placed in the "least restrictive setting."[17] The National Juvenile Coordinator reported that his office has drafted standards. ICE has also reached out to the NGO community to discuss the development of standards for family

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[12] The Intensive Supervised Appearance Program is an alternative to detention program under ICE that is currently in use at nine pilot locations. Aliens are equipped with electronic monitoring devices for the first 30 days, and must comply with curfews and regular appointments with a caseworker. The level of monitoring needed is reevaluated and adjusted accordingly every 30 days.

[13] House Committee on Appropriations, *Department of Homeland Security appropriations bill, 2006. report together with additional views (to accompany H.R. 2360)*, 109th Cong., 1st Session, 2005, H. Rep. 109-79.

[14] Robert Bernal, DHS supervisory detention and deportation officer, and Joe Cirulli, deputy director, Berks County Youth Center, interview by Michelle Brané and Emily Butera, Berks County Shelter Care Facility, October 27, 2006; Daniel Coronado, CCA public information officer, interview by Michelle Brané and Emily Butera, T. Don Hutto Residential Center, December 4, 2006; John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.

[15] House Committee on Appropriations, *Department of Homeland Security appropriations bill, 2007. report together with additional views (to accompany H.R. 5441)*, 109th Cong., 2d Session, 2006. H. Rep. 109-476.

[16] Stipulated Settlement Agreement, *Flores v. Reno*, Case No CV85-4544-RJK (C.D. Cal. 1996), http://web.centerforhumanrights.net:8080/centerforhumanrights/children/Document.2004-06-18.8124043749.

[17] John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006. We asked each of these parties for copies of the rules governing the different facilities, but never received a copy.

detention.[18] We welcome such a development, and urge DHS to involve child and family welfare experts to help assure that any proposed standards are as appropriate as possible.

Were standards to be developed, key elements should include the following:

- Using the least restrictive setting appropriate with a preference for parole, release or alternatives to detention;
- Utilizing nonpenal, homelike settings in the rare instances when some form of detention is necessary;
- Utilizing assessment procedures for verifying family relationships;
- Ensuring that the maximum length of stay not exceed three weeks;
- Promoting and supporting parents' ability to function in their roles as parents through adult mental health, medical and legal services that ensure that emotionally or physically compromised parents can adequately care for children;
- Meeting children's basic needs for food, sleep, bathroom access and play on a flexible and child-friendly schedule;
- Providing developmentally appropriate autonomous activities for children, including field trips, recreation time, school and other activities that do not require the continuous presence of parents;
- Retaining pediatric as well as adult specialists to oversee nutrition, health and mental health services;
- Providing children with high levels of psychosocial, developmental and educational stimulation;
- Ensuring that parents, not facility staff, have responsibility for child discipline; and
- Prohibiting the use of coercive control techniques such as involuntary separation of family members and environmental manipulation (keeping rooms very cold).

Flores *Settlement*

A class action lawsuit challenging the constitutionality of policies and practices governing the detention of unaccompanied children resulted in the 1996 *Flores v. Reno* settlement agreement.[19] This agreement, "intended to protect the rights of unaccompanied illegal juveniles in INS custody as well as to ensure their well-being,"[20] was also meant to become the basis for regulations that would codify a range of standards relating to care and confinement in the least secure setting possible, and a preference for release.[21]

Key *Flores* requirements include the following:[22]

- Separation of minors from unrelated adults;
- Preference for release of unaccompanied minors to the care of parents, legal guardians, other relatives, or foster homes or other facilities whenever possible;
- Detention of minors in licensed programs that comply with all relevant child welfare laws and regulations;
- Provision of suitable accommodations, food service, clothing and personal care items;
- Affirmation of children's right to wear their own clothes;

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[18] The ICE national juvenile coordinator states that ICE Detention and Deportation has drafted a set of new family detention standards that incorporate all the relevant standards and requirements of the adult Detention Standards and the *Flores v. Reno* settlement. These standards are awaiting approval by legal counsel. John Pogash, telephone interview by Michelle Brané, Washington, D.C., January 31, 2007.

[19] Women's Commission for Refugee Women and Children, *Prison Guard or Parent? INS Treatment of Unaccompanied Refugee Children*, (New York: May 2002): p. 9.

[20] U.S. Department of Justice, *Unaccompanied Juveniles in INS Custody*, Report Number I-2001-009, September 28, 2001, http://www.usdoj.gov/oig/reports/INS/e0109/exec.htm.

[21] Women's Commission, *Prison Guard or Parent?* pp. 9-10.

[22] *Flores v. Reno.*

- Provision of routine medical and dental care, family planning services and emergency medical care; administration of prescription medicine and accommodations for dietary restrictions; provision of mental health interventions as appropriate;
- One individual counseling session each week with a trained social worker and group counseling sessions at least twice each week;
- Provision of educational services appropriate to a child's level of development and communications skills;
- Recreation and leisure time including daily outdoor activity and one hour of large muscle activity each day;
- Prohibition of corporal punishment, humiliation, mental abuse and punitive interference with such daily functions as eating and sleeping; disciplinary actions may not adversely impact a child's health, physical or psychological well-being or deny a child regular meals, sufficient sleep, exercise, medical care, the right to correspondence or legal assistance;
- Expeditious processing of apprehended minors and timely provision of notice of their rights and the availability of free legal services; and
- Visitation privileges which encourage visitors and respect the child's privacy.

It is important to note that the *Flores* standards have not yet been codified into regulations. In addition, not only are provisions of the *Flores* settlement being violated in both family detention facilities, the preference for family reunification contained in the *Flores* settlement is being manipulated by DHS. When children are released from ORR custody, ORR notifies DHS of the child's release. In turn, DHS uses this information to apprehend and redetain children, this time with their parents.

Detention Standards

In its *Detention Operations Manual*, also known simply as the Detention Standards, DHS lays out 36 standards for ICE and ICE-contracted facilities. Standards cover visitation procedures, grievance policies, medical care, discipline, access to counsel, telephone access and food service, among other topics. In response to nongovernmental organization complaints about the detention of noncriminals in prisons, U.S. immigration authorities developed these standards to establish minimum requirements for care and custody and to afford detainees certain rights and protections. However, while these standards should obligate DHS to provide appropriate conditions of confinement, they are neither statutory nor incorporated into regulation,[23] creating a situation in which accountability is problematic and violations remain widespread.[24]

Aside from four standards related to legal access, the standards are largely derived from American Correctional Association standards, which are intended to regulate the custody of criminal inmates. Therefore, the standards reinforce the current culture of immigration detention in which harsh prison management practices are imposed on a noncriminal population.

Key Detention Standards requirements for adults in detention include the following:[25]

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[23] Women's Commission, *Behind Locked Doors*, p. 3.

[24] A report by the DHS Office of the Inspector General released in December 2006, found inappropriate conditions of confinement in all five adult facilities visited, including a failure to provide timely and responsive medical care and a safe and appropriate environment. Although the inspector general did not visit Hutto, the report is instructive as an illustration of common systemic problems that also occur in family detention. Department of Homeland Security Office of the Inspector General, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, Report No. OIG-07-01, December 2006. p. 1-2.

[25] U.S. Immigration and Customs Enforcement, *Detention Operations Manual* http://www.ice.gov/partners/dro/opsmanual/index.htm.

- Access to healthcare, including initial medical and dental screening, primary medical and emergency medical and dental care, and regular sick call; arrangements, as needed, for specialized health care, mental health care and hospitalization; translation assistance to facilitate medical assistance where needed
- Access to outdoor recreation or a large recreation space with exercise equipment and access to sunlight for at least one hour daily, five days a week; in Contract Detention Facilities, access to outdoor recreation seven days per week
- Written notification of disciplinary practices, prohibited acts and sanctions; written notification of protections against personal abuse, corporal punishment, excessive use of force, retaliatory disciplinary actions and deprivation of food, clothing, bedding, hygiene products, exercise, access to visitation, telephone access, correspondence, or access to the law library
- Formal grievance procedures for detainees that guarantee protection from reprisals
- Right to visitation, including private visitation with legal representatives
- Access to telephones during waking hours, including privacy for legal calls, one working phone for every 25 detainees and access to phone calls
- Opportunity to participate in religious practice and access to personal religious property including prayer beads, rosaries, prayer rugs and other items appropriate to religious practice; accommodations for dietary restrictions as required by religious practices

Accountability and Oversight

In addition to a lack of enforceable standards, procedures for assessing applicability of correctional standards and inspecting family detention centers give ICE tremendous independence in dictating how detained families are treated. The draft Inter-Governmental Service Agreement[26] under which Williamson County, Texas, is contracted to operate the Hutto facility states:

> The Provider is required, in units housing ICE detainees, to perform in accordance with the most current editions of the Reviewers Guide which contains Standards of Performance, ICE Detention Standards to the extent applicable in a family detention facility and as reflected in Provider's policies and procedures, American Correctional Association (ACA) Standards for Adult Local Detention Facilities (ALDF) and Standards Supplement, Standards for Health Services in Jails, latest edition, National Commission on Correctional Health Care (NCCHC). Some ACA standards are augmented by ICE policy and/procedure. In cases where other standards conflict with DHS/ICE Policy or Standards, DHS/ICE Policy or Standards prevail.[27]

Such phrases as "to the extent applicable in a family detention facility," coupled with the lack of written standards for family facilities, underscore the lack of clear and adequate standards and accountability. In addition, under current ICE policy ICE employees conduct inspections of ICE facilities. Such an inspection policy means that no independent, impartial oversight authority inspects family detention facilities for compliance with either ACA/NCCHC or ICE standards. Perhaps even more disconcerting, all inspectors responsible for conducting inspections of family detention facilities are trained in investigation techniques by the ICE national juvenile coordinator, the same staff person responsible for devising and administering family detention.[28]

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[26] We were able to obtain only a draft copy of this agreement.

[27] "Inter-Governmental Service Agreement between the United States Department of Homeland Security U.S., Immigration and Customs Enforcement, Washington, DC, and Williamson County, Texas," Modification 0001, ICE/WC IGSAMOD1-1. Marked "Unofficial Document."

[28] John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.

The recent DHS Office of the Inspector General report[29] raises concerns about the effectiveness of both oversight policy and existing standards in ensuring safe and humane conditions of confinement. Yet they remain the only relevant standards available for holding facilities accountable for the safety of detained families. While this indicates a fundamental flaw in the appropriateness of detention across the board, the absence of family-specific guidelines for care and custody provides further evidence that the entire system of family detention is without precedent and inappropriate.

III. Family Detention in the International Context

Many international conventions, including the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights*, and the *Convention on the Rights of the Child* apply to children and families in detention. In particular, such conventions elevate the role of the family as the fundamental unit in society and restrict the use of detention for asylum seekers, particularly children.

Unfortunately, the United States is not alone among peer nations in the detention of families. The United Kingdom and Germany, for example, detain families under conditions quite similar to those in the United States, despite European guidelines that prescribe consideration for family unity as a central element of immigration policy. However, nations such as Australia and Sweden offer alternative approaches that might serve as models for improved detention practice in the United States.

For more information about applicable international law and family detention practices in other countries refer to Appendix B.[30]

[29] DHS OIG, *Treatment of Immigration Detainees*, p. 1-2.
[30] See Appendix B on page 49.

IV. Conditions of Confinement

Facilities

T. Don Hutto Residential Center

The T. Don Hutto Residential Center (Hutto), a 512-bed facility located about 30 miles outside Austin in Williamson County, Texas, is operated by the Corrections Corporation of America (CCA) under a contract with the county. DHS has contracted with Williamson County to pay a rate of $2,801,643 as a fixed monthly payment for up to 512 detainees and an additional $79 per day for each detainee over 512. This is equivalent to approximately $180 a day per individual detained.[31] Hutto opened as a family facility in May 2006. Prior to its use for family detention, the facility held people with pending criminal trials, adults in immigration detention and criminal inmates for the U.S. Marshals Service, DHS and the state of Texas, respectively.

On the day of our visit, there were 377 detainees in Hutto, however DHS staff noted that this number had recently dropped from approximately 400. Although the majority of the families are nationals of Central or South American countries, a review of the total population statistics indicated that there were also detainees from Djibouti, Ethiopia, Greece, Haiti, Indonesia, Iraq, Jordan, Kuwait, Romania and Somalia. Many of these families had been apprehended along the U.S.-Mexico border and are in expedited removal proceedings, however there were also families who were apprehended in the interior as well as many asylum seekers.[32]

Berks County Shelter Care Facility

The Berks County Shelter Care Facility (Berks), an 84-bed facility located about an hour outside Philadelphia in Leesport, Pa., began holding migrant families in March 2001. This site is part of the larger Berks County Youth Center complex that includes a juvenile facility housing U.S. citizens charged with or convicted of crimes, juveniles detained with the U.S. Marshals Service, and some detained juveniles whom DHS has deemed to be "other than unaccompanied."[33] Until 2002 the complex also included a shelter that housed minors in INS custody. It is owned and operated by Berks County under a contract from DHS.

Berks is a sprawling, dormlike facility located in rural Pennsylvania. Berks County receives $194 per person per day from DHS for the first 60 detainees, and a fixed rate of $5.20 per person per day beyond that. In addition, DHS pays for all medical and educational costs. On the day of our visit there were twenty-some families in residence.[34] The majority of the detained families were from Central America. The largest number of detainees in 2006 were nationals of Guatemala, but the facility also housed detainees from China, Colombia, El Salvador, Guyana, Iraq and Pakistan at the time we visited. Many of those detained were apprehended trying to cross the U.S.-Mexico border and are in expedited removal proceedings. However there are also families who were apprehended in the interior.

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31 Inter-Governmental Service Agreement between ICE, and Williamson County.
32 We requested information regarding the percentage of families in expedited removal versus other proceedings, but did not receive it.
33 John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.
34 Just under 84 individuals.

DHS detained Luz, a woman from Ecuador, with her 15-year-old son. *"I have been living in the United States for more than four years. I have a U.S. citizen daughter who is now almost two years old. I sent for my son who is 15. He came across the border from Mexico, but he was detained. I received a call to come and pick him up, so I left my daughter with my friend who lived next door, and took a bus to Arizona to get him. I picked up my son and we went straight to the bus. At the bus station, I was approached by some officers and they detained both of us. I have been here for nine months without seeing my baby girl. She was only one year old when I left her with my friend. I don't know what is happening with her."*[35]

Physical Setting

Hutto

The Hutto facility is a former prison. It is surrounded on three sides by fencing and several layers of concertina wire, although this wire has been removed from around the entrance and the front gate remains open. Regardless, facility security vehicles circle the building on a constant basis, and there is no buffer between the facility's recreation areas and the perimeter wire. An ICE enforcement agent who accompanied the tour indicated that the agency would like to remove the remaining concertina wire, but noted that the cost of such refurbishment is prohibitive.[36]

Left, the entrance of the T. Don Hutto Residential Center in Williamson County, Texas. Right, several layers of concertina wire and fencing surround the former prison.

Hutto's interior layout features a system in which 11 pods, or living units, each with two levels of cells, open into a common area.

In addition, the facility has a cafeteria, gymnasium, law library, general library, medical wing, visitation area and processing area, as well as several classrooms and overflow education trailers. The hallways are long, wide and windowless, and walls are painted an institutional green. Some colorful murals have been painted in the cafeteria and in the pods, and pod common areas have been carpeted. Other modifications include padding the edges of bunks, modifying stair railings and installing bedrails.

Each hallway is separated from the next by wrought iron gates. The hallway gates were open during our visit, and individual cell doors were unlocked; however, all doors in and out of the pods and control

[35] Luz, interview by Michelle Brané, Berks Family Shelter Care Facility, October 27, 2006.
[36] Stacy Guerin, ICE San Antonio Field Office, interview by Michelle Brané and Emily Butera, T. Don Hutto Residential Facility, December 4, 2006.

rooms were locked. Guards are stationed around the pod exit doors. Doors and gates are opened and closed by computers in a central control room, and do not have sensors that halt movement if a person or object is in the way. This feature poses a safety hazard for families in detention, particularly for small children. One member of our delegation was almost caught in one of these doors when she fell behind the group. Doors to the outdoor recreation area and overflow educational spaces are not locked; however, these outdoor spaces are surrounded by concertina wire. Any doors leading outside the perimeter fencing are locked at all times or secured by a guard.

From the central control room, facility staff members monitor and record all activity within the detention center using over 100 newly installed pan/tilt/zoom cameras. Cameras record 24 hours a day. Control room staff demonstrated their ability to zoom close enough to be able to read what a detained person is writing on a piece of paper. All videotapes are archived and can be recalled to investigate incidents.[37]

Top, the exterior of the Berks facility, a former nursing home. Above, a mural adorns a hallway in the facility.

Berks

Because it is situated in a former nursing home, the 84-bed Berks facility has a more residential atmosphere than Hutto. Hallways still have an institutional appearance, but because they are ringed by offices and common spaces with external windows, the building receives some natural light. The hallways contain murals and artwork made by children detained in the facility, and families moving through the facility interact with staff members.

Although exterior doors are equipped with alarms, they are not locked from the inside. A sign instructs visitors to pass through a metal detector at the front entrance. A chain link fence surrounds a small outdoor area, but the Berks facility does not have any concertina wire or other perimeter fencing. All interior doors are unlocked and open, and when asked whether doors leading to the outside were kept locked, the ICE detention and deportation officer expressed surprise and asked why locked doors would be necessary in a facility that houses women and children.

The interior consists of two housing wings, each of which has common recreational space, in addition to a cafeteria that doubles as a multi-purpose room, a gymnasium, art room, classrooms, counseling rooms, courtroom, visitation spaces and medical clinic. Each wing has a control room, but unlike at Hutto, this is simply an office space with video monitors used by on-duty staff assigned to each wing.

[37] According to Daniel Coronado, public information officer, T. Don Hutto Residential Center, tapes have only been recalled to address complaints on the part of staff. He did not expand on what would constitute an incident warranting review.

Processing

Accounts of the time between apprehension and arrival at family detention facilities vary. Some families are separated for lengthy periods before being reunited, particularly at Hutto. Some separations are attributable to provisions of the *Orantes* injunction, which bars ICE from transferring Salvadoran nationals outside of the Customs and Border Protection (CBP) district in which they were apprehended for seven days. Because both Hutto and Berks are outside of this radius, Salvadoran families are separated at the border during this "waiting period." Children are either temporarily held at an ORR facility within the radius, held at juvenile facilities contracted by ICE or held at the border. Their parents are sent to adult facilities within this radius until they are reunited.[38]

At Hutto, each detainee is issued three sets of clothing—scrubs, underwear, socks and sweatshirts—and two pairs of shoes. They sleep in the same clothing.

Hutto

Families arrive at the facility and are brought into the processing area through a sally port. They are placed in cells where they can use the restroom and receive food and water. After they have had some time to rest they go through an intake interview with ICE staff. Each individual is fingerprinted and photographed and checked against the Automated Biometric Identification System (IDENT)[39] database for any pre-existing information. To verify identity and increase the likelihood that child victims of trafficking and smuggling can be identified, even the youngest of children are identified and entered into the system individually. Verification of family relationships generally occurs at the point of apprehension; however, ICE occasionally discovers children who are not in the company of their biological parents, and transfers them to ORR.

After being processed by ICE, detained families are processed by the Corrections Corporation of America (CCA). They turn over any personal effects and are issued clothing and toiletries. Each detainee receives three sets of clothing, including scrubs, underwear, socks and sweatshirts, and two pairs of soft-bottom shoes. In addition, each receives a blanket, sheets, a towel, a washcloth, soap, a toothbrush, a comb, toilet paper, toothpaste, deodorant and shampoo. Families with infants also receive diapers, bottles, sippy cups, a receiving blanket, a baby fork and spoon, baby hygiene products and a diaper bag. One former detainee, Rebecca, a Honduran woman detained with her three children, complained that people are not issued

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[38] American Bar Association, letter to Walter LeRoy, acting chief, Detention Standards Compliance Unit, Office of Detention and Removal Operations, U.S. ICE, Re: Separation of Detained Salvadoran Families in South Texas, October 6, 2006.

[39] John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.

enough clothing to accommodate the laundry schedule. Consequently, one day per week they are forced to wear dirty clothing, which is also the same clothing that they sleep in.[40]

Families who have been processed and integrated into the larger facility population are able to place requests with the commissary for additional hygiene items and snacks, provided that they have money in their account.

In addition to receiving personal items, all detainees who arrive at Hutto shower before leaving the processing area. Showers are located inside the processing area, so that while some new arrivals are showering, ICE and CCA staff members are processing other people. The shower areas are divided from the room and people in it by a wall along three sides and a curtain covering the entrance. There are two shower stalls, which include a dressing area inside the curtained partition, a baby bathtub and a changing table. Detained families interviewed by the University of Texas Immigration Law Clinic complained that the Hutto facility did not have hot water.[41]

After arrivals complete processing, they are transferred to the medical wing for a full medical assessment before being released into the general population. The Public Health Service (PHS) Division of Immigration Health Services officer told the delegation that pregnant women are given a lead screen to cover their abdomen for the X-ray taken for TB screening. Carmen, a pregnant women we spoke with who was detained at Hutto for three months, told us that she was X-rayed with no lead screen, even after she told the radiologist that she was five months pregnant.[42]

Within a few days of their arrival at Hutto, families also receive an orientation about the facility's rules and procedures and watch a "Know Your Rights" video.[43]

Berks

As families arrive at the Berks facility they are taken to a joint DHS and Berks County processing room. Both children and adults are fingerprinted and entered into the IDENT database. Family relationships are verified at the point of apprehension; however, DHS officers cross-check identity and relationships when they enter information into the database.[44] Detained individuals confirmed that they received a listing of attorneys at the time of this initial processing.

Unlike at Hutto, people detained at Berks are permitted to wear the clothing they had with them when they were apprehended, with the exception of shoes. Children seven and under receive soft-bottom sneakers, and children older than seven and adults are issued flip-flops. Those who did not have sufficient clothing with them when they arrived at Berks are issued clothing provided by the county. They can also purchase clothing during "field trips" to locations including Wal-Mart. During our visit we observed families sorting through and choosing from donated clothing on a rolling cart.

Families do their own laundry, using washers and dryers located in the bathroom areas. Gina, a Guyanan woman detained with her daughter, complained that the dryers frequently break and remain unrepaired for

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40 Rebecca, interview by Emily Butera, Austin, Texas, December 4, 2006.

41 CCA staff explained that there were initially problems with the water being so hot that children were getting scalded, so the facility installed regulators to prevent water temperature from exceeding 98 degrees. The officer in charge stated that she did not know whether or not there was hot water throughout the facility, but that she would check into the complaint.

42 Carmen, interview by Michelle Brané and Emily Butera, Brownsville, Texas, December 6, 2006. Two other pregnant women also recounted having been x-rayed without a protective screen (Dominica, interview by Brané, T. Don Hutto Residential Center, February 1, 2007; Noreen, interview by Brané, T. Don Hutto Residential Center, February 1, 2007).

43 The "Know your Rights" video, produced by the Florence Immigrant Rights Project, Florence Arizona, provides a brief introduction to various forms of relief available to individuals in immigration proceedings.

44 Robert Bernal, DHS supervisory detention and deportation officer, interview by Michelle Brané and Emily Butera, Berks County Shelter Care Facility, October 27, 2006.

weeks at a time. She also noted that there are not enough washers and dryers for the size of the population, and not enough times during the day when laundry could be done, making it difficult to wash clothing on a regular basis.[45]

Accommodations

Hutto

Family members are housed in old inmate cells located within housing pods. Within each pod there are approximately 20–30 cells on two levels with a communal area and showers in the center. Each cell has a single twin bed or a twin bunk bed, a pair of high-tension hooks to hang towels, a porcelain or stainless steel sink and toilet, and storage bins under the bed for storing extra clothing. The walls and floor are bare except for an unbreakable acrylic mirror. There were no personal items or toys visible. There is no divider separating the sleeping area from the toilet area, so families are not afforded any privacy when using the toilet. Cell doors must remain open except during count and after "lights out." Residents who need to use the toilet at other times can enter their cell and close the door.

Outside of sleeping hours, one hour of education, one hour of recreation time and 20 minutes for each meal, families are confined to the common area of their pod.[46] Men, women and children are commingled. Each common area has plastic couches, two televisions and some video games. There is also a refrigerator used for the evening snacks of milk and an apple that children bring back from dinner.[47] We observed groups of individuals playing cards, but no other toys were available. Individuals are able to use the phones located in the pods during this "free time."

During morning and evening free time, adults and children, respectively, are given five minutes to shower. The shower area is located within the common space, but has been covered from above as a modification for families. A curtain separates the shower area from the main room. Inside the shower area are three showerheads extending from the wall, divided by waist-high privacy barriers. The dressing area consists of a long bench with no privacy barriers. Within the shower area there is a baby bathtub.

Left, the communal area of a pod. Each pod contains 20 to 30 cells on two levels. Right, a cell with a single twin bed. There is no divider between the sleeping area and the toilet area in the cell, so families are not afforded any privacy when using the toilet.

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45 Gina, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006.
46 Approximately 13 hours a day, which includes time spent in cell during count.
47 Daniel Coronado, public information officer, T. Don Hutto Residential Center, comments during tour of center, December 4, 2006.

Before each meal and several times during the night, facility staff conduct counts of the detainee population. During these counts, people are confined to their cells and cell doors are closed. These counts can take up to one hour.

Because each cell has only one twin bed or bunk bed, and possibly a crib, family units are not necessarily housed in the same cell. Staff try to assign parents with young children to the first floor. If a parent has more than one child, some children may be assigned to a different cell. If a father is detained along with an older daughter, they will be assigned to different cells.[48] Efforts are made to house family units in adjacent cells; however, the fluctuating population does not always allow this, and at times children are held on the second floor of the pod.[49] Infants sleep in cribs that can be brought into the cells at night. When we visited, there were no cribs in the cells, but there were several in the common area.

Some parents decide to keep all of their children with them, in which case multiple family members may share one twin bed. Dominica is a pregnant asylum seeker detained at Hutto with her two daughters, ages 3 and 9. She told us that all three of them sleep together on the bottom bunk of their cell because they are afraid.[50]

At night cell doors are closed, but not locked. Instead CCA has installed laser sensors that are tripped when a cell door opens more than four inches. Consequently, if children wake up in the night and want their parents, they set off an alarm. CCA staff, who monitor the residents all night, respond to such disturbances. Rebecca complained that her son suffered from anxiety and woke frequently during the night. She explained that she asked facility staff if they could share a room, and that when her request was rejected, "they told me that my son was experiencing anxiety because I am a bad parent, and that they would not contribute to this by housing my son with me."[51]

All adults are assigned daily chores from a rotating list, and complete their chores during either a morning or afternoon rotation. As such, they are responsible for cleaning and upkeep of the pods and their cells, including bathroom areas.

Berks

The layout of Berks also requires that members of the same family are sometimes placed in separate rooms; however, the housing areas have a more dormlike feel compared to the cells at Hutto. Berks families are housed in one of two residential wings, which consist of multiple dorm style rooms, common areas and men's and women's bathrooms. Families are housed in the same wing, but do not necessarily share a room. Instead, the population is divided into three groups: parents with children under six, juveniles and adults.

A parent with children under six typically shares a room with his or her young children and parents of the same sex who also have children under six. Children six and older are housed in same-sex juvenile rooms. Adults who have only older children share same-sex rooms with other such adults. For example, a family consisting of a mother, father, 4-year-old girl and 7-year-old boy would be divided as follows: the mother and 5-year-old girl would be in one room, possibly together with other women and their young children; the 7-year-old boy would be in a room with other children over five; and the father would be in a room with other adult men. Whenever possible, children over five share a room with their same-sex siblings. In other cases, facility staff try to arrange the room assignments so that parents and children are close together. Outside each door is a list with the names of the individuals assigned there.

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48 Ibid.
49 Ibid.
50 Dominica, interview by Brané, T. Don Hutto Residential Center, February 1, 2007.
51 Rebecca, interview by Emily Butera, Austin, Texas, December 4, 2006.

Rooms range from just a few beds to rooms with seven or eight beds. Some rooms have bunk beds and others have standard beds, but all are twin size. Each room also has multiple armoires for clothing storage, and families are allowed to keep personal effects such as books and toys in their rooms.

It was difficult to ascertain the degree to which parents have access to their children at night. According to former detainee Sophia, a Colombian asylum seeker who was detained at Berks with her three young daughters, if children wake up in the middle of the night, they are able to get to their parents, and the night staff help them do so.[52] However, some currently in detention said that their children cry at night and they are not allowed to go to them. The Berks facility deputy director told us that the night staff would intervene to see what the children needed and to help ensure that they did not disturb others.

Each housing wing has common space with televisions and couches. The wing we toured had three such rooms, two of which had televisions in them. Families spend time in these common areas when they are not in school or involved in other activities,[53] and although the Berks deputy director told us that once families leave their rooms for the day they are not allowed back in until "lights out," we observed school books on children's beds during the morning break, which suggests that they are at least allowed into their rooms to drop off and pick up items.

The bathroom facilities provide more privacy than at Hutto, but the layout and procedures are still quite institutional. Parents and children have to share space, and detainees have to shower and dress in front of many other people. Each housing wing has bathrooms divided by sex. The bathrooms consist of several toilets, three showers, a dressing area, a row of sinks and washers and dryers. Showers are only permitted at night. The showers are in individual stalls, but they appeared very run-down and were located at the top of a small set of stairs. Parents complained that the water temperature was too hot and scalded the children. Consequently, when we were there many had taken to using their personal hygiene containers (in which they store their toiletries) to give children sponge baths in the sink. We raised this issue with the detention and deportation officer and the deputy director, and on our second visit detainees told us that the problem had been resolved. In addition, the toilet areas had privacy curtains instead of doors, and the dressing area was not separated from the rest of the room by a privacy barrier.

All adults in detention are assigned daily chores from a rotating list, and complete their chores during either a morning or afternoon rotation. As such, detainees are responsible for cleaning and upkeep of the bathroom areas.

Gina complained about the toilet area, stating that in her housing wing two toilets had been broken for several weeks, and one of the two sinks in the ladies bathroom was also broken. She also noted that when maintenance fixed the broken toilets they failed to replace the curtains that serve as stall doors. As a result, women in her housing area were not using these toilets.[54] Because of broken facilities and limited hours for bathroom usage, she told us that there were not enough toilets and sinks, and some people were not afforded a turn. Another detainee, Hasan, a Pakistani man detained with his brother, complained that he was not permitted to comply with his religious obligations. In particular, he noted that women are allowed to shave their legs and armpits and men are permitted to shave their faces, but no other body parts, although such practices are prescribed by his religion.[55]

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[52] Sophia, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.
[53] Approximately 8 hours a day, or less if additional recreation time is given or a coordinated or organized activity is scheduled.
[54] Gina, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006.
[55] Hasan, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006.

Food Service

Hutto

Families detained at Hutto eat breakfast, lunch and dinner in the cafeteria, and children carry an apple and milk back to their pods after dinner for an evening snack. No other food may be taken out of the cafeteria. The menu repeats every week. Families are cycled through the cafeteria by pod. To get their food, detainees proceed through a line, and cafeteria workers pass them trays of food through a long narrow slot. This slot was widened from the slide-through prison model as an accommodation for family detention, but it is not wide enough to permit those detained to easily see who is distributing food or to observe the kitchen area. Detained individuals are not permitted to select their food.[56]

There were bins containing baby food and high chairs available for use. A menu was posted alongside the food service area. The CCA public information officer told us that each detainee received 3,500 calories per day. He added that pregnant women and children receive extra calories as needed. However, several pregnant women we spoke with told us that they did not receive any special diets even after making requests. [57] Detained individuals wear wristbands that list their allergies or any special dietary needs.

Each pod is given 20–25 minutes to eat.[58] However many of the detained individuals we spoke with told us that they have only 5–15 minutes, and that sometimes staff members yell at them to get up and leave before they have finished eating or feeding their children. This discrepancy was explained as the result of detainees' placement in line. The clock starts running when the first families arrive in the cafeteria. Those in the middle or end of the line have only 10–15 minutes by the time they get their food. Families eat together, and staff facilitators are available in the cafeteria. When asked about the role these facilitators play at meal times, the public information officer told us that they help the parents with small children get their trays and set up high chairs. The tables are bolted to the floor and can accommodate four adults.

The menu was heavily based on American food, including such items as hamburgers and cereal. All of the families we interviewed complained about the food, and most said that their children were often unable to eat it, frequently had upset stomachs, and were losing weight. Lily was five months old when she entered the Hutto facility and weighed 18 pounds. According to her mother, three months later she weighed 14 pounds.[59] In addition, detainees expressed frustration that they were not given enough time to feed themselves and their children. It is difficult to ascertain whether the food is making children sick because it is unsafe, because it is not culturally appropriate, or because of stress or depression. However, it bears noting that a CCA staff member pulled one member of our delegation aside and in confidence urged her to take a close look into the food situation because it is poor and children are hungry. The staff member also noted that when the children are hungry in the evenings, staff can give them milk, bnt no food.

A recent report of the Office of the Inspector General for Homeland Security on ICE's lack of compliance with the Detention Standards at five adult facilities found instances of undercooked food, dirty food trays and improper food temperature at two of the five facilities they investigated.[60] Given the wider context of ICE noncompliance with standards, as found in the Office of the Inspector General report, complaints from those in detention and staff at Hutto raise deep concerns regarding food at this facility.

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[56] Lisa Berkman, County Commissioner, Williamson County, Texas, telephone interview by Michelle Brané, January 23, 2007. Commissioner Lisa Berkman toured the facility shortly after we were given access. She states that since that visit she has been working with CCA to make some improvements to the food, including offering a choice of entrée and vegetable.

[57] Carmen, interview by Michelle Brané and Emily Butera, Brownsville, Texas, December 6, 2006; Dominica, interview by her attorneys at the T. Don Hutto Residential Center, January 2007.

[58] Daniel Coronado, public information officer, comments during Hutto tour, December 4, 2006.

[59] Carmen (mother of Lily), affidavit obtained by the University of Texas Law School, October 23, 2006.

[60] DHS OIG, *Treatment of Immigration Detainees*, p. 10.

Since our visit in December 2006, attempts have reportedly been made to address complaints with the food. A Williamson County Commissioner was told that those in detention are now receiving a choice of entrée and vegetable instead of having no choices at all.[61] A questionnaire was distributed to those in detention asking them what kinds of food they would like to be served. Detained individuals confirm receiving and completing the questionnaire, but also say that there have been no menu changes so far.

Berks

In general, those detained in Berks did not have the volume of complaints about food service and quality that people detained in Hutto had, although some remarked that there was a shortage of culturally appropriate food and options for vegetarians. Gina noted that the food is only tolerable, but that detainees have no choice so they take what they get.[62] Detainees take all three daily meals in a cafeteria-style setting, where they go through a line and salad bar and select their food. According to the Berks deputy director, detained individuals have 45 minutes for each meal and because of the small size of the facility, all housing wings can be accommodated simultaneously. Since we did not receive a tour of the food service area and were not in the facility during mealtimes, we were not able to observe the quality of food or the menu. The detention and deportation officer and the deputy director said that there is always a vegetarian option. We did not receive any feedback from the facility or DHS on the availability of kosher or halal food.

Medical Care

Hutto

As of August 1, 2006, health care has been provided by the Public Health Service (PHS) Division of Immigration Health Services,[63] a service that provides health care for ICE detainees. We received conflicting information about the composition of the medical staff and are therefore unable to say with certainty the degree to which the facility has full-time staffing. The CCA public information officer told us that there are PHS nurses, one nurse practitioner and one dentist on site Monday through Friday. In addition, he told us, the facility has a contract with one pediatrician and one doctor, who come to Hutto once a week and on emergency calls. In contrast the PHS representative in charge of the medical clinic told us that there is only one contracted doctor—a family practitioner. The PHS representative also told us that there will ultimately be a pharmacist on staff and in the meantime the facility handles prescriptions though a mail service and an emergency contract with a local pharmacy. In addition to examination rooms, the facility has a negative pressure room for the treatment of suspected tuberculosis cases.

In addition to medical screening upon entry, the public information officer informed us that families in detention receive ongoing medical care as needed. In particular he informed us that they provide pregnant women with gynecological services. However, women we spoke with said they did not receive adequate prenatal care.[64]

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61 Lisa Berkman, County Commissioner, Williamson County, Pa., telephone interview by Michelle Brané, January 23, 2007.
62 Gina, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006.
63 Refer to http://www.inshealth.org/Provider/CustodialFacilityResponsibilities.htm.
64 Carmen, interview by Michelle Brané and Emily Butera, Brownsville, Texas, December 6, 2006; Carmen, affidavit; Noreen, telephone interview by Michelle Brané, February 1, 2007; Dominica, interview by Brané, T. Don Hutto Residential Center, February 1, 2007.

Carmen told us that she did not receive adequate prenatal care. Her pregnancy was confirmed on August 18, 2006. No further exam or treatment was given. On September 23 she fainted and was taken to the hospital. She was told that she had a kidney infection and that she should drink lots of water. She was not given any antibiotics. Carmen received her first prenatal exam on October 20, 2006. On this occasion she and several other pregnant women were transported by van to a clinic together. At this time she estimated that she was seven months pregnant, but no medical estimate was given to her. She reported that she was not given any vitamins or special diet during this time, and that no milk was available. "It is only available to the children," she said. [65]

Since our visit, and in response to complaints regarding prenatal care, Hutto has made a contractual agreement with a local clinic. Pregnant women are now taken to the clinic for regular prenatal screenings and care.[66] Despite this improvement in prenatal care we remain concerned. Women are shackled when traveling to and from the clinic. In addition, we continue to question the appropriateness of these conditions of confinement for pregnant women. As noted above, Dominica, an asylum seeker who was seven months pregnant at the time we interviewed her, has been taken to see the doctor on several occasions because of difficulties with her pregnancy. She tells her attorney that the doctors say she is not receiving enough nutrition and has to eat more, but she finds the food difficult to eat. She is now receiving extra fruit at mealtimes, but reports that despite the doctor's directive that she drink more milk, milk continues to be available only for the children.[67]

When detainees require medical attention, they place a medical call slip in a box in the hallway or give it to facility staff. According to the PHS representative, these slips are checked twice a day and people are called to the clinic for care. However, families complained about delays of several days between submitting a request and receiving treatment. If a parent or child requests sick call, the entire family is required to go to the medical clinic as facility licensing requirements prevent families from being separated for more than a short period of time. This rule extends to the need for quarantine or treatment in the negative pressure room. If one member of the family requires such observation or care, the entire family will be quarantined in the medical clinic. According to the CCA public information officer, if a parent has to go to the hospital, the facility can provide supervisory care for their children for up to 72 hours. In such cases facility staff members are assigned to care for the children.

Information gathered from current and former detainees raises substantial concerns about the availability of medical care. Many mothers complained about their children getting rashes. All said that they were told by the medical staff that it was an allergy and to give the child more water.[68] During our interviews with families we observed a one-year-old child who had a rash on his cheeks and chest. These parents also told us that the doctor said it was an allergy and to give him lots of water. In addition, they told us that he would not eat anything and would only drink milk.[69]

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65 Ibid.

66 Lisa Berkman, County Commissioner, Williamson County, Texas, telephone interview with Michelle Brané, January 23, 2007. According to Commissioner Berkman, the facility has contracted with the Lonestar Circle of Care, a federally qualified health care clinic.

67 Griselda Ponce, attorney at law, telephone interview by Michelle Brané, January 23, 2007.

68 Carmen, interview by Michelle Brané and Emily Butera, Brownsville, Texas, December 6, 2006; Carmen, affidavit; Dominica, interview by Brané, T. Don Hutto Residential Center, February 1, 2007; Juan and Luisa (child's parents), interview by Michelle Brané, T. Don Hutto Residential Center, December 4, 2006.

69 Juan and Luisa, interview by Michelle Brané, T. Don Hutto Residential Center, December 4, 2006.

Rebecca complained that her child suffered from repeated vomiting, but when "I asked for medical attention the staff told me that they would need to see vomit to believe that he was sick." In addition, she reported that guards frequently tell people not to bother them with sick requests. She also told us that her son had a toothache and she put in a request to see the dentist. After three weeks, "he was finally taken to see the dentist, who pulled his tooth without Novocain or anesthesia. My son was in terrible pain." When Rebecca experienced uterine pain, she went to see the nurse. The nurse told her that she was not permitted to prescribe medicine and put Rebecca on the list of detainees who needed to see the doctor. She waited some time for the doctor to come, as her condition was not deemed an emergency. She had to wait for the doctor to be called in on an emergency. Finally, more than a week later, the doctor came for a call in the middle of the night, and Rebecca and her children were awoken at 3:00 a.m. and taken to see the doctor. On another occasion, Rebecca raised concerns about her children having skin infections, a complaint that was corroborated by another detainee. Her children did not receive medicine until they began to bleed from the rash.[70]

Lily was five months old when she arrived at the Hutto facility. She developed a rash while in detention. She also had no appetite. The medical personnel told her mother that Lily's condition was caused by an allergy to an antibiotic that emergency room doctors had prescribed to treat pneumonia prior to her transfer to Hutto. Hutto took the antibiotic away and told her to give the baby lots of water. After the rash became worse, she was given a cream, but the cream did not help. After her release Lily's mother took the baby to a pediatrician who told her that the rash was not related to an allergy. He prescribed another cream and the rash has improved. The rash was still visible when we met with her several months after release.[71]

Another child, Julian, also had problems with the food. His mother, Alicia, told us that the food makes him vomit almost every day. The only medicine they have given him is acetaminophen. Alicia noted that even she knows that acetaminophen isn't appropriate to deal with stomach problems. She reports that whenever children have problems sleeping or have been anxious, they are told to drink water. She also reported that all of her children have lost weight. Her 15-year-old daughter weighed 100 pounds when she first arrived in Hutto and at the time of the interview weighed 85 pounds.[72]

Berks

Medical care at the Berks facility appears more comprehensive than at Hutto. Care at this site is administered through a contract with a local family practice clinic, and the doctors are family practitioners who rotate coming to the facility. All people receive an initial medical screening upon entry, just as at Hutto. There is a nurse on site daily and a doctor on site four days a week. Unlike at Hutto, sick call is held seven days a week, and a nurse is on call during hours when no medical staff members are on site.

Detainees who require immediate medical attention due to illness or injury are taken to a local hospital. A dentist is on site on Thursdays. However, Mirsa, who was detained with her young child, had a visibly swollen jaw when we spoke with her. She told us that when she asked to see the dentist, county staff told her that dental care was only available for the children.[73]

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70 Rebecca, interview by Emily Butera, Austin, Texas, December 4, 2006.
71 Carmen, interview by Michelle Brané and Emily Butera, Brownsville, Texas, December 6, 2006.
72 Alicia, affidavit obtained by University of Texas Law School Clinic, November 2006.
74 We mentioned her condition to Joe Giulli, deputy director, Berks County Youth Center, and Robert Bernal, DHS supervisory detention and deportation officer, who indicated that they would look into the situation.

The nurse provides as much treatment as possible during sick call, and will call a doctor if medical care is required outside scheduled physician's hours. If children cannot provide proof of vaccination they are revaccinated. Specialist visits or tests must be pre-approved by the Division of Immigration Health Services,[74] which is responsible for health care for individuals in ICE custody. Both DHS and Berks County staff expressed frustration with the delays in the approval of medical care caused by DHS bureaucracy; however, they acknowledged that services are generally better for families than for individuals.

Detained families with whom we spoke confirmed that it is relatively easy for Berks detainees to obtain medical care. Requests for medical attention are submitted to county staff, and individuals are able to see the nurse that same day. However, some individuals expressed frustration that placing a sick call is the only way to get nonprescription painkillers such as aspirin, and that if you have a headache in the morning it can take all day to get medicine. They also complained that because people are not permitted to be in their rooms during the day, they are not allowed to lay down if they do not feel well. A woman we spoke with complained that she was placed in medical isolation for a month and not told why.[75] During this time other mothers in detention had to provide care for her children.[76]

Mental Health Care

Hutto

Hutto's PHS representative advised our delegation that Hutto officials are seeing less need for mental health services than they had originally anticipated. They speculated that this is because family units are together. Yet they also advised us that depression is the most common disciplinary problem, and that many detainees do not want to participate in activities because they are depressed. In the course of interviews with people currently and formerly detained, all exhibited symptoms of psychological distress that have been previously linked to the trauma of detention, including visible fear, crying and expressing a desire for medication to alleviate their depression and anxiety.[77]

There are two mental health providers on site—a PHS mental health counselor and a mental health coordinator. The PHS representative told us that they were both licensed, but the mental health coordinator later he told us that he was working toward licensing but has not yet been licensed. He also told us that in an ideal situation people would be scheduled for weekly counseling visits and that the mental health counselor is considering developing counseling groups, but that conducting such therapeutic treatment in a short-term setting is difficult. Individuals with behavioral problems and their family members are assigned to counseling. Information gathered in the course of providing mental health services is kept confidential, but there is a duty to warn DHS and CCA if individuals present a danger to their own or others' safety.

Detainees indicate that mental health services are not regularly provided, and that they are discouraged from accessing them through a combination of factors. Rebecca told us that there is not regular counseling, and that when someone asks to speak with a counselor staff members tell them that they are crazy and that DHS will take their children away. In addition, she told us that she met with a counselor on

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[74] Refer to http://www.inshealth.org/Provider/CustodialFacilityResponsibilities.htm.

[75] Mirsa, interview by Michelle Brané, Berks Family Shelter Care Facility, October 27, 2006.

[76] Joe Cirulli, deputy director, Berks County Youth Center, told us that the woman had tested positive for tuberculosis and that they had explained to her that this was the reason they had put her into isolation. Her lack of understanding may have been due to a language barrier and lack of interpretation.

[77] Heaven Crawley and Trine Lester, *No Place for a Child: Children in UK Immigration Detention: Impacts, Alternatives and Safeguards*, (London: Save the Children UK, 2005), p. 29; see also Physicians for Human Rights and Bellevue/NYU Program for Survivors of Torture, *From Persecution to Prison: the Health Consequences of Detention on Asylum Seekers*, (Boston and New York City, June 2003), p. 38.

one occasion, but was not able to communicate with him because he did not speak Spanish.[78] Carmen also confirmed the lack of translation services when she told us about being sent to counseling on one occasion. She stated that the counselor seemed nice, but that she did not find the session helpful because he did not speak Spanish.[79] If one member of a family is referred to counseling or asks to speak with a counselor, the entire family must attend the session. This rule extends to children, who must have a parent in the room during any conversations with a counselor. Susanna, an asylum seeker detained with her young daughter began to see a counselor when she became very distressed and anxious that she and her daughter would be separated. She was given a regular appointment with a social worker, which she found helpful. Her daughter was in the room during all sessions. She sat in a corner and colored.[80]

Berks

There are no licensed clinical social workers on staff at Berks; however, the county provides caseworkers to staff the detention center and families detained at Berks appear to receive regular and ongoing case management services. In addition, two licensed social workers are available to the families every Thursday to provide therapeutic care.

During our visit we observed families meeting with caseworkers. These caseworkers provide services as specified by Pennsylvania Department of Public Welfare guidelines, which include developing a family service plan for each family. Case managers are available to assist individuals in areas of need. Several weeks after our second visit, we received a letter via fax from a teenager that we interviewed. This letter indicated that she had been speaking to the caseworker about her frustrations with being detained. This caseworker, knowing that we had developed a rapport with the young woman, had suggested that she reach out to us, and assisted her in sending a fax.[81]

Christina, a 14-year-old girl who was detained at the Berks family facility for over two years, sent us a letter:

"My problem is that this man [who works at the facility] is always looking for ways to bother me by making fun of me to his co-workers. This happens all the time. He calls us 'dirty undocumented' or 'ignorant people.' This really hurts me…. Today he asked me where I got my socks, they are yellow and on the edges it says 'Livestrong.' He made fun of me and asked me if I knew what that meant. I said 'No.' He laughed and said something I didn't understand. I tried to just walk away but he made me feel so bad that I couldn't stand it and started to cry. One of the workers here saw me crying and asked me if I was okay. They told me I didn't have to be quiet and that I should tell someone. She told me to write to you and tell you. Please don't tell anyone I am complaining, I don't want to get in more trouble here." Note: Christina has since been released and has given us permission to print this letter.

Caseworkers play a role in detainees' submission of grievances. Hasan told us that he had filed three grievances during the time he was at Berks. Each time, he sent these grievances to the resident director, who suggested that he raise his concerns with the caseworker. Hasan reported that the caseworker's response was to caution him that people have been thrown out of the center, and their families separated, because they complained.[82] The detention and deportation officer informed us that all complaints about treatment and conditions are directed to the county.

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[78] Rebecca, interview by Emily Butera, Austin, Texas, December 4, 2006.
[79] Carmen, interview by Michelle Brané and Emily Butera, Brownsville, Texas, December 6, 2006.
[80] Susanna, interview by Michelle Brané, T. Don Hutto Residential Center, December 4, 2006.
[81] Christina, letter via fax to Michelle Brané, December 5, 2006.
[82] Hasan, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006.

Education

Hutto

On the day we visited, the high school class at Hutto was learning about child development, specifically at what age a child can be toilet trained. At the time of our visit, children and adults received one hour of education daily.

At the time of our visit to Hutto, children and adults received one hour of education daily, Monday through Friday. This abbreviated educational schedule was the result of licensing requirements that limited the number of hours per day parents and children could be apart. According to ICE, educational programming has since been expanded to four hours per day, and the curriculum complies with Texas state standards.[83] In response to her queries about the educational situation, a county commissioner was told that the center would now be following Texas education requirements.[84] We have received reports from people in detention that they now receive more hours of education per day, but we have not been able to confirm the total number of hours or the substance of educational hours claimed. The Hutto school has a principal and teachers who are either state-certified or eligible for certification. ICE reports that a different subject is taught each day, including science, social studies, language arts and math. There are 10 teachers and three teacher's aides, and students are separated into classes by age group. The older students, ages 13–18, are in one class. Younger students between approximately four and 12 attend the same class, and the youngest children either sit in the adult classes or go to the elementary classrooms. At the time of our visit, parents attended English language classes and sessions on parenting skills. Classes were taught in English, and guards were posted in all classrooms.

On the day we visited, the high school class was learning about child development, specifically at what age a child can be toilet trained. In the elementary classroom, the children were coloring. Only the adult education class seemed appropriate for the students' needs, focusing on basic English words and phrases for expressing illness. Detainees complained that in the elementary classes children just sing and color. Alicia told us that at first the older children were only taught math, but then they told the teachers that they wanted to learn English, so an English class was added to their curriculum. They are also now taught U.S. history and the names of body parts.[85]

The principal told us that because they were finding that more and more of the students had been living in the United States for years before being apprehended, and had attended U.S. schools, the facility was considering offering advanced placement courses so that students would not be behind when they return to mainstream school. However, it posed a challenge to integrate an advanced placement class into an environment where students only have one hour of education a day. In addition, our tour included a visit to the computer lab, which was being set up at the time of the tour but was not yet in use. Staff members told us that when computers were operational they would have basic parenting and English instruction programs installed.

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[83] John Pugash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.
[84] Lisa Bottman, County Commissioner, Williamson County, Texas, telephone interview with Michelle Brané, January 23, 2007.
[85] Alicia, affidavit obtained by the University of Texas Law School Clinic, November 2006.

Berks

Children's educational services at the Berks facility are administered by the Berks County Intermediate Unit, with funding from DHS. Classes are governed by the Pennsylvania Alternative Curriculum Standards, a set of guidelines for alternative and special needs schools. The children are divided into elementary and middle/high school classes and attend school for four hours a day. All children's classes are taught in English, and students study English, social studies, math and science. In addition, each classroom is equipped with computers that utilize the PLATO computer-assisted instruction program to create lessons tailored to individual students' abilities and needs.

In addition to children's education, adults at Berks attend English as a second language classes four days a week. We encountered adults in the English program during our tour. These classes are conducted in the cafeteria, and appeared to consist mainly of workbook study, given that the space was not equipped with a blackboard or appropriate seating for lecture-style education. While the adults and older children are in class, the youngest children accompany their parents, play in a small cordoned-off area in the cafeteria, or participate in activities led by staff members in a small gymnasium inside the facility.

Children and parents with whom we spoke indicated that they had no significant complaints about the quality of education provided at Berks. One family was released during the time that we were researching this report, and the children now attend public schools in the area. Although they had only been in mainstream school for about a week when we spoke with them, they seemed to be doing well in their classes and performing at grade level. In addition, all three of the children learned to speak English quite well during the time they were at Berks.

The outdoor play area at Hutto is fenced in by concertina wire. Children said that they had not been outside on the playground in several months.

Recreation

Hutto

Families in detention receive one hour of recreation and large motor exercise per day, Monday through Friday. There is a large gymnasium inside the facility, and people rotate through recreation time by housing unit. In the gymnasium we observed several basketball nets and basketballs, and for toddlers and younger children a play area cordoned off with furniture. There did not seem to be much opportunity for indoor large muscle activity for the younger children or adults, but during our visit most of the older children were playing basketball. There were a few toys in the cordoned off area, most notably plastic trucks and kitchenettes. We observed no stuffed animals and no dolls. This is the only time that the younger children have access to age-appropriate toys. The pods have couches and games, TVs and video games appropriate for older children. Children are not permitted to have their own toys or to receive toys from outside the facility.[86] On our tour we were told that children are allowed to hang pictures in their cells, but we did not observe anything on the walls of any of the cells during our visit. Families told us that no toys are allowed in the pods and that nothing can be hung or taped to the walls.[87] Despite the fact that computer paper and

[86] Margarita, affidavit obtained by the University of Texas Law School Clinic, November 2006.
[87] Leila, telephone interview by Michelle Brané, February 1, 2007.

crayons seemed to be available in many parts of the facility, families told us that children are not allowed to keep the pictures they draw or color.[88]

In addition to the indoor gymnasium, Hutto has an outdoor recreation area with a large soccer field, two jungle gyms, slides and three covered tables. This area is surrounded by perimeter fencing with concertina wire. The public information officer told us that families are allowed to go outside for at least one hour per day, Monday through Friday, weather permitting, and that they try to give families more time whenever possible. We received conflicting reports from families in detention on this issue. Some people told us that they rarely go outside because staff members tell them it is either too hot or too cold. At least one detainee, Margarita, said that they go outside for one hour a day rain or shine, hot or cold. She said that the children are given sweaters when it is very cold, but the adults are not.[89] On the weekends detainees are not allowed outside at all.

Families in Hutto do not participate in any off-site recreational activities. The public information officer reported that they try to organize activities on-site, including cultural activities, whenever possible. There are no programs coordinated with outside volunteer groups, and there have been several reports in the media indicating that local groups who have offered to conduct activities for detained families have been denied permission to do so. Each pod has two facilitators; staff members accompany families to all activities to make sure that each family unit is engaged in an activity and interacting with each other. We observed facilitators playing basketball with the older children, but otherwise not interacting with the parents and younger children. For the most part, the parents seemed to spend their recreation time sitting on the furniture that separates the young children's area from the large gymnasium.

Families receive one hour of recreation per day, Monday through Friday. Recreation is the only time that younger children have access to age-appropriate toys.

In addition to the gymnasium Hutto has a general library and a law library; however, people are only allowed in the library during their orientation to the facility. Library carts circulate to the pods every five days, and detainees are permitted to take one book at a time. According to the public information officer, detainees can request that a particular book be placed on the cart, and there are books in languages other than English. But a cursory review of the library revealed few foreign language or children's books, and the collection is minimal given the size of the facility.

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[88] Ibid.

[89] Margarita, affidavit obtained by the University of Texas Law School Clinic, November 2006.

Berks

Recreational programming at the Berks facility surpasses that at Hutto, perhaps because of its smaller size.

When children and adults are not in classes, and adults are not assigned to the chore rotation, the families have free time. Although families and individuals cannot move freely within the facility and are escorted in lines from one activity to another by county staff, they spend their free time in a more homelike space. Each housing wing has at least two recreational spaces with carpeting, couches and televisions. At the time of our tour, cartoons were playing in one room and a news program in the other. They seemed to be able to move freely between the two rooms, although they were not permitted outside the housing wings during this time. Each recreational room had some toys available. These were common toys including trucks, teddy bears and dolls. Children were allowed to take one toy with them to their room. One of the recreation rooms had an armoire filled with board games and puzzles. There was also a game table in the room.

Families are afforded outdoor recreation time whenever the weather permits. Detainees confirmed that they often had more than the standard one hour, and that on weekends in particular they could spend all morning outside if the weather was moderate. However they also reported that recreation time could be taken away for as long as two weeks for "bad behavior." It was very cold on the day of our first visit, but on our second visit we observed people outdoors playing soccer and relaxing on a grassy area outside the facility. Facility staff members guard families during this outdoor recreation time, but there is no fencing cordoning off the recreation space from the road.

In addition to outdoor recreation time, there is a small gymnasium in which the younger children were playing on the day of our first visit. They were engaged in activities including playing with balls and riding scooters. The facility also features a well-equipped larger gymnasium with fitness equipment and free weights, but this area is strictly limited to staff use.

In addition to athletic recreation time, the facility offers other activities for families in detention. The law library has computers available for use, a bookmobile delivers reading materials and there is an art room where crafts are organized. On the day our delegation visited, the children had painted pumpkins. Staff members also told us that local church groups come and lead activities at the facility, including art projects and holiday parties. Individuals are permitted to participate in facility-run field trips to places such as McDonald's, Wal-Mart and the local farmer's market. However, no one with a final order of removal is allowed to go on a field trip, and the facility does not permit an entire family unit to go on the same field trip.

Discipline

It has proven difficult to ascertain institutional disciplinary practices in family detention facilities, and the absence of any clear standards for family detention compounds this problem. ICE has no policy guidelines for family detention facility staff regarding disciplining children. Discipline is seen as the parents' responsibility, and guards and staff members are to exercise common sense when handling a situation in which the parent is unable or unwilling to control a child.[90] Local and headquarters officials repeatedly stated that the only problems they encounter are parents who want to use corporal punishment, which is not allowed in the facilities.

[90] John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.

Hutto

The public information officer repeatedly told us that disciplinary problems are handled by sending the entire family to the counselor. "Time-out" is a commonly used form of discipline. In addition, families informed us that threats of separation are frequently used as a means of discipline. In particular, staff members encourage parents to keep their children quiet and get children to behave by telling children and their parents that if the child does not do what they are told to do by staff they will be taken away. Nelly, a 9-year-old girl detained with her 3-year-old sister and her mother, who is applying for asylum, told us that if she misbehaved she would be separated from her mother. When asked why she believed this she said, "Everyone knows that; that's what they say."[91] All those we interviewed expressed frustration that children are punished for what is normal behavior for young children like running around, making noise and climbing on the couches. One detainee that we interviewed experienced this in the context of children getting out of line while walking through the hallways. Another said that these threats are made even when children are crying and cannot be consoled.[92] Susanna, a mother detained with her 6-year-old daughter, complained that the guards were unnecessarily strict with rules and regulations. She gave the example of her daughter's needing to use the bathroom during an attorney visit. The guards refused to let her use the bathroom because they were about to have a "count." They made the girl wait for more than 15 minutes while she cried. When the attorney complained to staff, the mother became worried that she and her daughter would be separated.[93] Parents confirmed, "It is the parents' job to keep their kids under control."[94] They also said that staff members tell them that if their children are loud or misbehave they will be written up, and that this information will go into their record and could affect their court case.[95] Another form of disciplinary action is to put children in the corner for 30 minutes and not allow them to talk or move.[96]

Noreen, an asylum seeker who has been released from Hutto, recounted an incident in which a 6-year-old child cried when he was not allowed to take a picture he had colored into his room. When the guard shouted at the child for crying, the child's father intervened. Noreen does not know exactly what happened next, but says that the family—child, mother and father—were separated into different pods for three days after the incident.[97]

Carmen confirmed that if children misbehaved, either the child or the parent would be "written up." A write-up could result in loss of television privileges or recreation time, or in children being sent to their cells. She told us that when the children in the pods were too loud or active, guards would turn up the air conditioning so that the room became very cold. She also stated that when detainees were angry, guards turned off the hot water so that only cold water was available.[98]

Berks

Disciplinary practices at Berks also raise concerns. We interviewed several detainees and some former detainees who said that their physical needs were being met, but suggested that they were psychologically and verbally abused by staff.

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91 Nelly, interview by Michelle Brané, T. Don Hutto Residential Center, December 4, 2006.
92 Susanna, interview by Michelle Brané, T. Don Hutto Residential Center, December 4, 2006.
93 Ibid.
94 Alicia, affidavit obtained by University of Texas Law School Clinic, November 2006.
95 Ibid.
96 Rebecca, interview by Emily Butera, Austin, Texas, December 4, 2006.
97 Noreen, interview by Michelle Brané, T. Don Hutto Residential Center, February 1, 2007.
98 Carmen, interview by Michelle Brané and Emily Butera, Brownsville, Texas, December 6, 2006.

As at Hutto, parents reported that children were often disproportionately punished for small incidents that are normal child behavior. Detainees and DHS officials both stated that time-outs are a common disciplinary tactic, and detainees reported that a prohibition against talking is another form of discipline at Berks. All families interviewed express a general sense that they were disrespected by staff members, frequently yelled at and issued unnecessarily harsh punishments for behavior as simple as not being able to do homework for lack of a pencil.[99] One family told us that a child spoke back to a member of the staff, telling him that he was not her mother and that she did not have to do what he said. The staff member became angry with the child and pushed her.[100] In another instance, a girl got caught passing a note in class. Passing notes of any kind is a violation of the facility rules.[101] She received the punishment of not being allowed to talk to anyone of the opposite sex for two weeks. When she violated the prohibition, she was prohibited from speaking with anyone other than immediate family members for two weeks. The family was told that if they did not comply, the girl would be sent to the juvenile facility.[102] This incident caused extreme stress to the child and the entire family.

Threat of separation is another frequently used disciplinary tactic. Several families told us that facility staff would threaten them with separation if they misbehaved, and on several occasions it seems that children were sent to the secure juvenile detention facility without an opportunity to defend themselves in court.[103] When we asked the detention and deportation officer and the deputy director how they handle disciplinary problems, they told us that since Berks is not a criminal facility, adults exhibiting criminal behavior would be placed in an appropriate adult facility and their now unaccompanied children would be turned over to the custody of ORR. If children exhibited severe behavioral issues, staff might need to transfer them to a secure facility. Unless their accompanying parents had other children with them at Berks, they would be sent to an adult facility. We pressed for an explanation of what constitutes severe behavioral issues, but did not receive any concrete examples. We heard several second-hand stories of separation. One case appeared to be the result of a child fighting with a staff member. In another instance a minor had gotten into a fight in the cafeteria and hit another minor. Families told us that sometimes juveniles were sent to the Berks County Youth Center Juvenile facility, which is not an ORR facility, for a few days as punishment for misbehaving.[104] Sophia and her daughter, Christina, recounted an incident in which some new arrivals had resisted when treated badly by guards and had been "sent away." The prevailing belief among families in detention is that they will be separated if anyone misbehaves, which creates an environment of extreme psychological stress.

In the course of our interviews there emerged some confusion about whether or not parents are allowed to discipline their children. One parent indicated that she could, but another parent said that it could be quite difficult to discipline children because the facility's rules strip the parents of any authority in their children's eyes. Her daughter told us, in a separate conversation, that she saw how much it bothered her mother to not be able to parent them.[105] Parents told us that many children lost respect for their parents because of the parents' lack of control at the facility. "Parents are not the ones who decide what their child is or isn't allowed to do. It is the guards who decide and have the ultimate control to punish or discipline the children and the adults."[106] Many children expressed anger or frustration with their parents

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[99] Sabrina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

[100] Sophia, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007; Christina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007; Sabrina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

[101] "Berks county INS Family Shelter, Adult Program Rules," supplied by Berks County Youth Center, on file with the Women's Commission for Refugee Women and Children.

[102] Christina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007. Confirmed by José, interview by Michelle Brané, Berks County Shelter Care Facility, November 29, 2006.

[103] Sophia, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007; Christina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

[104] Christina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007; Sabrina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

[105] Christina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

[106] Sophia, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

for leading them into detention and for being powerless or unwilling to help. Some children asked or cried for their parents to sign for deportation so that they could go home.[107]

In addition, adults and children both complained to us of verbal disrespect, including suggestions that the families should just give up and go home because they would never get out of detention. They also recounted instances in which detainees were told that they were worthless, stupid or dirty immigrants. This type of verbal abuse seemed to cause particular distress to children who often cried or became depressed. Hasan told us that staff members made jokes about Ramadan and Muslims. He also complained that female staff members look into male residences.[108] Both he and another woman complained that staff members sit outside the bathroom doors while children are showering. He and Gina complained that staff members wake them up by shouting at them and turning the lights in their rooms on and off.[109]

When asked in separate interviews what one thing they would change about the facility one child said, "Replace all the staff." Her mother said, "Hire only people with child care experience or expertise."[110]

Access to Counsel

Hutto

According to the CCA public information officer, families in detention are provided with a list of legal services providers during their orientation. Detainees told us that they receive the list the first time they go to court. The facility has a law library with three computers, two typewriters and access to LexisNexis and numerous other legal resources. Those detained can reportedly use the law library at any time if they make an appointment to do so.

Hutto has two televideo courtrooms, which are used for master calendar hearings and credible fear hearings. Masters are done every day with judges from San Antonio and Houston, and people are taken to court for all merits hearings.[111] Per DHS staff, one or two families bond out each day, and the number of individuals granted bond seems higher overall than at Berks. The director of the DHS San Antonio Field Office governs parole of asylum seekers in the office's jurisdiction. According to DHS staff accompanying us on the tour, very few asylum seekers are granted parole in the San Antonio district. Dominica is a pregnant asylum seeker with two children. She is having complications with her pregnancy. Her mother is a legal permanent resident of the United States. She has requested parole and has waited more than two months without a response.[112] We requested more detailed information from DHS on grant rates for parole, but did not receive this information in time for publication.

A listing of legal services providers was posted next to each phone in the pod we visited, and the phones were set up to direct dial frequently called providers and consulates. A list of free legal service providers was also posted. We tested the direct dial system and we were able to get a call through to the University of Texas Immigration Law Clinic. However, we reached an answering machine. These phones cannot

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[107] Sophia, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007; Christina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

[108] Hasan, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006.

[109] Hasan, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006; Gina, interview by Emily Butera, Berks Family Shelter Care Facility, October 27, 2006.

[110] Sophia, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007; Christina, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

[111] A master hearing is an initial hearing before an immigration judge. Credible fear hearings allow arriving aliens to establish whether or not they meet a minimum legal threshold for fear of return to their home countries. Satisfaction of this minimum threshold is a necessary step towards applying for asylum before an immigration judge. Merit hearings take place before an immigration judge and give aliens an opportunity to substantively present their applications for relief.

[112] Griselda Ponce, attorney at law, telephone interview by Michelle Brané, January 23, 2007. Ponce is Dominica's attorney of record.

receive incoming calls, so leaving messages on a machine is of limited use to people in detention. Detainees told us that they did not receive a listing of legal service providers, and Rebecca told us that staff members sometimes took the phone out of her hands and hung it up when she was talking to attorneys.[113] One formerly detained person told us that according to DHS there are no free lawyers and she would be sent back to her country unless she could pay a lawyer to represent her. She found the phone number for the Political Asylum Project of Austin on the posted list of service providers, and has now been released pending adjudication of her application for asylum.

Attorneys are able to access the facility, but since the Legal Orientation Program[114] does not exist in family detention centers, they only come when contacted by a detainee. Attorneys reported that many of their clients are domestic violence-based asylum applicants. They report that the U.S. Customs and Immigration Services (CIS) office in Houston routinely denies credible fear rulings to applicants whose claims are based on domestic violence. Detained asylum seekers reported that guards at the Hutto facility tell them that domestic violence is not a basis for asylum and that if they request asylum they will be detained for eight months.[115]

Attorney-client meetings are conducted in a private room, but parents must keep their children with them during the meetings. This has posed problems in ensuring adequate representation, particularly in asylum cases and cases involving rape and domestic violence. Because parents do not want to discuss the facts of their case in front of their children, attorneys do not get the information they need to effectively represent their client. Recently, attorneys have been informed that they are limited to speaking with 10 people per visit, and that children are included in the total. Attorneys have complained that this severely limits their ability to meet with their clients. Because of family size, and because children must always accompany the parent regardless of whether the attorney wants to meet with the child, this rule effectively limits visits to three clients or fewer.[116]

Removals are effected every other week, and are dependent on the cooperation of individual consulates. Because of the high volume of Central American expedited removal cases, removals to these countries take place fairly frequently. However, nationals of other countries may wait longer before removal is effected. Because the facility has not yet been open a year, data on length of stay is insufficient to allow any clear conclusions. ICE informed us on December 20, 2006, that the average length of stay at Hutto was 18.5 days.[117] Most recently, ICE reported that the average length of stay for families not seeking asylum is 40 days.[118] These averages can be misleading. Many are only detained for very short periods of time because they are immediately returned to their country or accept voluntary departure or return. Others, such as asylum seekers, might have cases that go on for months while they remain in custody. Many of those with whom we spoke had been detained for three or four months. It is likely that the average length of stay at Hutto will increase as its length of operation increases. Since the facility had only been open for approximately six months at the time of our visit, it would have been impossible for anyone to be detained for longer than that time period, which contributed to a low average length of stay.[119]

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113 Rebecca, interview by Emily Butera, Austin, Texas, December 4, 2006.

114 The Legal Orientation Program is run by the Board of Immigration Appeals within the Executive Office for Immigration Review. Through the program attorneys conduct "Know Your Rights" presentations in detention centers, allowing them to explain to detainees what their legal options are. The program also assists detainees with finding *pro bono* attorneys if they want to pursue asylum claims. The program has been very effective in protecting the rights of detainees as well as saving government time and expense. Many detainees, particularly those in expedited removal, realize that they have no claim for relief and accept voluntary removal or deportation rather than remaining in detention. See http://www.usdoj.gov/eoir/probono/probono.htm.

115 Barbara Hines, University of Texas Law School, telephone interview by Michelle Brané, November, 2006; Frances Valdez, University of Texas Law School, telephone interview by Michelle Brané, November 2006; Carmen, interview.

116 Griselda Ponce, attorney at law, telephone interview by Michelle Brané, January 23, 2007.

117 John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.

118 Gary Meade, press tour of T. Don Hutto Residential Center, February 9, 2007.

119 At Berks, which has been in operation since 2001, we encountered families that had been detained for as long as two years.

Berks

The Berks facility's distance from a major metropolitan area makes it difficult for families to locate counsel and limits the availability of *pro bono* attorneys.

The facility has accommodations for legal matters. Within the facility asylum officers use an attorney-client visitation room to conduct orientation and interviews for detainees who express credible fear. Immigration judges from York, Pa., conduct hearings both in person and by video conferencing in a courtroom at Berks. The facility also has a law library. Although ICE staff told us that detainees never used this space, we observed someone using the computer on our second visit. In general, local policy is that master calendar hearings are conducted by video conferencing every Thursday, and merit hearings are done in person at the York courthouse. Because York was short one immigration judge in recent months, the Executive Office for Immigration Review has resorted to conducting merits hearings by video at times.

Families report receiving a list of legal services providers upon arrival. No Legal Orientation Program is offered at Berks. Both the deputy director and the detention and deportation officer expressed an interest in having local immigration service providers conduct rights presentations at the Berks facility, noting that such sessions would ease anxiety and help unclog the system, which they explain becomes burdened by people who have no form of relief. However, conversations with potential service providers confirm that limited funding and staff resources make this unlikely in the short term.

Per the detention and removal officer, parole is only available in instances of significant public benefit or urgent humanitarian need.[120] In his analysis, most detainees are in expedited removal proceedings and are subject to mandatory detention. Consequently, parole rates are quite low at Berks, and officials could not recall anyone who had been paroled recently. While the parole option may be limited for non-asylum seekers in expedited removal it is contrary to policy statements with respect to asylum seekers. Per an INS Policy Guidance issued in 1997, "parole is a viable option and should be considered for aliens who meet the credible fear standards, can establish identity and community ties, and are not subject to any possible bars to asylum involving violence or misconduct…."[121] Although ICE did not respond to our request for statistics about parole rates in the York district, we met several families at Berks with pending asylum claims who were eligible for parole but had not been released.

Bond rates are set by the immigration judge, and are often prohibitively high, as was the case for a woman and her son whose bond was set at $15,000 even though she had a U.S. citizen child who was being cared for by friends during her detention.

ICE headquarters informed us that on December 20, 2006, the average length of stay at the Berks facility was 58 days. In the course of interviewing, we found that most families seem to have been at Berks between five and six months. However, we encountered several families who had been detained at Berks for much longer periods of time, including one who had been there for over two years, another just under two years and another almost a year.

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[120] He acknowledged that parole is almost never granted. When asked for an example of who might qualify, he said, "someone who is about to discover cancer."

[121] "Expedited Removal: Additional Policy Guidance," memorandum from Michael Pearson, Executive Associate Commissioner for Field Operations, to INS Regional Directors, District Directors and Asylum Office Directors, December 30, 1997.

Telephone Access

Hutto

Telephone access at Hutto is compromised by the cost of phone cards and the location of phones. Detainees are able to purchase $10, $15 and $20 phone cards. The $10 cards allow for 20 minutes at 50¢ a minute. A bank of four phones is located in the center of each pod, and neither individual phones nor the phone bank have privacy screens. The phones located in the pods worked at the time of our visit. Information about attorney access by phone is documented above.

Berks

Telephone access is similar at Berks. The facility has two telephones, which are located in a hallway. Detainees are able to purchase calling cards with rates of $1 or more per minute. A $30 card allows for 20-25 minutes of talk time. Indigent individuals are issued calling cards at government expense. In addition, one detainee with whom we spoke noted that individuals are sometimes permitted to use a phone belonging to facility staff. Another detainee told us that the telephone had been broken the previous week, which prevented anyone from being able to contact relatives or attorneys.

Visitation and Spiritual Support

Hutto

Non-attorney visitation is permitted at Hutto on weekends between 8:00 a.m. and 5:00 p.m., and attorney visits are permitted seven days per week. However all non-attorney visits are non-contact. A Plexiglas wall separates detainees from their visitors, and they must communicate through a telephone handset attached to the wall, allowing a visitor to talk to only one member of a family at a time. Children are required to be with their parent for the visit and guards are present on the detainee side of the visitation space. Detainees are permitted to use the restroom only one time during a visit.

A Plexiglas wall separates detainees from their visitors. Visits are non-contact to eliminate the need for strip searches following a visitation.

The public information officer explained that visits are non-contact to eliminate the need for strip searches following visitation. Dominica, a pregnant asylum seeker detained with her two daughters, summed up the tremendous strain that non-contact visits pose on people who have not seen each other in many years. She explained that while she is happy to finally see her mother again, it is difficult to be forbidden to touch her.[122] In some cases, visitors are U.S. citizens, whose parents, spouse or children were apprehended and detained.

Spiritual counseling and services are provided as needed. Most available services are Christian but the public information officer told us that accommodations are made for Muslims.

[122] Dominica, interview by Brané, T. Don Hutto Residential Center, February 1, 2007.

Berks

Families are permitted to have visitors seven days per week. All visitors pass through a metal detector as they enter facility. Contact visits are permitted, but actual contact is limited. The husband of one detained woman complained to us that when he went to visit his wife, staff would yell at him when he would try to hug her. Although he is a U.S. citizen by birth, staff members told him to go back to his country.[123]

Availability of spiritual counseling and services is intermittent and varies among different faiths. Berks used to take families to churches located in the surrounding community, but this practice has been discontinued.

[123] Paul, interview by Michelle Brané and Emily Butera, Reading, Pa., January 16, 2007.

V. Conclusions

The penal setting at Hutto is clearly an inappropriate and disturbing setting in which to hold families. Although the previous sections have revealed significant differences in the conditions of confinement at Berks versus Hutto, these discrepancies do not negate the central argument that conditions at both facilities are inappropriate. Both settings strip parents of their role as arbiters and architects of the family unit; both place noncriminals in facilities modeled on the criminal justice system, with little regard to national and international standards for the care and protection of children and families; and neither provides an acceptable model for addressing the reality of the presence of families in our immigration system. Furthermore the current models do not meet the standards dictated by Congress, including alternatives to detention and nonpenal, homelike environments.[124] In fact, ICE has made no effort to develop release alternatives to family detention.

Our concerns include the following:

Licensing

The concept of family detention is not one that has any precedent in the United States, therefore no appropriate licensing requirements exist.

- *Flores* requires that minors be placed in licensed programs that comply with all relevant child welfare laws and regulations. Yet family detention facilities that house a significant number of young children as well as vulnerable adults are not yet required to obtain a license, because no licensing category exists for this type of facility.

- Lack of licensing requirements for family detention facilities presents a logistical problem for entities charged with operating such facilities. Berks County asked the licensing board to create a category or "box to check" even though none officially existed, because they refused to open without some form of license.[125] This demonstrates their belief that appropriate licensing should be required when operating such a facility.

- The Texas Department of Family and Protective Services exempted Hutto from child care licensing requirements because the children detained there are considered accompanied since their parents are detained with them.[126] The repercussion of this exemption is that it effectively requires children to be in the company of their parents at all times. The requirement that parents not be separated from their children means that adults detained at Hutto cannot speak with their attorneys, medical personnel, visitors or counselors without their children in the room. As individuals such as asylum seekers or victims of domestic violence may feel uncomfortable relaying sensitive or disturbing information in front of their children, their medical care and legal representation may be compromised. If they cannot give medically or legally vital information to medical workers or attorneys, they will likely not receive the services they need or relief for which they qualify. In addition, children are not being interviewed separately from adults to assess whether they may have independent claims to legal relief. Furthermore, this exemption has led to a system in which children were only receiving one hour of education a day.

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[124] *Department of Homeland Security appropriations bill, 2007: report together with additional views.*

[125] John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.

[126] Hutto contacted the department about child care licensing. It was determined that they were exempt from CCL (Child Care Licensing) by 40 Texas Administrative Code, Chapter 745, Subchapter C. Specifically, Section 745.117 provides that a "program of limited duration" with "parents on the premises" can be exempt from licensing. For more information see http://www.dfps.state.tx.us/child_care/child_care_standards_and_regulations/.

- If ICE claims that family detention facilities are following licensing standards laid out in the *Flores* settlement, appropriate authorities should license facilities in which children are held.

Standards

The lack of family detention standards means that no consideration has been made for the particular needs or situations that arise from detaining families.

- The only guidelines that exist to provide oversight of family detention are the ICE Detention Standards and the *Flores* settlement. ICE told us that the facilities operate on a hybrid of the Detention Standards and *Flores* standards that has yet to be finalized. These guidelines do not take into account the unique needs of families.

- Because *Flores* and the Detention Standards are not statutory or codified in regulations, and because inspections are conducted by its own staff, ICE is not held accountable for compliance. This lack of independent accountability contributes to a system in which vulnerable children and families are not provided with appropriate and humane conditions of confinement.

- There is a fundamental clash of cultures emerging from efforts to apply a criminal justice model to a noncriminal family population. The underlying system is flawed, and cosmetic adjustments will not resolve this conflict.

Physical Setting

The current facilities being used for family detention are modeled on a penal system and are not the least restrictive settings appropriate to children's age and special needs or to the preservation of the family unit.

- *Flores* presumes release for unaccompanied minors, and indicates that minors who are not released should be placed in the least restrictive setting possible.[127] While ICE has carried out modifications to make Hutto and Berks more family-friendly, the use of a jail-like structure and the imposition of policies and procedures borrowed from the criminal justice system place families in a fundamentally inappropriate setting. While CCA and ICE staff at Hutto noted during our December 2006 tour that the facility is still undergoing "softening," it will remain a jail-like environment. Consequently, it is concerning to note that DHS views the Hutto facility as a prototype for future expansion of family detention.[128] Given what we learned and observed during our visit, a Hutto-like facility is not an acceptable setting for even the short-term detention of migrant families.

- *Flores* specifies that facilities maintain adequate temperature control and ventilation,[129] but a central complaint of detainees in both facilities was that staff would set the air conditioning very high, a complaint that we concurred with on our visits.

- The *Flores* settlement states that children should be afforded the right to wear their own clothing when possible.[130] In addition, in keeping with recommendations by Physicians for Human Rights, detained migrants should be able to wear their own clothing as a simple yet important way "to

[127] *Flores v. Reno*, Exhibit 2(b), Instructions to Service Officers re: Processing, Treatment and Placement of Minors.
[128] John Pogash, ICE national juvenile coordinator, interview by Emily Butera and Michelle Brané, Washington, D.C., December 20, 2006.
[129] *Flores v. Reno*, section on Temporary Custody.
[130] Ibid., Minimum Standards for Licensed Programs, ¶12, p. 16.

identify themselves as individuals and not criminals."[131] However, at the Hutto facility, children and their parents wear prison uniforms. In addition, at both Hutto and Berks, older children and their parents are required to wear flip-flops or slippers, a policy adopted from criminal correctional practice. This encourages deeper institutionalization of an already inappropriate environment.

- According to accounts from families detained at Hutto, they are not afforded sufficient clothing or laundering services so that they are forced to wear a dirty or used set of undergarments at least one day a week.[132]

- Families do not have freedom of movement within the facilities, being able to move only for prescribed activities and when escorted by facility staff.

- Parents and children are separated during sleeping hours. At Hutto laser control systems that effectively serve as locks on cell doors prevent parents from attending to their children's needs after "lights-out." In addition, at Berks children over five years of age sleep separately from their parents. This policy prevents parents from carrying out traditional parenting roles, breaks down the bond between parent and child, and undermines children's trust that parents will take care of them. This policy also causes psychological distress for both children and parents.

- Those detained at Hutto are not afforded any privacy in the use of toilets and showers, and facilities fail to regulate water temperature appropriately for children.

Food Service

Food service is rushed and is not culturally appropriate. It does not sufficiently meet the nutritional needs of children and pregnant women, and it does not permit parents to make basic decisions about their children's health.

- The *Flores* settlement stipulates that facilities holding children should provide for their dietary needs in keeping with all applicable state child welfare laws and state and local health and safety codes.[133] In addition, the Detention Standards state that facilities must provide quality food service and nutritious meals. Neither children nor adults at Hutto are receiving appropriate or sufficient food to ensure ongoing physical development. In fact, many children and pregnant women claim to be losing weight due to insufficient caloric intake, unsafe or unfamiliar food or depression.

- Many detained at Hutto indicate that they only receive 5–10 minutes to eat, and that sometimes staff members yell at them to get up and leave before they have finished eating or feeding their children.

Medical Care

Health care in family detention facilities is inadequate to meet the needs of detained families, particularly the special needs of vulnerable children and expectant mothers.

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131 Physicians for Human Rights and Bellevue/NYU, *From Persecution to Prison*, p. 191.
132 In violation of standards set in the U.S. ICE *Detention Operations Manual*.
133 *Flores v. Reno*, Exhibit 1(a).

- The ICE Detention Standards state that all in detention "shall have access to medical services that promote detainee health and general well-being," and that facilities should provide both primary and emergency medical care and emergency dental care.[134] In addition, as specified in the *Flores* settlement, these detention facilities should be providing appropriate, routine medical and dental care and emergency health care services.[135] Those detained at both Hutto and Berks complained about inadequate medical and dental care.

- Detainees at both Berks and Hutto did not receive medical treatment in a timely manner despite following procedures to request medical attention.

- Detainees are sometimes provided medicines that are inappropriate for their medical needs.

- Pregnant mothers reported that they were not provided with prenatal care.

- At Berks adults reported being denied dental care, and at Hutto detainees reported receiving dental care without the use of Novocain or anesthesia.

- Physical symptoms and complaints by detainees may be manifestations of psychological stress that is not being adequately addressed and in fact is exacerbated by the conditions of detention.[136]

Mental Health Care

Detained families do not receive sufficient or culturally appropriate therapeutic mental health care services necessary to address the unique psychological stresses implicit in the migration and detention experience.

- Our observations about the psychosocial health of those detained in both facilities stand in stark contrast to comments from CCA staff and the ICE national juvenile coordinator that there was less need for mental health care than previously anticipated. Every interview subject cried during interviews conducted inside Hutto, as did many of the families interviewed at Berks.

- Many current and former detainees expressed a desire for counseling services and, in some cases, for anti-depressant or anti-anxiety medications. This contrast between what we were told and what we observed reflects staff members' and administrators' lack of expertise in identifying signs of mental and emotional stress and lack of awareness of how existing policies and procedures exacerbate the psychological stresses for families.[137]

- Hutto employs facilitators who travel with families from each housing pod. The facilitators are responsible for keeping families engaged in activities and with each other. The need for staff to compel engagement suggests that detained individuals in this facility suffer from depression that manifests itself through physical inactivity and disengagement.[138]

- The *Flores* settlement stipulates that children will receive "at least one (1) individual counseling session per week conducted by trained social work staff. In addition, the settlement prescribes group counseling sessions at least twice per week.[139] There are no regularly scheduled individual

[134] U.S. ICE *Detention Operations Manual*, Medical Care.
[135] *Flores v. Reno*, Minimum Standards for Licensed Programs, ß 2: pg. 15.
[136] Physicians for Human Rights and Bellevue/NYU, *From Persecution to Prison*, p. 88.
[137] Ibid., Pg. 1.
[138] Ibid., pp. 7 and 38.
[139] *Flores v. Reno*, Minimum Standards for Licensed Care, #6 and 7.

or group counseling sessions at either facility, other than family meetings with county caseworkers at Berks and family disciplinary counseling at Hutto. The lack of regular counseling at Hutto is reinforced by the mental health coordinator's statements that in an ideal situation detained individuals would be scheduled for weekly counseling sessions, and that his colleague was uncertain how to develop group sessions in a short-term setting.

- Detainees indicate that they are discouraged from accessing mental health services through a combination of factors, including threats of family separation in response to mental health problems, language barriers and the requirement at Hutto that all members of the family attend any session with a mental health staff member.

- Women and children migrants frequently become the victims of sexual violence in the course of making their way to the United States.[140] These populations have a need for specialized and frequent therapeutic counseling services that are not accommodated in either the Berks or Hutto facilities.

Education

Educational services at the Hutto facility are not appropriate to the children's level of development and do not meet educational standards.

- The *Flores* settlement stipulates that children in custody should receive "educational services appropriate to [their] level of development…in a structured classroom setting…which concentrates primarily on the development of basic academic competencies…[including] science, social studies, math, reading, writing and physical education."[141] However, at Hutto we observed middle and high school students being taught child development and elementary students coloring. We did not observe any classroom activity that would suggest that the educational services are appropriate to students' level of academic competency or that the curriculum included a focus on the subjects prescribed above.

- The *Flores* settlement also stipulates that children receive educational services appropriate to their communication skills,[142] which suggests that provisions should be made for accommodating various levels of English proficiency. At Hutto, parents complained that their children are not learning in the classes because they do not speak English and teachers are not able to speak Spanish.

- Until recently, children detained at Hutto received only one hour of schooling per day, Monday through Friday. Recent media reports and an affidavit from a detainee state that this has recently been increased to four hours per day, but we have not been able to confirm length or changes in quality of the new program.

- Teachers at the Hutto facility are required to be only "license-eligible" in the State of Texas. They do not have to hold a license from the state or school district to obtain employment at this facility.

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140 Women's Commission, *Behind Locked Doors*, p. 3.
141 *Flores v. Reno*, Minimum Standards for Licensed Programs, ¶ 4, p. 15.
142 Ibid.

Recreation

Recreational activities provided are insufficient for the physical and mental well-being of children and families in detention, and prevent the natural development of parent-child relationships.

- The *Flores* settlement specifies that children should receive one hour per day of outdoor activity, seven days per week, and at least one hour of large muscle and one hour of structured recreational activity per day. This recreation allotment should be increased to three hours per day on days when school is not in session.[143] However, children do not consistently receive this required level of recreation at either facility. At Berks, children do not get to go outside for fresh air every day. At Hutto, there was a discrepancy about outdoor recreation, with some in detention telling us that outside recreation was provided when the weather was moderate, and others telling us that they had to go outside for one hour every day regardless of weather conditions. Those detained at Hutto do not receive any recreation time on the weekends. However, the Detention Standards stipulate that people at contract detention facilities such as Hutto be provided with access to outdoor recreation seven days per week.

- Both Hutto and Berks had few toys or sports equipment available for children or adults. The few toys that we did see were trucks and kitchenettes, as well as video games at Hutto and some games and a game table at Berks. The absence of toys that encourage fine motor skills, muscle control, physical strength and imaginary play can compromise natural child development and psychological well-being.

- Children at Hutto were not allowed to have their own toys, so whatever toys they could find to play with during their one hour of recreation time had to be left behind in the gymnasium. No toys are permitted in the cells at Hutto.

- The ICE Detention Standards state that volunteer groups may provide recreational or educational programming for people in detention.[144] However, the Hutto facility does not permit outside groups to provide activities for people in detention.

Discipline

Both children and adults are subject to inappropriate disciplinary practices. Disciplinary policies are unclear, and are not formulated with consideration for parental roles or the range of ages and maturity in the program. In addition, staff members are not culturally sensitive to the needs of alien minors.

- The *Flores* settlement prohibits the use of corporal punishment, humiliation, mental abuse and punitive interference with such daily functions as eating and sleeping. In addition, under *Flores* disciplinary actions may not adversely impact a child's health or physical or psychological well-being. Nor may they deny a child regular meals, sufficient sleep, exercise, medical care, the right to correspondence or legal assistance.[145] The disciplinary practices at both facilities violate these standards.

- The Detention Standards stipulate that written notification of disciplinary practices, prohibited acts and sanctions must be provided to detainees. In addition, the standards prohibit corporal punishment; excessive use of force; retaliatory disciplinary actions; or deprivation of food,

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[143] Ibid., # 5, p. 15.
[144] U.S. ICE *Detention Operations Manual*, Recreation.
[145] *Flores v. Reno*, Exhibit 1, Section C.

clothing, bedding, hygiene products, exercise, access to visitation, telephone access, correspondence or access to the law library. The disciplinary practices at both facilities violate these standards.

- Both Berks and Hutto have standard disciplinary policies in place, but neither has guidelines or written policies regarding the disciplining of children. Minors are subject to humiliation, mental abuse and punitive interference with the daily functions of living, particularly exercise.

- Because there are no staff guidelines or ICE policies on disciplining children, neither parents nor guards are clear about what to do in a situation where a parent is unwilling or unable to control his or her child. In our interviews with families and through personal observations we found that discipline issues played a large role in undermining family unity, health and stability. On the one hand parents have no control and feel powerless to discipline or influence their children's behavior. On the other hand the fear of being separated from their children due to disciplinary issues creates enormous pressure to control their children. This results in extremely stressful parent-child relationships. Additionally, children feel anger and resentment toward their parents for leading them into the detention setting and for not being able to protect them, while the parents feel guilt, stress, helplessness and frustration.

- The absence of disciplinary guidelines also leads to situations in which staff members apply punishments that are disproportionate to actual incidents.

- Recreation is inappropriately withheld as punishment, in violation of both *Flores* and Detention Standards.[146]

- Climate control—particularly extremely cold temperatures—is used for discipline or for controlling loud or active children, in violation of the *Flores* settlement.[147]

- Threats of separation are used as discipline, and children and parents alike are very afraid that they will be separated, which creates a climate of extreme stress.

- Actual separation, in which one or more family members are sent to a prison or juvenile center, does occur. It is not always clear whether the actions that led to the separation rose to the level that would necessitate such a transfer.

- Separation of days or months has reportedly been employed as a disciplinary tactic.

- Verbal abuse is used as a form of discipline, in contravention of both the *Flores* settlement and the Detention Standards.[148] Abuse includes such tactics as telling detainees, particularly children or adolescents, that they are worthless.

Access to Counsel

<u>We observed or received reports of instances in which access to counsel or the use of telephones was compromised.</u>

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[146] *Flores v. Reno*, Exhibit 1, Section C; U.S. ICE *Detention Operations Manual*, Disciplinary Policy.
[147] *Flores v. Reno*, V (12).
[148] *Flores v. Reno*, Exhibit 1, Section C; U.S. ICE *Detention Operations Manual*, Disciplinary Policy.

- Both the *Flores* settlement and the Detention Standards require that children and adults in detention be afforded access to legal counsel.[149] Access to counsel is a key element in a detainee's likelihood of obtaining relief. However, policies and procedures at both Hutto and Berks limit the ability of families in detention to communicate with counsel and to make informed decisions about their cases.

- People detained in Hutto reported that they are routinely told that applying for asylum will result in being detained for eight months or longer, which discourages them from seeking political asylum.

- ICE is failing to implement its own parole criteria (credible fear, community ties, establishment of identity and not a suspected security risk) for asylum seekers and failing to release them.[150]

- At Hutto there were four phones in each pod, none surrounded by a privacy screen, although both the *Flores* settlement and the Detention Standards require that detainees must be provided with privacy during legal calls.[151]

Visitation

Restrictions on contact and privacy exacerbate emotional stress on families in detention.

- The *Flores* settlement affords detained children visitation rights, stipulating that visitation be structured to encourage privacy for visitors and children during visitation to the extent practicable.[152] However, at Hutto all visits with friends and relatives are non-contact and take place by telephone through a Plexiglas wall. In addition, at both Hutto and Berks guards are present in the visitation rooms, undermining families' sense of comfort and ability to communicate openly with visitors.

- At Hutto if any member of a family wishes to receive a visitor, all members of the family must participate in the visit, a policy that prevents adults from speaking openly with friends and family without exposing children to traumatic information.

- At Hutto detainees are only permitted to use the bathroom one time during a visit. For families with small or several children, this can be difficult and may discourage visits.

Clash of Cultures

The use of family detention has created a clash of cultures. A correctional model is being improperly imposed upon noncriminal families.

- The penal model of family detention leads to babies in uniforms with name tags, cribs inside prison cells, parents losing the ability to discipline their children, and families unable to live as a normal family unit. Yet there is no means by which traditional correctional practices can be successfully applied to this noncriminal population without severely compromising the physical and psychological well-being of families.

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[149] *Flores v. Reno*, Exhibit 1, A(14); U.S. ICE *Detention Operations Manual*, Visitation.
[150] "Expedited Removal: Additional Policy Guidance."
[151] *Flores v. Reno*, Exhibit 1, A(12); U.S. ICE *Detention Operations Manual*, Telephone Access.
[152] *Flores v. Reno*, Exhibit 1, A(11).

- The lack of precedent and standards for family detention suggests that a penal model cannot be reconciled with child and family welfare practice.

- When children are released from ORR into the custody of their undocumented parents, ICE sometimes redetains them along with their parents. This discourages parents from coming forward to reunify with their children, creates a conflict with the *Flores* settlement's preference for release, and places additional burdens on ORR. Finally, this practice causes severe emotional distress for both children and parents.

VI. Recommendations

Recommendation One

Discontinue the detention of families in penal institutions.

- Close the T. Don Hutto Residential Center. **(ICE)**
- Begin transitioning to the use of nonpenal, homelike facilities for families not eligible for release on parole or bond or to alternatives to detention. **(ICE)**

Recommendation Two

Institutionalize a preference for release for all families who can establish identity and community ties and who do not pose a security risk.

- Complete release as soon as possible but no later than three weeks after apprehension. **(ICE or ORR)**
- Codify parole criteria to ensure that asylum seekers who do not present a flight risk or pose a threat to the community are released from detention.[153] **(ICE)**
- Authority to parole asylum seekers should be shifted to an objective decision-making body, such as the asylum corps or the Executive Office for Immigration Review. **(ICE, CIS and EOIR)**
- Where at least one member of the family has established credible fear or is applying for a valid form of relief, release the family or transfer them into an alternatives program or a nonpenal, homelike environment. **(ICE)**
- Grant temporary work authorization to asylum seekers whose cases are pending and who have been released into the community. **(CIS and ICE)**
- Liberalize parole criteria for families in expedited removal proceedings. **(ICE and Congress)**
- Make bonds for families accessible and not excessive. Children detained as part of a family unit should not be assigned an individual bond. **(EOIR)**

Recommendation Three

Implement alternatives to detention for families not eligible for parole or release.[154]

- Implement alternatives to detention as soon as possible but not later than three weeks after apprehension. **(ICE or ORR)**

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[153] U.S. Commission on International Religious Freedom, *Report on Asylum Seekers in Expedited Removal*, Volume I: Findings and Recommendations, p. 55.

[154] For additional information on alternatives to detention see Appendix D.

- Expeditiously develop pre-hearing release programs or alternatives to detention for families nationwide, such as supervised release and shelter care under the auspices of nonprofit social service agencies with expertise in meeting the needs of refugee families. **(ICE and NGOs)**

- Individuals in expedited removal proceedings should be eligible for alternatives to detention such as the Intensive Supervised Appearance Program. Snch programs should be considered to be a form of custody. **(ICE)**

- Grant temporary work authorization to asylum seekers whose cases are pending and who have been released into alternative programs. **(CIS and ICE)**

Recommendation Fonr

Families not eligible for parole or release into the community or alternative programs should be housed in appropriate nonpenal, homelike facilities.

- Transfer responsibility for custody of families in immigration proceedings to ORR, which is better equipped to address the special needs of refugee families. **(Congress)**

- Homelike facilities should permit families to share the same living space and enable parents to prepare food for and care for their children. **(ICE or ORR)**

- Separation of families who remain in homelike detention should never be used as a form of punishment. However, short-term voluntary separation within the facility should be permitted for purposes such as educational activities, recreation activities, medical examinations, counseling sessions and meetings with legal counsel. **(ICE or ORR)**

- Homelike facilities should employ a daily release model of family detention similar to that reportedly used in Australia, where parents and children are permitted to leave the facility during the day.[155] Pending asylum applicants detained in homelike facilities should be granted temporary work authorization to enable them to work in the surrounding community. **(CIS and ICE or ORR)**

- All facilities used for the detention of families should be licensed by appropriate regulatory bodies. Local, state and national governments that do not yet have standards should develop standards to ensure safety and dignity of children and families in detention and to prevent situations where services and safety are compromised by licensing requirements. In addition, because parents do not have control over conditions of confinement, regulatory bodies should err on the side of mandating facility compliance with all relevant standards for housing children. Internal procedures should provide adequate protection for children and meet their ongoing educational, physical and psychosocial development needs. **(ICE or ORR, local government)**

- Develop and codify family detention standards that take into account the needs of families, parental roles and the particular needs of children. Standards should ensure protection and continued educational, physical and psychosocial development of children throughout the period of detention. **(ICE or ORR)**

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[155] See Appendix C.

- Homelike family detention facilities should be subject to oversight and inspection by an independent authority. **(ICE or ORR)**

- Homelike detention facilities should take care in hiring staff who have employment experience and expertise with child welfare, family protection or family preservation, and not only with the criminal or juvenile justice systems. In addition staff should receive continued specialized training in the unique physical and psychological needs of immigrant families. All staff training should be based upon a child and family welfare model and not a criminal or juvenile justice model. **(ICE or ORR)**

- Visitation policies in homelike facilities should permit contact visits. Noncriminal families should not be subject to strip searches after visits. **(ICE or ORR)**

- Any pending asylum applicant who cannot be released from detention should be permitted to participate in a work release program. **(CIS and ICE)**

Recommendation Five

Children released from ORR custody should not be redetained with their parents upon family reunification.

- This practice creates a conflict with the predisposition for release of unaccompanied minors under the *Flores* settlement by discouraging parents from reuniting with their children. **(ICE)**

Recommendation Six

Enhanced public-private partnerships should be employed to provide Legal Orientation Programs, including legal information and *pro bono* legal access, for all detained families, including those in expedited removal proceedings.

- Assure access to legal orientation as soon as possible and no later than one week after being detained. **(ICE or ORR, and EOIR)**

- Expand the Legal Orientation Program or a similar model to all family detention sites. Presentations should include information on claims involving domestic violence, sexual violence, gang membership and other issues of unique importance to children and families' eligibility for relief. **(ICE or ORR, EOIR and NGOs)**

- Children whose families are in immigration proceedings should be treated as individuals who may be eligible for forms of relief separate from those available to their parents. Public-private partnerships should include the development of information and representation models that facilitate an exploration and pursuit of children's individual claims. **(ICE and NGOs)**

- Public-private partnerships such as the CAIR Coalition model should be expanded to provide legal representation for families and individual family members at credible fear interviews. **(CIS and NGOs)**

- Staff members charged with conducting credible fear interviews should receive appropriate training regarding minimal threshold requirements, particularly regarding domestic violence-based asylum claims. **(CIS)**

Appendix A: Methodology

This report is based on an assessment of the conditions of detention at the Berks Family Shelter Care Facility in Leesport, Pa., and the T. Don Hutto Residential Center in Taylor, Texas. The Women's Commission for Refugee Women and Children and Lutheran Immigration and Refugee Service carried out all research between October 2006 and February 2007. Research consisted of tours of these facilities and interviews of individuals currently and formerly detained. In addition, we engaged in formal and informal conversations with facility staff; local and national DHS staff; staff of Williamson County, Texas, and Berks County, Pa.; and attorneys representing detainees at Hutto.

We followed up our visits with ongoing conversations with ICE National Juvenile Coordinator John Pogash. Since these discussions, a considerable amount of public and press attention has been directed toward family detention in general and the Hutto facility in particular. As a result of this attention some modifications have been made.

Ease of access to the facilities differed between the sites. We were afforded easy access to the Berks facility. DHS and Berks County Youth Center staff responded quickly to initial and follow-up requests. During the course of our tour, we asked permission and were allowed to sit and talk with detained families in the cafeteria for some time. During these conversations, ICE and facility staff remained out of earshot. We were also allowed follow-up visits with detainees of our choosing.

LIRS and the Women's Commission were the first NGOs permitted to tour Hutto. It took several months to gain access. Ultimately we were given access and were able to speak with three families detained in the facility. With the exception of the first interview, a member of the Hutto staff was present in the room during these interviews. We were not able to gather all relevant information during our brief facility visits, and some questions about policies, statistics and physical plant remain. We have requested statistics and other clarifying documentation from the ICE national juvenile coordinator in an effort to resolve these outstanding questions. ICE has responded unofficially by stating that they have been deluged with requests for information regarding Hutto and family detention in general, and are unable to process our requests at this time. They requested that all inquires be processed through the quarterly DHS/ICE liaison meetings.[156] Consequently, where there is a lack of additional information available, we have made note of this in the text.

[156] John Pogash, telephone interview by Michelle Brané, Washington, D.C., January 31, 2007

Appendix B: Family Detention and International Law

Both treaty law and customary international law prohibit prolonged arbitrary detentions and provide a directive for the humane treatment of detainees. Article 3 of the Universal Declaration of Human Rights, the basis for most human rights law, states, "everyone has the right to life, liberty and security of person."[157] Article 16(3) specifies that "the family is the natural and fundamental group unit of society and is entitled to protection by society and the State."[158] More specifically, Article 25 asserts that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." Additionally, Article 9 states, "No one shall be subjected to arbitrary arrest, detention, or exile."[159] These articles support the notion that all human beings, regardless of their political status, deserve a basic, decent level of treatment.

The International Covenant on Civil and Political Rights, to which the United States is a party, corroborates the above principles. Article 9(1) states that "no one shall be subjected to arbitrary arrest or detention."[160] Article 9(4) elaborates, "anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful."[161] The convention outlines specific guarantees for families. Article 23 states, "The family is the natural and fundamental group unit of society and is entitled to protection by society and the State."[162] Moreover, Article 17 states, "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks."[163]

Although the United States has not ratified the *Convention on the Rights of the Child*, it is widely accepted by the international community as international law. Various provisions in the convention apply to the current problems in U.S detention facilities. Article 10 speaks specifically about the obligation of states toward children separated from their families. "Applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family."[164]

Article 16 states "No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation and the child has the right to the protection of the law against such interference or attacks."[165]

Specific articles target the requirement of states to provide certain basic services to children regardless of their political status. Article 25 asserts, "States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances

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157 *Universal Declaration of Human Rights*, 71 U.N. Doc A/810 (1948), Article 3.
158 Ibid, article,16(3).
159 Ibid, article 9.
160 *International Covenant on Civil and Political Rights*, U.N. General Assembly Resolution 2200 A (XXI) (December 16, 1966) (entered into force March 23, 1976), article 9(1).
161 Ibid., article 9(4).
162 Ibid., article 23.
163 Ibid., article17.
164 *United Nations Convention on the Rights of the Child*, U.N. General Assembly Resolution 44/25 (November 20, 1989) (entered into force September 2,1990), Article 10.
165 Ibid., article 16.

relevant to his or her placement."[166] Article 27 affirms, "States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development."[167] Lastly, Article 31 maintains that "States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity."[168]

In February 1999 the Office of the United Nations High Commissioner for Refugees issued the *UNHCR Revised Guidelines on Applicable Criteria and Standards Relating to the Detention of Asylum Seekers*. In it, UNHCR proclaims that the detention of asylum seekers is inherently undesirable, and that it should be avoided as a general principle. It recommends that there be a presumption against detention, but that if used, detention should be limited to a minimal period of time. Guidelines 6–10 require states to provide certain basic levels of treatment of detainees including education, health care and counseling, and outlines specific conditions for detention. The Guidelines also call for special protection of populations at risk, including women and children. This means that, according to Guideline 2 and the UNHCR guidelines on protection and care of refugee children, minors who are asylum seekers should not be detained.[169] These guidelines are predicated on the 1951 *United Nations Convention Relating to the Status of Refugees* and its 1967 Protocol, both of which the United States ratified in 1968. It mandates that countries not impose penalties on asylum seekers on account of their illegal entrance or presence as long as they present themselves without delay to the authorities and show good cause for the illegal entrance or presence.

UNHCR directly addressed concerns about U.S. detention policies in 1993, before the extreme growth of detention sites in 1996 and again at present:

> The UNHCR Executive Committee has expressed deep concern about the detention of refugees and asylum seekers merely on account of their undocumented entrance or presence in search of asylum, Executive Conclusions, No. 44 recommended that 'in view of the hardships which is involves, detention should be normally avoided.' Detention of refugees and asylum seekers should be normally limited to the shortest time necessary to establish the applicant's identity and the elements of the asylum claim.[170]

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[166] Ibid., article 25.
[167] Ibid., article 27.
[168] Ibid., article 31.
[169] Office of the U.N. High Commissioner for Refugees, *UNHCR Revised Guidelines on Applicable Criteria and Standards Relating to the Detention of Asylum Seekers*, February 1999, http://www.unhcr.org/protect/PROTECTION/3bd036a74.pdf.
[170] Rene Van Rooyan, representative, UNHCR Branch Office to the United States, letter to Doris Meissner, Commissioner, Immigration and Naturalization Service, March 4, 1993.

Appendix C: Family Detention Practice in the International Context

The European Union adopted a directive in 2003, binding on all member states, that declares that asylum seekers within the European Union "may move freely" within the territory of the host member state, but that when necessary for "legal reasons or reasons of public order, Member States may confine an applicant to a particular place in accordance with their national law."[171] The directive also mandates that "Member States shall take appropriate measures to maintain as far as possible family unity as present within their territory, if applicants [asylum seekers] are provided with housing by the Member State concerned."[172]

In 2005, the Council of Europe's Committee of Ministers adopted a set of guidelines that address the "forced return" process. One of those guidelines states that people in immigration detention in Europe "pending their removal from the territory should not normally be held together with ordinary prisoners," and that "the principle of the unity of the family should be respected and families should therefore be accommodated accordingly."[173] The guidelines also state that member states should only detain immigrant children as a last resort, that detained children have a right to education and leisure, that detained families should have separate and private accommodation, and that the "best interest of the child shall be a primary consideration in the context of the detention of children pending removal."[174] However, the guidelines are not binding on member states; rather, member states are "encouraged" to adopt them, but they do not "imply any new obligations for Council of Europe member states."[175]

Britain: Detention of Families and Children

Rules for immigration detention centers in the United Kingdom were promulgated in 2001 in accordance with the Immigration and Asylum Act 1999.[176] The rules state that families in detention are "entitled to enjoy family life at the detention centre save to the extent necessary in the interests of security and safety."[177] They also are to be provided with "accommodation suitable to their needs," and with everything "reasonably necessary" for the care and well-being of infants and children.[178]

The British government has claimed that it seeks to detain families only for as short a time as possible.[179] However, some "NGOs working with detained families argue that there is a gap between stated policy and what happens in practice to families, citing prolonged periods of detention in some cases."[180] In other cases, British immigration officials have engaged in questionable apprehension and detention tactics. One family of asylum seekers in Glasgow, Scotland, after being told by officials that "everything was fine" with their claim, was forcibly taken into detention at 6:00 a.m. one morning. The husband was separated from his wife and son, and they were taken to a detention center in separate cars. Before leaving, they were told that they were "being sent back to their own country," not a detention center. After being

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171 European Union, "Council directive of 27 January 2003 laying down minimum standards for the reception of asylum seekers," Article 7.
172 Ibid., article 8.
173 Committee of Ministers of the Council of Europe, *Guidelines on all stages of the 'forced return' process*. [CM (2005) 40], Guidelines 10 and 11, quoted in Amnesty International, *Italy: Temporary Stay—Permanent Rights: The Treatment of Foreign Nationals Held in 'Temporary Stay and Assistance Centres,'* AI Index: EUR 30/004/2005. (London: June 2005), pp. 61-62.
174 Ibid., guideline 11, p. 62.
175 Ibid., p. 57.
176 D. Stevens, "The Immigration and Asylum Act 1999: A Missed Opportunity?" *The Modern Law Review*, 64(3): 413-438, (2001): p. 431.
177 Detention Centre Rules 2001 SI 2001/238 pt 2 r 11.
178 Ibid.
179 Amnesty International, *Seeking Asylum Is Not a Crime: Detention of People Who Have Sought Asylum*, AI Index: EUR 45/015/2005. (London: June, 20 2005), p. 14.
180 Ibid.

detained for 17 days, they were released on bail; at the time of their interview with Amnesty International their asylum claim still had not been decided.[181]

Germany: Immigration Detention

Much like the United States, anyone without authorization to be in Germany may be detained, including those whose "asylum claim has been rejected and who are subject to…deportation."[182] In terms of families of asylum seekers, anyone over the age of 16 may be detained, and "pregnant women are also detained (as they are in Britain and France), but are sent to hospital six weeks before the due date and allowed to remain for six weeks after the birth."[183] Conditions in German immigration detention facilities can vary from state to state,[184] but in one detention center the conditions appear similar to many American detention centers. It is difficult to move around, and detainees must ask permission for even the smallest privilege, e.g., "to open a window…or fetch hot water for tea."[185] Furthermore, "[t]here are no work or training possibilities in Köpernick and detainees are only allowed one hour's exercise in the yard."[186] Pro bono attorneys visit to dispense legal advice once a week, but detainees are responsible for retaining and paying for their own attorneys.[187]

Australia: Community Detention

Australia maintains several immigration detention centers, called "immigration reception and processing centres."[188] In a review of publicly available documents on the experiences of children in Australian immigration detention, the Australian advocacy group Children Out of Detention found that "[t]wenty five documents allege that detention itself is the cause of significant mental health problems in children, additional to the trauma and persecution already experienced by them in their home country and during their journey to 'freedom.' "[189]

Furthermore, the same review found that "[t]wenty five documents allege that detention itself is a damaging environment for children."[190] In a 2002 submission to a government inquiry on children in detention the Professional Alliance for the Health of Asylum Seekers and Their Children, of which the Royal Australasian College of Physicians is a main sponsor, said that they had learned of a family that had been detained for 10 months without a decision on their refugee status.[191]

Since the publication of the 2002 Children Out of Detention report the Australian Parliament adopted a new law that ends the practice of detaining children and families. With this 2005 law, Parliament gave the minister for immigration and multicultural and indigenous affairs the "non-compellable power" to "specify alternative arrangements for a person's detention," so that the minister can "allow families with children to reside in the community at a specified place (instead of at a detention centre or residential

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181 Ibid., p. 15.
182 Michael Welch and Liza Schuster, "Detention of Asylum Seekers in the US, UK, France, Germany, and Italy: A Critical View of the Globalizing Culture of Control," *Criminology and Criminal Justice*, 5(4): 331-355, (2005), p. 341.
183 Ibid.
184 Ibid.
185 Ibid.
186 Ibid., p. 342.
187 Ibid.
188 International Detention Coalition, *The Heart of the Nation's Existence: A Review of Reports on the Treatment of Children in Australian Detention Centres*, January 2007, p. 2, http://idcoalition.org/portal/component/option,com_remository/Itemid,105/func,fileinfo/id,16/.
189 Ibid.
190 Ibid.
191 Professional Alliance for the Health of Asylum Seekers and Their Children, *Submission to Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention*, (May 2002), p. 27, http://www.racp.edu.au/hpu/policy/asylumseekers/alliance_inquiry.pdf.

housing project) in accordance with conditions that address their individual circumstances."[192] The new law also specified that minors should only be detained as a last resort.[193]

This program was developed in response to the failure of a program to detain all asylum seekers arriving by boat or without valid entry documents in remote detention facilities.[194] Now, all families with children under 18 are released into "community detention" programs in which NGOs provide care and accommodations for families who are still deemed to be in custody of the Australian government. In this program, the "Minister [of the Department of Immigration and Multicultural Affairs] can stipulate different conditions for each family, such as when they need to be at the residence and when they need to report to DIMIA officers. However, within these conditions families can go out shopping, go to school and so on, without being accompanied by a guard."[195]

Sweden: A Model for Others?

Sweden is known for the generosity of its immigration laws as compared to the laws of its peer countries. This reputation extends to its detention policies as well. The Australian study sponsored by the Royal Australasian College of Physicians discussed above also describes several positive aspects of the Swedish system of receiving, housing and sometimes detaining asylum seekers.

- According to Swedish law, someone under the age of eighteen can only be detained for three days or less.[196]
- Unaccompanied minors who arrive in Sweden are taken to government-run group homes.[197]
- Families that arrive without documentation are given family accommodation and must report daily to the Department of Immigration.[198]
- If the Swedish government is uncertain about possible risks to national security, only the husband is detained while other members of the family are released to group homes outside of the detention center. The family members can visit the husband often.[199]
- Asylum seekers can either choose to reside with a relative or friend, or can rent an apartment from the Swedish Migration Board.[200]
- Families of asylum seekers are offered a daily allowance from the Swedish government, and children are "not obliged to attend school although the municipal authority is responsible for ensuring that those who wish to attend school are offered a place" on the same terms as other Swedish citizens and residents."[201]

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192 House of Representatives, Parliament of the Commonwealth of Australia, *Migration Amendment (Detention Arrangements) Bill 2005: Explanatory Memorandum*, http://www.ajustaustralia.com/resource.php?act=attach&id=78.
193 Ibid.
194 Mina Fazel, "Detention of Refugees," *BMJ*, 332:251-252, February 4, 2006, http://bmj.bmjjournals.com/cgi/content/full/332/7536/251.
195 Children Out of Detention, "Community Detention for Families in Australia," http://www.chilout.org/information/community_detention.html.
196 Professional Alliance, *Submission to Human Rights and Equal Opportunity Commission*, p. 51.
197 Ibid.
198 Ibid.
199 Ibid.
200 Swedish Migration Board, *Reception of Asylum Seekers in Sweden*, March 2006, http://www.migrationsverket.se/infomaterial/asyl/allmant/mottagandet_en.pdf.
201 Ibid.

Appendix D: Alternatives to Detention

Executive Summary of the UNHCR Report on Alternatives to Detention of Asylum Seekers and Refugees[202]

In 2002, UNHCR's Agenda for Protection urged 'States more concertedly to explore alternative approaches to the detention of asylum seekers and refugees …'[203] in response to the increasing use of detention of asylum seekers and/or refugees by host governments. This study is a contribution towards that objective. This study undertook research into the practices regarding the use of *alternatives* to detention for asylum seekers and/or refugees of thirty-four States. The information presented herein is valid up to 31 March 2004 and takes no account of changes in law or practice between that date and the date of publication. This study has two main parts. First, it presents a concise overview of the legal standards under international law applicable to both detention as well as alternatives to detention that may give rise to some restrictions on the freedom of movement of asylum seekers and/or refugees. Second, and forming the main part of this study, it presents a range of alternatives to detention used by many receiving countries and attempts to evaluate those measures, specifically in relation to rates of absconding.

This study found that there is a significant difference in the level of effectiveness of a particular alternative depending on whether it is applied in a primarily 'destination', as opposed to a primarily 'transit', State. The statistical data available suggests that restrictive alternatives involving close supervision or monitoring, for the purpose of ensuring compliance with asylum procedures, are seldom if ever required in destination States where most asylum seekers wish to remain. In such States, the rate at which asylum seekers abscond, prior to a final rejection of their claim and/or the real prospect of removal from the territory, seems to be low. Projects established to provide alternatives to detention throughout the duration of refugee status determination procedures in such countries are therefore all highly effective, but this appears to be due less to their design than by happenstance, that is, asylum seekers who reach their 'destination' country are unlikely to abscond because they have a vested interest in remaining in the territory and in complying with the asylum procedure. With this context in mind, there is a real risk of certain alternatives, such as electronic tagging, being misapplied to asylum seekers who would not and should not otherwise be detained, thereby becoming an unnecessary restriction on their freedom of movement and other rights.

In some countries with well-articulated national legislation in which consideration of alternatives is required prior to the issuing of any detention order, official information was unavailable with regard to the implementation of the relevant articles. Available figures and anecdotal evidence from asylum lawyers in those countries suggest, however, that alternative measures were rarely if ever applied to their clients. Although detention of asylum seekers prior to a decision on a claim is, to date, a relatively exceptional measure in those contexts, the non-implementation of the available alternative measures is of concern. In transit States, where the rate of absconding is usually higher, this study found several examples of reception policies and programmes which successfully reduced this rate, without recourse to detention. In some southern European countries, for example, the partial or recently introduced provision of State accommodation and support to asylum seekers is making a marked reduction in the rate at which such persons abscond and move on irregularly to other countries.

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[202] United Nations High Commissioner for Refugees, *Alternatives to Detention of Asylum Seekers and Refugees*, prepared by Ophelia Field and Alice Edwards, Division of International Protection Services, POLAS/2006/03, April 2006.

[203] UNHCR Agenda for Protection, June 2002, A/AC.96/965/Add.1, p.8.

Even in primarily destination States, certain factors were found to further reduce the low rate at which asylum seekers there abscond. The provision of competent legal advice and concerned case management, for example – which serve as non-intrusive forms of monitoring and which ensure that asylum seekers fully comprehend the consequences of non-compliance – were found to raise rates of appearance and compliance. Similarly, legal support, guardianship and specialised group homes run by nongovernmental agencies were found to successfully reduce the rate at which separated asylum-seeking children disappeared from several European countries. Early, detailed interviewing of such children at the border, to fully establish the nature of their situation, was also found to be an effective alternative to placing 'protective' restrictions upon their freedom of movement after admission.

The effectiveness of alternatives used to ensure the availability for removal or compliance with removal proceedings of persons found not to be in need of international protection is less certain, though there were several successful examples to be cited even here. Several countries report successful results from projects for counselling persons not in need of international protection about consenting to mandatory return, and both Australian and British nongovernmental organizations report high rates of success in monitoring sample groups of people released while awaiting removal. Return-oriented centres established in some European States for persons who refuse to cooperate with their forced return (or for asylum seekers with manifestly unfounded claims or, in one case, for separated children), have not so far produced similar evidence of success. For persons found not to be in need of international protection who cannot be returned to their home country, reporting requirements are successfully used in a number of States as an alternative to the inhumane and unlawful prospect of indefinite detention.

This study further found that, where comparative costs of detention vis-à-vis alternatives to detention are available, alternatives are universally more cost-effective than detention. Finally, this study advocates for further empirical research, transparency and public education at the national and international level in relation to all these issues.

ICE Intensive Supervision Appearance Program (ISAP)[204]

See pages 56 to 59.

Legal Orientation Program[205]

See pages 60 to 62.

[204] Handouts, meeting with ICE, June 21, 2004.

[205] Steven Lang, *Pro Bono* Coordinator of the U.S. Department of Justice, Executive Office for Immigration Review, "*Pro Bono* Program Update – January 2005," memorandum to all immigration judges and court administrators, January 2005.

U.S. Immigration
and Customs
Enforcement

Alternatives to Detention

Intensive Supervision Appearance Program (ISAP):

- Contract awarded to Behavioral Interventions, Inc. (BI) April 2004.
- Eight pilot sites initially: Baltimore, Philadelphia, Miami, St. Paul, Denver, Kansas City, San Francisco, and Portland, OR.
- Up to 200 alien participants at each site.
- Purpose of program is to intensely supervise aliens released into the community to ensure their appearance at their immigration hearings and compliance with the immigration judge's order.
- Congress specifically allocated base funding for this type of alternative to detention program.

U.S. Immigration
and Customs
Enforcement

Alternatives to Detention

Intensive Supervision Appearance Program (ISAP):

- ISAP includes utilization of supervision tools such as curfews, electronic monitoring, decreasing levels of restrictions as participants demonstrate compliance, and community collaborations to support the participant.
- The target groups for this program are detained adults (over 18) and meet the eligibility criteria that includes:
  - - Aliens who are not mandatory detention cases
  - - Identity of alien has been established and verified
  - - Alien will maintain a local address within jurisdiction of the ISAP field office site
  - - Alien is non-violent and not a threat to public safety
  - - Aliens must volunteer to participate in the program

U.S. Immigration and Customs Enforcement

Office of Public Affairs
U.S. Department of Homeland Security

U.S. Immigration and Customs Enforcement

June 17, 2004

Contact: ICE OPA
202-514-2648

News Release

ICE UNVEILS NEW ALTERNATIVE TO DETENTION

Pilot project to be introduced in eight cities

Washington, D.C. – U.S. Immigration and Customs Enforcement (ICE) today announced a new pilot program providing a less restrictive alternative to detention. The Intensive Supervision Appearance Program (ISAP) will be introduced on June 21, 2004, at eight ICE locations across the United States. The cities where this new program will be introduced are Baltimore; Philadelphia; Miami; St. Paul; Denver; Kansas City; San Francisco; and Portland, Oregon.

"ISAP is an alternative to detention that further enables ICE to prioritize detaining criminals and other public safety and security risks;" said Acting Director of Detention and Removal Operations Victor Cerda. "ISAP aims to promote integrity in the immigration system by helping to ensure compliance with court appearances and orders, and will likely relieve pressure on detention space in pilot cities by providing this alternative to aliens who might otherwise be detained."

ICE's Office of Detention and Removal Operations (DRO) manages ISAP in partnership with Behavioral Interventions, Inc. (BI) of Boulder, Colorado. ISAP, one of several alternatives to detention pilot projects currently being tested, is a supervision program in which case specialists are assigned to a limited caseload of participants and are responsible for monitoring those participants in the community by using tools such as electronic monitoring (bracelets), home visits, work visits and reporting by telephone. Case specialists will also assist participants in obtaining pro-bono counsel for their hearings and help them to receive other types of assistance to which they may be entitled.

In order to be eligible for participation in ISAP, an alien must be an adult with a confirmed identity who does not pose a threat to the community or national security. Additionally, ISAP will be available only to aliens who are not subject to mandatory detention; who are pending immigration court proceedings or are awaiting removal from the United States; and who will be residing within the managed area. ISAP is a voluntary program; all participants must agree to participate and comply with the conditions of their release. Aliens who violate the conditions of their release may face detention or increased supervisory restrictions. ICE will evaluate the program at the end of the pilot and based on the results determine any possibilities for future implementation.

- ICE -

U.S. Immigration and Customs Enforcement (ICE) is the largest investigative arm of the Department of Homeland Security, responsible for the enforcement of border, economic, infrastructure and transportation security laws. ICE seeks to prevent acts of terrorism by targeting the people, money and materials that support terror and criminal networks.

www.ice.gov

U.S. Department of Justice
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Pro Bono Program Update - January 2005

To: **All Immigration Judges and Court Administrators**

From: **Steven Lang, Pro Bono Coordinator**

I am pleased to send all of you this update on the Pro Bono Program. Since April of 2000, the Pro Bono Program has worked to improve the level and quality of *pro bono* representation. This has been carried out primarily through initiatives which facilitate access to information and create new incentives for attorneys and law students to take on *pro bono* cases before the immigration courts and Board of Immigration Appeals (BIA). The Program has also continued to perform an important community relations role, with the Coordinator often serving as liaison between our agency and the non-profit legal community on issues related to legal assistance for indigent aliens.

Many of the Program's accomplishments owe their success to the numerous Immigration Judges, Court Administrators and Headquarters' staff whose interest and active involvement in the Program have helped to shape its approach and direction. Our agency has long recognized the mutual benefits derived from strong *pro bono* participation in the immigration hearing process. Working together, the Program continues to look forward to your comments, suggestions, and enthusiasm as we contend with current and future challenges.

In these difficult budget times, the Pro Bono Program has limited its focus over the past year to three major initiatives - the Legal Orientation Program, the BIA Pro Bono Project, and interagency initiatives aimed at improving access to *pro bono* legal services for Unaccompanied Alien Children. The Program also continues to promote and develop two earlier initiatives - the Pro Bono Program webpage, and the Model Hearing Program (MHP).

I. Legal Orientation Programs

In FY'02, Congress appropriated $1 million to the INS for "Legal Orientation Programs." The Pro Bono Program lead efforts to transfer these funds to EOIR, as well as to determine the best available means of funding such programs across the country. These funds have recently been renewed. We are currently in the process of evaluating program performance and reviewing proposals for continued, as well as new funding.

EOIR's past experience with Legal Orientation Programs (also known as "Rights Presentations") demonstrated that they are beneficial to all parties involved. These programs result in greater judicial efficiency for EOIR, less time for aliens in DHS detention, and greater access for detained aliens to legal information, counseling, and *pro bono* representation.

Through such orientations, representatives from nonprofit organizations provide comprehensive explanations about immigration court procedures along with other basic legal information to large groups of detained

individuals. The orientations are normally comprised of three components: 1) the interactive group orientation, which is open to general questions; 2) the individual orientation, wherein non-represented individuals can briefly discuss their cases with experienced counselors; and 3) the self-help component, wherein those detainees who wish to pursue claims for relief are provided with self-help legal materials and assistance through group workshops, where appropriate.

EOIR currently maintains a contract (Blanket Purchase Agreement - BPA) with Norwich University to carry out a comprehensive Legal Orientation Presentation Training Program at six detention sites across the country. Serving as the Contracting Officer's Technical Representative (COTR), the Pro Bono Coordinator has worked with Norwich University, six non-profit agency subcontractors, EOIR components, DHS and local detention facility representatives to implement the programs at the following sites:

	Detention/Immigration Court	Subcontractor
1.	Port Isabel, Texas	American Bar Association (through ProBAR)
2.	Eloy, Arizona	Florence Immigrant & Refugee Rights Project (FIRRP)
3.	Batavia, New York	Erie County Bar Association VLP
4.	Seattle, Washington	Northwest Immigrant Rights Project (NWIRP)
5.	Lancaster, California	Catholic Legal Immigration Network, Inc. (CLINIC)
6.	Aurora, Colorado	Lutheran Immigrant & Refugee Services (LIRS), together with the Rocky Mountain Immigrant Advocacy Network (RMIAN)

More than 23,000 detainees are expected to benefit from the program in the first 12 months of full operation, or roughly 20 percent of all DHS detainees who appear before the Immigration Courts each year. As of the end of August 2003, preliminary results have shown an **average decrease in detained proceeding completion times of 1.5 days per detainee** (from receipt to proceeding completion date), with three of the **newest sites averaging 2.2 days** (from first Master Calendar hearing to proceeding completion date) as compared to the 12-month period preceding each sites' start date.

II. The BIA Pro Bono Project.

Since its implementation in January of 2001, the Project has succeeded in recruiting over 350 attorneys, law students and Accredited Representatives to write appeal briefs for over 250 DHS detainees who would have otherwise appeared without representation before the BIA. The Project was recently expanded to include certain non-detained case appeals, as well.

Under the Project, the Catholic Legal Immigration Network (CLINIC), Capital Area Immigrant Rights (CAIR) Coalition, American Immigration Law Foundation (AILF) and National Lawyers Guild send experienced volunteer attorney "screeners" to the BIA Clerk's Office every week to review selected case appeal transcripts. After review, the screeners write redacted summaries for cases they believe to be most suitable for *pro bono* representation. These summaries are e-mailed to participating *pro bono* representatives throughout the country who may select cases in which to enter as counsel. Those representatives who accept a case under the Project receive a copy of the file, as well as additional time to file the appeal brief.

Legal representation in many of these cases has already had a meaningful impact. Since attorneys or accredited representatives usually identify and argue the issues better on appeal, immigrants with meritorious cases have a greater chance of success. Representation also reduces procedural errors and enables the BIA to provide a more effective and timely case review.

III. Unaccompanied Alien Children in DHS/ORR Custody

Since early 2003, the Pro Bono Program, together with OCIJ, has been working with the newly-created Division for Unaccompanied Children's Services at the Office of Refugee Resettlement (ORR) to discuss, among other matters, new initiatives aimed at improving legal assistance for this special population.

EOIR's involvement with ORR was anticipated by Section 462 of the Homeland Security Act in "developing a plan to be submitted to Congress on how to ensure that qualified and independent legal counsel is timely appointed to represent the interests of each such child," and in "compiling, updating, and publishing at least annually a state-by-state list of professionals or other entities qualified to provide guardian and attorney representation services for unaccompanied alien children."

Efforts are currently underway to develop and implement a pilot program in Chicago which would combine greater pro bono attorney involvement with a new volunteer 'Guardian Ad Litem' (GAL) component. The GAL would function *in loco parentis* in the context of any immigration court proceedings to encourage the child to participate to the fullest extent possible. The GAL would also make a determination as to the best interests of the child which may be offered to the attorney and/or immigration court as a recommendation.

Together with ORR, the Pro Bono Program is also forming an interagency pro bono committee to better coordinate national and local pro bono efforts to assist these children.

IV. Pro Bono Program Webpage

The Pro Bono Program has steadily expanded its heavily-visited internet webpage (#1 beyond Homepage). The webpage currently includes an online version of the "List of Free Legal Service Providers," and a variety of links to governmental and non-governmental sites, including bar associations, law school immigration clinics, human rights groups and *pro bono* organizations providing access to asylum documentation and self-help legal materials (http://www.usdoj.gov/eoir/probono/probono.htm).

Also found on the Pro Bono Program webpage are the recently-posted "Immigration Court Representation Summaries." These concise reports provide detailed information regarding the number of case completions, as well as custody status, nationality, language, and forms of relief requested by individuals in removal proceedings. The reports are designed to assist *pro bono* groups in their efforts to assess the needs of their local communities in order to better direct their services.

V. Model Hearing Program

The Model Hearing Program is an educational program developed by the Pro Bono Program to improve the quality of advocacy before the court, as well as increase levels of *pro bono* representation. Model Hearings consist of small-scale 'mock' trial training sessions held in the immigration court and presented by volunteer immigration judges. The training sessions, carried out in cooperation with partnering bar associations and/or *pro bono* agencies, provide practical and relevant 'hands-on' immigration court training to small groups of attorneys/law students with an emphasis on practice, procedure and advocacy skills. Participants receive training materials and CLE credit, and agree to perform a minimal level of *pro bono* representation throughout the year. Since June of 2001, over 13 Model Hearing training sessions were held in the following court locations: San Diego, Dallas, York, Cleveland, Newark and New York City. Special thanks to the immigration court judges and staff in York, Pennsylvania, New York City, and Dallas for their help in facilitating Model Hearings this past year.

Appendix E: Facility Comparison Chart

	Hutto	Berks
Physical Setting	• 512-bed facility • Brownsville, Texas (30 miles outside Austin) • Former prison • Pod system • 100 pan/tilt/zoom cameras • @ $180 a day per detainee at full capacity	• 84-bed facility • Leesport, Pa. (1 hour outside Philadelphia) • Former nursing home • @ $195 a day per detainee
Processing	• Detainees wear prison uniforms • Detainees not issued enough clothing to accommodate the laundry schedule	• Detainees permitted to wear own clothing except shoes
Accommodations	• Detainees sleep in prison cells • Limit of two beds and a crib in each cell, so larger families are separated at night • Cell doors closed at night but not locked, laser beam prevents entry/exit • If not sleeping in same room, parents cannot access children at night • Residents confined to pod common area when other activities not scheduled • Common area in pod equipped with TVs, video games, playing cards • Adults and children given five minutes to shower • Head counts several times a day • No toys allowed in cells; nothing may be attached to walls • At time of visit, no stuffed animal or dolls	• Detainees sleep in dorm-style rooms • Parents separated from children over five at night • Guards stationed at dorm room doors at night • Mixed reports regarding parental access to children at night • Detainees confined to two common areas when other activities not scheduled • Common areas equipped with sofas, TV, plastic toys, games, game table • One toy, doll or stuffed animal allowed in room at night
Food Services	• Menu repeats every week • Detainees not permitted to select food • No food besides children's snacks may be taken out of cafeteria • 10-20 minutes to eat • 3,500 calories per day • Many complaints about food; children and pregnant women claim to be losing weight	• Cafeteria style – detainees select their own food • Shortage of culturally appropriate food and choice for vegetarians • 45 minutes for each meal
Medical Care	• Medical screening at arrival • Health care provided by PHS • One nurse practitioner, one dentist, 5 days/week; doctor once/week • Detainees submit medical call slip to request medical attention • Medical care not received in a timely manner • Medicines provided not appropriate • Pregnant mothers reported not being provided with prenatal care • Detainees reportedly receive dental care without the use of Novocain or anesthesia	• Medical screening at arrival • Care administered through contract with family practice clinic • Sick call seven days/week; nurse on call when physician not on site • Medical services not always provided in timely fashion • Medicines provided not appropriate • No major complaints regarding medical service • Dental care reportedly available only for children
Education	• At time of visit, one hour of education per day (later increased to four) • Teachers either state certified or eligible for certification • Subjects include science, social studies, language arts, math and ESL • Elementary classes just sing and color	• Education administered by Berks County Intermediate Unit – four to five hours per day • Classes governed by the Pennsylvania Alternative Curriculum Standards • Students study English, social studies, math, science • Each classroom equipped with computers that utilizes PLATO program
Recreation	• One hour of recreation Monday–Friday; none on weekends	• Recreation for minimum of one hour/day, seven days/week, often more

	• Recreation held in large gym equipped with basketball hoops and balls, kitchenettes, plastic trucks • Children not permitted to have their own toys or to receive toys from outside the facility • Families report never going outside, not being allowed to go outside on weekends • Detainees not permitted to leave facility for recreational outings • Library carts circulate to pods every five days	• Outdoor recreation when weather permits • Gym available for recreation; basketballs, nets, small scooters available • Detainees participate in facility-run field trips • Organized activities for detainees • Library cart rotates regularly
Discipline	• Time-outs • Verbal and psychological abuse by staff • Recreation withheld as punishment • Disproportionate punishment for small incidents and normal child behavior • Threats of family separation frequently used as means of discipline • Actual separation of days or months reportedly used as disciplinary measure • Write-up of child or parent for child's misbehavior • Disciplinary problems handled by sending entire family to counseling • Climate control used for discipline	• Time-outs (sometimes as long as 30 minutes) • Verbal and psychological abuse by staff • Recreation withheld as punishment • Disproportionate punishment for small incidents and normal child behavior • Enforced silence of a week or more used as disciplinary measure • Threats of family separation frequently used as means of discipline • Actual separation of days or months reportedly used as disciplinary measure • Many children lose respect for parents because of parents' lack of control at the facility
Access to Counsel	• Detainees provided with list of legal services; list also posted at phones • Law library available • Two televideo courtrooms • Attorney-client meetings conducted in private room, but parents must keep their children with them • Attorneys limited to speaking with 10 people per visit • No Legal Orientation Program	• Detainees provided with list of legal services • Law library available • Some televideo courtrooms; actual courtroom for masters • Attorney-client visitation room (also used for asylum officer to conduct credible fear interviews) • No Legal Orientation Program • Distance from major metropolitan area limits availability of *pro bono* counsel
Telephone Access	• Four phones in common area • Detainees able to purchase $10, $15 and $20 phone cards	• Two phones located in hallway • Vending machine sells phone cards @ $1/minute
Visitation and Spiritual Support	• All non-attorney visits are non-contact • Communication occurs through telephone handset attached to wall, meaning that visitor can talk to only one member of family at a time • Visitation hours limited to 8 a.m.–5 p.m. on weekends; detainees permitted only one trip to restroom during visitation • All detained family members must participate in any visitation • Guards present in visitation rooms • Spiritual counseling and services provided as needed; most services Christian; accommodations made for Muslims	• Detainees permitted visitors 7 days/week, actual contact limited • Guards present in visitation rooms • Service and spiritual counseling available intermittently and depending on religion • Transport to local churches discontinued

Appendix F: Acknowledgements

This report was written by Michelle Brané, director, detention and asylum program, Women's Commission for Refugee Women and Children, and Emily Butera, policy advocate for Lutheran Immigration and Refugee Service (LIRS). Content review was conducted by Andrea Black, network coordinator for Detention Watch Network; Susan Krehbiel, LIRS vice president for protection; Joan Timoney, Women's Commission director of advocacy and external relations; Matt Wilch, LIRS senior counsel for policy and advocacy; and Liana Del Papa, Women's Commission program specialist, advocacy and detention and asylum program. Additional content support was provided by Scott Kuhagen, LIRS assistant for access to justice; Clare Berke, LIRS legislative assistant; and Women's Commission interns. We would like to thank Ralston Deffenbaugh, LIRS president; Carolyn Makinson, Women's Commission executive director; and Annie Wilson, LIRS executive vice president, for their support and guidance. Style and copyediting performed by Valerie Anne Bost, LIRS publication specialist and Cassandra Champion, LIRS director for communications. Megan McKenna, Women's Commission senior coordinator, media and communications, provided content review and editing. Diana Quick, Women's Commission director of communications, provided editorial support. Grace Cheung, Women's Commission program manager, communications, designed the report.

The Women's Commission and LIRS wish to acknowledge the assistance of the University of Texas Law School Immigration Clinic, which has shared with the authors of this report numerous accounts regarding the treatment of families at the T. Don Hutto Residential Center, and who interviewed many of their clients on our behalf. We would also like to acknowledge ICE staff, CCA staff and Berks staff for the time they took to show us their facilities.

Finally, the Women's Commission and LIRS wish to thank the legal service providers and academics who provided both logistical support and their expertise to the delegation. Above all, we would also like to express a special thanks to the courageous families who shared with us their testimonies of experiences in family detention.

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Francisco Castaneda

- *Detained by ICE from March 2006 to February 2007.*
- *Suffered from very painful lesions on his penis; increasing in size and frequently bled.*
- *Denied treatment (circumcision) and biopsy because immigration medical personnel concluded that any treatment was "elective."*
- *Upon release, diagnosed with penile cancer; penis surgically removed; 5+ rounds chemo*

DIHS Public Statement	Response
"I don't see this as improper care. I think this is good care. . . . It's just unfortunate that this had a bad outcome." Timothy Shack, medical director for the Division of Immigration Health Services, quoted in Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASHINGTON POST, June 13, 2007.	1. Doctors agreed the proper treatment was circumcision, and the proper diagnostic test to determine if he was suffering from cancer was a biopsy. He received neither. This was not good care, it was no care. 2. When Castaneda finally saw an oncologist, the oncologist "strongly agree[d] that it requires urgent urologic assessment of biopsy and definitive treatment." But medical personnel at SDCF declined to admit Castaneda for urologic consultation and biopsy because an outpatient biopsy would be "more cost effective." He was not taken to see that urologist until 11 weeks later.

Martin Hernandez Banderas

- *Detained by ICE from October 26, 2006 to February 22, 2007.*
- *Developed gangrenous, infected ulcer.*
- *By the time he was taken to the hospital, he had a severe, potentially fatal bone infection and doctors nearly amputated his foot.*

DIHS Public Statement	Response
"I have 173 pages of records showing that he was properly monitored." Timothy Shack, medical director for the Division of Immigration Health Services , quoted in Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASHINGTON POST, June 13, 2007.	The length of the print out is irrelevant. The substance is not. Records show he complained for weeks about increasing pain and a foul odor coming from the wound, which was increasing in size, turning black, and oozing. But from January 11-15, 2007, on-site medical staff described the wound as healing, with "a normal, healthy tissue type odor" and "no sign of active infection, pus or purulence." When Banderas was rushed to the hospital on January 17—just two days later—doctors diagnosed him with a large, gangrenous ulcer in his foot and ankle and a severe, potentially fatal bone infection that nearly resulted in amputation.
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"He was not among the general population. He was receiving 24-hour care." Timothy Shack, medical director for the Division of Immigration Health Services , quoted in Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASHINGTON POST, June 13, 2007.	According to DIHS's own medical records, Tim Shack's statement is untrue. Banderas was in general population throughout his detention, except for a brief eight-day period when he received intravenous antibiotics in the infirmary. After those eights days he was returned to general population for four weeks, where he was not given 24-hour care, and was not even given assistance over the weekend in changing the dressings on his wound.

Physical Examinations for Detainees

ICE Public Statement	Response
"ICE officials denied claims of medical mistreatment, noting that detainees undergo physical examinations within 12 hours of entering detention." Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASHINGTON POST, June 13, 2007.	1. The DHS OIG attempted to review 115 medical files at four detention facilities to ensure that each detainee received an initial medical screening upon arrival. 19% of the requested files either contained insufficient documentation to even determine whether the detainee received an initial screening or evidenced that the detainee failed to receive the initial screening. 2. The DHS OIG also attempted to review 122 medical files to determine whether detainees received a physical examination within 14 days of arrival (not 12 hours). 21% of the requested files either contained insufficient documentation or evidenced that the detainee did not receive a physical examination within 14 days of arrival.[1]

[1] Department of Homeland Security, Office of Inspector General, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, OIG-07-01 (December 2006), 3-4, available at http://www.dhs.gov/xoig/assets/mgmtrpts/OIG_07-01_Dec06.pdf.

Respect for Privacy

ICE Public Statement	Response
"Virginia Kice, a spokeswoman for U.S. Immigration and Customs Enforcement, said privacy laws prevented the agency from discussing the details of treatment." Greg Krikorian and Francisco Vara-Orta, *Groups Seek U.S. Probe of Inmate's Death*, LOS ANGELES TIMES, Aug. 29, 2007.	1. ICE and DIHS cannot pick and choose when they will answer questions about poor medical care and in-custody deaths. Both ICE and DIHS have spoken publicly about Francisco Castaneda and Martin Hernandez Banderas,[2] and have provided details about the death of Rosa Isela Contreras-Dominguez, a 38-year-old pregnant detainee who died in El Paso.[3] 2. In a series of lawsuits filed by the ACLU on behalf of children detained at the Hutto facility, ICE publicly filed private medical records for the minor plaintiffs as well as private medical and mental health records for the children's parents, who were not even parties to the lawsuits. The Court scolded the government for disclosing this private health information without consent. In the order sealing the medical records, the Court wrote that "Defendants have abused their control of these sensitive records throughout this litigation. When these cases were first filed, Defendants refused Plaintiffs and their parents access to their own medical records without ever providing a rational basis for the refusal to Plaintiffs or this Court. Now, Defendants have made these same records public in a manner that is both inappropriate and legally deficient."[4]

[2] Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASHINGTON POST, June 13, 2007.

[3] Darryl Fears, *3 Jailed Immigrants Die in a Month*, WASHINGTON POST, Aug. 15, 2007; Susan Carroll, *Pregnant Woman Dies in Immigration Custody*, HOUSTON CHRONICLE, Aug. 10, 2007; Associated Press, *Pregnant Woman Dies at ICE Detention Center in El Paso*, HOUSTON CHRONICLE, Aug. 9, 2007.

[4] Order, *Emptage v. Chertoff*, No. 07-cv-158 (W.D. Tex. Apr. 6, 2007).

October 4, 2007

For a hearing on "Detention and Removal: Immigration Detainee Medical Care" before the House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law

Written testimony submitted by Fr. Thomas P. Greene, S.J., Research Fellow at the Jesuit Social Research Institute of Loyola University, New Orleans

My name is Fr. Thomas Greene, SJ and I am an attorney, a Jesuit, and a Catholic priest. I currently work with the Jesuit Social Research Institute of Loyola University of New Orleans, which conducts research and advocacy on immigration issues. I write from my perspective as a research fellow, but also from my experience as a priest and attorney, who has represented I.C.E. detainees before the immigration court (E.O.I.R.). I began representation of immigrants in 1997 and since that time, I have witnessed a steady decline in the standard of medical care. I have worked in detention facilities in California, Texas, and Louisiana. I have also visited detention centers in Mexico, the Dominican Republic, and Haiti. I used to hope that those detention facilities would bring their standard of medical care up to those of the Unites States; however, I now believe that we are lowering our standard of care to the level of those countries. My recent visits to detention centers in Louisiana and Texas raise significant concern over the medical treatment of I.C.E. detainees.

The thirty-eight standards of care for detainees issued by I.C.E. provide a foundation for resolving medical issues, yet the privately contracted facilities are not diligent in their efforts to comply with these regulations. Often when medical complaints are brought to the attention of privately run I.C.E. facilities, they respond that these standards are not legally enforceable, but rather goals for which they should strive. In sum, the lack of enforceable standards makes the situation untenable, and leaves detained immigrants in situations of undue pain and suffering due to lack of medical care. I strongly urge this committee to make medical care standards and guidelines a mandatory feature of ICE detention facilities and a legislative priority.

Recently, I met with a detainee who suffered from epileptic seizures. He asked me to expedite his deportation proceedings because his medicine was confiscated at the time of his arrest. Although he was being given medication, the dosages were not adequate for his condition. Upon arrival at the detention facility, he requested a bottom bunk bed due to his medical condition and fear of falling out of bed if convulsions occurred. His request was denied, and he later fell from the bed during a seizure episode in the middle of the night. The guards attempted to bring him out of the seizures by throwing water on him and kicking his torso. The failure to properly medicate the detainee or train the staff in basic medical procedures is inexcusable.

Mr. Jawetz has pointed out the grossly deficient standard of care for those with acute and critical medical conditions, and documented the bureaucratic procedures which must be followed when a detainee requests medical care. Other panelists have offered powerful and compelling testimony concerning the deaths of loved ones. I cannot offer anything more to what has been said regarding what those traumatic events, yet I wish to add that even the most simple and basic levels of medical care are absent in many detention facilities.

I have received numerous reports from legal service providers in South Texas regarding deficiencies in the following areas:

- mental healthcare, including the failure to screen severe cases of mental illness in placing detainees with the general population
- an increase in miscarriages of pregnant women at a detention center, including five in one facility
- an infestation of Brown Recluse Spiders, which has caused bites and subsequent infection from lack of medical care at the detention center

I.C.E. detention facilities are proliferating in the South and Southwest. Detainees are arriving from all parts of the United States, and the detention centers in the rural South and Southwest are unable to keep up with the pace at which detainees are being transferred into their facilities. These remote "turnstile" facilities provide no means for a detainee to access his or her medical records. Property, including medicine, is confiscated from detainees when local police arrest them, and the detainees are quickly shipped thousands of miles away to remote detention facilities, where the property and medicine never arrive. Consequently, doctors and medical staff at the receiving I.C.E. facility are left with no medical records or prescription information with which to prescribe treatment. The basic *Guidelines of the American Medical Association for Physicians Counseling Patients on Prescription Medication*[1] are, therefore, disregarded. This places doctors and detainees in a position of having to guess and experiment with correct dosages and types of medication. Surely, this situation can be resolved with communication between I.C.E. and local police authorities; however, to date there has been little impetus for change, and we continue to receive an inordinate amount of complaints regarding confiscated property and medicine.

It is my hope and prayer that this Committee will take steps to improve accountability on the part of I.C.E. The medical care of detainees is a situation which is dire and getting worse each day as the detention facility industry expands. It appears that D.H.S. is beginning to base its standard of care on human documents (i.e., legal status) rather than human dignity. I urge Congress to pass binding immigration standards that will ensure the delivery of adequate healthcare for detained immigrants. I thank the members of the Subcommittee for their time in considering my testimony.

Respectfully submitted,

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[1] Guidelines of the American Medical Association Regarding Prescription Medications are available at http://www.fda.gov/ohrms/dockets/dockets/00n0001/c000004.pdf

Statement of the National Immigrant Justice Center
Hearing of the House Committee on the Judiciary
Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law
Hearing on Detention and Removal: Immigration Detainee Medical Care
October 4, 2007

The National Immigrant Justice Center promotes the human rights of non-citizens through legal services, advocacy, and strategic impact litigation. Based in Chicago, Illinois, the National Immigrant Justice Center offers free or low-cost legal representation to approximately 8,000 immigrants, refugees, asylum seekers, unaccompanied immigrant children and victims of human trafficking each year, including hundreds of immigrants detained in jails under contract with U.S. Immigration and Customs Enforcement (ICE).

The National Immigrant Justice Center is a leading national voice for immigration reform, advocating for access to legal counsel and due process protections for all non-citizens. In addition to legal representation, National Immigrant Justice Center attorneys, *pro bono* attorneys, and accredited representatives regularly visit the ICE-contracted jails to offer "Know Your Rights" legal orientation presentations to detained immigrants, and individual consultation to determine whether individuals are eligible for legal remedies.

The National Immigrant Justice Center is nationally recognized for its quality legal services and impact litigation, working with the largest *pro bono* network in the nation. This network includes 700 *pro bono* attorneys, who handle individual cases and strategic litigation in the federal courts.

The National Immigrant Justice Center is grateful for the opportunity to submit this statement for the hearing record. Our years of experience serving the detained immigrant population prompt us to make the following points and recommendations for reform.

Revelations of Deaths in Immigration Detention Reflect Systemic Problems with the Provision of Health Care

In June 2007, the *New York Times* reported the shocking news that 62 immigrants died in civil detention between 2004 and 2006.[1] The number surprised legal aid advocates, who were well aware of gross failures to provide medical attention in certain cases as well as systemic

[1] Nina Bernstein, "New Scrutiny as Immigrants Die in Custody," *New York Times*, June 26, 2007.

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weakness in the provision of basic care. Nonetheless, most dedicated legal aid providers were unaware that the number of deaths was so high.

The *Times* article demonstrated the lack of transparency and accountability in the immigration detention system. Many of the 27,500 immigrants held in federal custody each day are in county jails and/or in rural areas, far from family and legal aid providers, who might help these non-citizens obtain medical care as well as legal representation. Under such circumstances, it is tragic but not impossible for deaths to go unnoticed. ICE declined to share details on the 62 cases with the *New York Times*; non-governmental organizations are pressing for the release of this data.

A. The DHS Office of Inspector General Finds Poor Treatment of Immigrants in Federal Custody

The *Times* article came on the heels of a January 16, 2007, report by the Office of Inspector General (OIG) of the Department of Homeland Security (DHS) on the treatment of immigrants held in detention by ICE. Reviewing five detention facilities around the nation, OIG investigators documented systemic failures to respond to detainees' requests for medical treatment and denial of information regarding legal services.

The report echoed problems that detainees in the Chicago area and in other parts of the country routinely report to attorneys at the National Immigrant Justice Center (NIJC). The most common complaints are a lack of adequate medical care, limited access to legal information, non-functioning telephones, and poor access to legal representation.

NIJC provided data to OIG investigators in 2004 and 2005 as they undertook the study. In addition, NIJC filed a series of Freedom of Information Act (FOIA) requests regarding DHS compliance with minimum detention standards, following evidence of widespread non-compliance in the Midwest and nationally. NIJC is currently litigating the FOIA case in federal court.

The National Detention Standards were developed in 2000 by the then-Immigration and Naturalization Service and the American Bar Association to ensure the "safe, secure, and humane treatment of individuals" detained by federal immigration enforcement, now conducted by ICE. Each of the facilities investigated by the OIG was noncompliant with the detention standards in one way or another. For example, detainees were not screened for health conditions, and four of the five investigated facilities failed to respond to detainee requests for medical treatment.[2] At two of the facilities investigated by the OIG, detention officials told investigators that they were not aware that there are specific ICE standards for detainees and that they had no knowledge of ICE's policies and procedures pertaining to ICE detainees.[3] These correctional officers were trained to treat criminal inmates the same as immigrant detainees under civil confinement.[4]

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[2] Report of the DHS Office of Inspector General, "Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities," OIG-07-01, December 2006, at 1.
[3] *Id.* at 31.
[4] *Id.*

In addition to the problems outlined by the OIG, detainees in the Midwest face additional obstacles in accessing adequate health care because they are often isolated and dispersed in small county jails. One woman who was detained at McHenry County Jail in Woodstock, IL, following a worksite raid in Indiana in March 2007 told *Chicago Public Radio* that she was without her medications for Lupus, a chronic autoimmune disease, for the eight days she was in custody.

The National Immigrant Justice Center has encountered other detainees with untreated medical conditions, including women who have been separated from newborn babies and denied appropriate post-natal care. In another case, a woman asylum seeker detained in McHenry County Jail in 2005 died in custody after repeatedly requesting mental health treatment for herself because she was at risk of suicide. A wrongful death case is currently pending in the federal courts.

In addition to its findings related to health care, the OIG found that in some facilities, detainees do not have regular access to working phones, which restrict their ability to contact attorneys. Non-citizens in remote jails who have no access to lawyers face virtually insurmountable obstacles to pursuing the legal relief for which they may be eligible. Likewise, without legal representation, these individuals will almost certainly struggle to obtain needed medical care that is denied by the government. In fact, it is often lawyers who raise the issue of health and medical care for their clients. Unrepresented immigrants may never have a forceful voice advocating for their care.

The OIG described one example in which the jail facility "took at least 16 business days to grant a detainee's request to call an attorney as opposed to the 24-hour time limit required by the [detention] standard."[5] In the experience of the National Immigrant Justice Center, which represents detained immigrants held in Illinois and Wisconsin, certain jails' phones work sporadically at best, impeding the ability of detainees to contact counsel.

B. U.S. Commission for International Religious Freedom Finds Asylum Seekers are Particularly Vulnerable in Detention

Asylum seekers, torture survivors, victims of domestic violence and trafficking are particularly vulnerable to harm in immigration detention, whether through the denial of mental health treatment or the failure of jailers to identify their unique medical and mental health needs. Shortly after the OIG report was released in January 2007, a bipartisan panel criticized the Department of Homeland Security (DHS) for detaining asylum seekers in penal conditions.

The bipartisan U.S. Commission on International Religious Freedom (USCIRF) issued an initial report in 2005 calling on DHS to modify its policies. DHS never formally responded to the recommendations. The Commission's "report card," released on February 7, 2007, excoriated DHS for its failure to ensure that asylum seekers are protected and given an opportunity to seek refuge in the United States. Like the OIG, the USCIRF also chastised

[5] *Id.* at 24.

DHS for denying these individuals the opportunity to find legal advocates. The USCIRF also found that asylum seekers are typically treated as criminals while they are detained.

Detention weighs heavily on asylum seekers who are detained, especially if they fled police or government persecution in their countries of origin. Shahid Haque, a Chicago attorney at the law firm of Jenner & Block provided *pro bono* representation to a detained Togolese asylum seeker in collaboration with the National Immigrant Justice Center. "Several months of detention wore on my client's health," Haque said. "He had trouble sleeping, and this affected his ability to recall the level of detail required for his asylum hearing." In addition to the detention standards' requirement that detainees be provided medical treatment, domestic and international law provide protections for asylum seekers. DHS routinely violates these safeguards.

Even those who are responsible for detaining non-citizens under ICE contracts have complained about the failure of the agency to meet basic health standards. "The Department of Homeland Security has made it difficult, if not impossible, to meet the constitutional requirements of providing adequate health care to inmates that have a serious need for that care," stated Thomas Hogan, the warden of a York County, PA, detention center in an affidavit last year.[6]

Recommendations:

Important legislation designed to protect the rights and ensure the health and safety of immigrants in detention is pending in the 110th Congress in both the House of Representatives and the Senate. The Secure and Safe Detention and Asylum Act was included in the STRIVE Act (H.R.1645) last winter. It was adopted by unanimous consent in slightly different form as an amendment to the Senate comprehensive immigration reform bill (S.1348), which was sidelined by a filibuster in June 2007.

This legislation, championed by Representatives Gutierrez and Flake and Senator Lieberman, makes a number of positive changes to the immigration detention system including implementation the ICE Detention Standards and improved provision of medical care. The bill also creates an oversight body to monitor implementation and bring greater accountability to the detention system. This oversight office would conduct frequent and unannounced inspections of all detention facilities.

The Secure and Safe Detention and Asylum Act also improves access to counsel for detained immigrants, which is critical to guaranteeing that the rights of detainees are respected and that these individuals are afforded proper medical treatment. Specifically, the Act expands legal orientation programs (LOPs) for detained immigrants to ensure that immigrants understand their rights and the availability of relief, if any. Now available in only a small number of locations, LOPs would be offered nationwide under the Act, providing non-citizens held in remote areas access to information on their rights and the possibility of securing legal representation. The Act also calls for detention facilities to be located near sources of free or

[6] *Id.*

low-cost legal services.

Finally, Congress must press ICE to exercise its discretion to release immigrants who are not a threat to the community or a flight risk on their own recognizance or on bond. To detain individuals who are not a danger to the community is an unnecessary expense to taxpayers. Detention costs, on average, $65 to $85 per day per detainee.[7] Alternatives to detention cost as little as $8 per day.[8] When detention is necessary, alternatives that have been proven reliable and cost effective should be fully utilized. Congress should increase funding for these alternative programs rather than continue to increase the number of detention beds for immigrants. The Act calls for increased use of detention alternatives, such as the successful pilot Intensive Supervision Appearance Program, or programs run by faith-based or other non-governmental groups.

Conclusion

We are a nation of immigrants. Americans have always welcomed immigrants, who in turn have made significant contributions to our society. American values and traditions provide for the just treatment of individuals, not the detention and deportation of hard-working and otherwise law abiding individuals. These values certainly do not support the deprivation of health care to those who are in need and who, because they are incarcerated, have no opportunity to obtain treatment on their own.

# # # #

[7] "Different sources estimate that it costs ICE an average of $65-$80 a day to detain one person although in some facilities the costs have been as high as $225 a day. Despite the fact that effective alternative programs have an estimated cost of only $8 per day per person, they have long been under-funded by Congress. For example, $90 million was recently approved to increase ICE's detention capacity, while only $10 million was approved for detention alternatives." Fact sheet by Detention Watch Network, *available at* http://detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/Detention %20overview-Final.doc.

[8] *Id.*

RESOLUTION CONCERNING JUST TREATMENT FOR ALIENS AND ASYLUM SEEKERS

Submitted by the Policy Committee of the Lutheran Office of Governmental Ministry in New Jersey, and the New Jersey Synod Justice and Peace Mission Team

WHEREAS, God commanded Israel: "The stranger who resides with you shall be to you as the citizen among you; you shall love the stranger as yourself, for you were strangers in the land of Egypt: I am the Lord your God" (Leviticus 19:34); and,

WHEREAS, Lutherans have welcomed and assisted strangers through Lutheran World Relief, Lutheran Immigration and Refugee Service and Lutheran social service organizations-including Lutheran Social Ministries of New Jersey- for more than 50 years; and,

WHEREAS, in the 2004 Federal Fiscal Year, U.S. Immigration and Customs Enforcement (ICE) "detained 235,347 aliens nationwide and held approximately 20,000 aliens in custody per day"; and,

WHEREAS, in New Jersey, ICE "detained approximately 700 aliens per day; 60 percent of those were criminal aliens. At the Elizabeth Contract Detention Facility ICE detains 245 [non-criminal] aliens each day" (ICE News Release 1-24-05); and,

WHEREAS, asylum seekers entering the United States must prove to an immigration official at ports of entry that they have "a credible fear" of persecution if they are returned to their home country, in order not to be immediately returned to that country; and

WHEREAS, Congress required that those subject to this "Expedited Removal" process, including asylum seekers, be detained until the United States removes them. However, if a "credible fear" is established, Congress allowed that discretionary parole should be considered for those who can establish identity and community ties, and are not subject to any possible bars to asylum involving violence or misconduct; and,

WHEREAS, the study on Asylum Seekers in Expedited Removal by the US Commission on International Religious Freedom reports that "...detained asylum seekers in Expedited Removal are subject to conditions of confinement that are virtually identical to those in prisons or jails. These conditions create a serious risk of institutionalization and other forms of psychological harm," and,

WHEREAS, the United Nations High Commission on Refugees' (UNHCR) guidelines state: Conditions of detention for asylum-seekers should be humane with respect shown for the inherent dignity of the person. They should be prescribed by law. ...The use of prisons should be avoided. If separate detention facilities are not used, asylum-seekers should be accommodated separately from convicted criminals or prisoners on remand; and,

WHEREAS, U.S. detention standards are based on a correctional model and U.S. law does not provide standards specific to non-criminal asylum seekers; and,

WHEREAS, in FY2003, in the Newark, New Jersey District only 3.8% of asylum seekers were released (paroled) prior to a decision in their case, compared with the Harlingen, Texas District, where 98% of asylum were released; and,

WHEREAS, immigration judges, who currently determine asylum eligibility, vary significantly in their individual approval rates, and grant asylum in 25% of represented applicants but only 2% in unrepresented asylum cases;

Therefore, be it Resolved, that the New Jersey Synod memorialize the 2005 ELCA Churchwide Assembly to:

- request our leaders, including the presiding bishop and the synodical bishops of the Evangelical Lutheran Church in America, pastors, and lay leaders to pray for and advocate for just and compassionate treatment of asylum seekers and all those who are held in detention;

- request that congregations continue to respond in love, spiritual care, and support for those who are detained by the US Department of Homeland Security (DHS), Bureau of Immigration and Customs Enforcement (ICE) through visits, letters, prayer, and assistance.
- to call upon Congress and the administration to immediately end the detention and imprisonment of non-criminal asylum seekers, undocumented laborers and others, in jails or jail-like facilities;
- urge the implementation of just, consistent and humane practices regarding the treatment of asylum seekers, such as those suggested in US Commission on International Religious Freedom's February 2005 Study on Asylum Seekers in Expedited Removal.

Be it further resolved that the Bishop of the New Jersey Synod urge the Director of Detention and Removal Operations, Bureau of Immigration and Customs Enforcement (ICE), Newark District Office, to parole asylum seekers waiting their credible fear interview into the community through Temporary Sanctuary Communities – groups of religious congregations and other community groups acting on behalf of asylum seekers – or family members.

RESPONSES TO POST-HEARING QUESTIONS FROM U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT

Question #:	1
Topic:	performance-based
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: Recently, Assistant Secretary Julie Myers announced that ICE is working on new "performance based" detention standards for immigration detention facilities.

What does ICE mean by "performance based" standards?

How would these new standards differ from the current ICE National Detention Standards?

Will the new standards replace or augment the current standards?

How will ICE evaluate a detention facility's performance in general and with regard to providing appropriate medical care to detainees, in particular?

The former INS worked with many outside experts and stakeholders, such as the American Bar Association, to develop the current ICE National Detention Standards. What outside experts and stakeholders, if any, is ICE working with in developing these new standards? What criteria did ICE use to select outside experts and stakeholders for consultation?

Please describe the ways in which outside experts and stakeholders are involved in the development of the new standards. For example, has ICE formed advisory panel of such outside experts for consultation?

What does ICE mean by "Performance Based" Standards?

Performance Based Standards (PBS) provide transparency to our service providers, the public, non-governmental organizations (NGOs) and outside oversight groups by clearly stating Immigration and Customs Enforcement (ICE) goals and objectives. We strongly believe that this new format will improve the delivery of care to detainees. Unlike "policy and procedures" that focus solely on what is to be done, the performance-based approach focuses on the results and/or outcomes the required procedures are expected to accomplish. The use of performance-based standards encourages service providers to find optimal ways to meet performance criteria, while promoting creativity and innovation. As a result, a more efficient operation can continue to ensure safety, security, and appropriate conditions of confinement. The most notable change to the National Detention Standards (NDS) is that every mandatory expected practice identified by the

Question #:	1
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Committee:	JUDICIARY (HOUSE)

American Correctional Association (ACA) is addressed in the revised performance-based standards.

How will the new standards differ from the current ICE National Detention Standards (NDS)?

ICE recognizes the need to modernize the NDS inherited from legacy Immigration and Naturalization Service (INS) to reflect ICE's experience with the application of the current standards and information received from the public and other NGOs.

This modernization effort presents ICE with the opportunity to reformat its detention standards consistent with correctional industry standards developed by the ACA. The newly implemented standards will require that the reviewer focus on results and outcomes for each standard. Trends can be reviewed each year to determine if the facility is meeting particular goals or can also be an indication of possible problems.

Will the new standards replace or augment the current standards?

Once implemented, the new performance based standards will replace the current national detention standards. This change will not degrade the current standards in any fashion; the new standards will simply make it easier to measure performance and hold facilities accountable for their compliance with the performance-based measures.

How will ICE evaluate a detention facility's performance in general and with regard to providing appropriate medical care to detainees, in particular?

ICE is currently developing and will soon implement outcome measures that will be used to evaluate the medical care provided to detainees. In addition, in an effort to increase the levels of compliance and independent external oversight, ICE is improving its review process with the assistance of Creative Corrections Corporation and the Nakamoto Group, two companies that provide subject-matter expertise in the area of detention standards compliance and oversight. They will conduct annual reviews and will place subject-matter experts (SMEs) in selected facilities on a daily basis to monitor both the compliance with the detention standards and the detainees' quality of life. This effort will provide an independent and objective layer of oversight to the Detention Review Process.

ICE remains committed to ensuring that all Service Processing Centers (SPCs) and Contract Detention Facilities (CDFs) that house ICE detainees are fully compliant with the NDS, and all Inter-governmental Service Agreement (IGSA) facilities meet the intent

Question #:	1
Topic:	performance-based
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of those standards. Within each detention standard, there are implementing procedures identified for SPCs and CDFs. SPCs and CDFs must operate according to the precise terms of each standard. However, IGSAs may adopt, adapt, or establish alternatives to the procedures specified for SPCs and CDFs, provided they meet or exceed the "intent" or "objective" represented by each standard. For example, the ICE Classification Standard requires color-coded uniforms for detainees that coincide to their classification level. The ICE standard requires blue, orange, and red uniforms for levels 1, 2, and 3, respectively. If an IGSA instead classifies their detainees using green, blue, and purple uniforms, the facility is meeting the intent of the standard and would be considered in full compliance with the standard.

Most IGSA facilities are owned and operated by local governments and as such are not contractually required to adopt PBS. These IGSAs are ICE partners that provide needed detention bed space. Many IGSAs are located in small, rural areas of the country where a PBS requirement may pose additional administrative and financial burdens that the locality is unable to support. It is not our intent to unnecessarily burden the local government entities if the IGSA meets or exceeds the intent of the PBS. In cases where the standards are not met, ICE does have the option to place detainees elsewhere or to terminate the agreement in its entirety.

ICE CDFs contain a Quality Assurance Performance clause and are supported by Quality Assurance and Quality Control Surveillance Plans. The Contracting Officers Technical Representative (COTR) periodically evaluates and inspects the facility to determine the contractor's adherence to these standards. The contractor is required to correct any noted deficiencies to the government's specifications and return the facility to maximum operating efficiency. If a facility fails to timely correct deficiencies, that facility may be subject to certain penalties, as outlined in the contract, based on the recommendation of the Contracting Officer. When facilities are unable and/or unwilling to come into compliance, ICE may discontinue the facility's use either by terminating the contract or by simply transferring aliens from the non-complaint facility to a complaint facility. When performance based standards are implemented, the Quality Assurance Surveillance Plans will reflect the whole philosophy of performance based contracts, which are results-oriented. The improvements detailed above – such as an independent review of contract oversight and improved NDS compliance review processes – combined with a greater focus on training for COTRs and on monitoring their program will pay dividends in administration of CDFs.

The former INS worked with many outside experts and stakeholders, such as the American Bar Association (ABA), to develop the current NDS. What outside experts and stakeholders, if any, is ICE working with in developing these new

Question #:	1
Topic:	performance-based
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standards? What criteria did ICE use to select outside experts and stakeholders for consultation? Please describe the ways in which outside experts and stakeholders are involved in the development of the new standards. For example, has ICE formed an advisory panel of such outside experts for consultation?

As you note, the NDS were developed to ensure that safe, secure and humane conditions of confinement exist for ICE's detained population and were developed in cooperation with the ABA. These are the basis of the new performance based standards.

Beginning with the existing NDS, ICE recognizes the importance of updating policies and procedures to reflect past experiences, agency practices, and protocols, as well as current correctional industry standards. Predicated on the results of recent Office of the Inspector General (OIG) and Government Accountability Office (GAO) audits, ICE is vigorously working to transform the current detention standards into a performance-based format, consistent with the approach used by the American Correctional Association.

ICE has hired several subject matter experts (SMEs) as contractors who have assisted with this process. The selected individuals are currently either ACA Auditors or retired from state or federal correctional agencies and have extensive experience in corrections.

In addition, ICE acknowledges the importance of continuing collaborative efforts while developing the standards, and has considered the recommendations from the OIG, the GAO, the public, NGOs and other governmental oversight entities in the initial stages. Assistant Secretary Myers has expressed to several NGOs that it is our ultimate desire to improve our detention standards and to work with them towards our common purpose of ensuring quality care for all in ICE custody. Accordingly, we are forming a small working group of NGOs to assist in the review and analysis of the standards.

Question #:	2
Topic:	USMS
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: I understand that you held several managerial positions with the U.S. Marshals Service (USMS) before you joined ICE.

Some facilities hold both USMS and ICE detainees. Are there any differences in the way off site medical care is provided to each type of detainees?

For instance, if a doctor at such a detention facility thought that a USMS detainee needed an MRI or should see an oncologist to get a biopsy, would that doctor be able to set up the appointment without prior authorization from the Division of Immigration Health Services (DIHS) or some other off site entity, or would the doctor have to follow the same or similar process that he would with an ICE detainee with an identical problem?

Answer:

Yes, the process for off site medical care for USMS detainees is handled in a similar manner as ICE detainees. The USMS has their own managed care system which reviews off site medical requests.

Question #:	3
Topic:	transfers
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: There have been numerous reports of detainees who are transferred from one facility to the next, without having their medical records or medications transferred with them.

How does ICE ensure that detainee medical records accompany them when detainees are transferred and/or deported?

What tracking and quality assurance mechanisms does ICE have in place to ensure that detainee medical records are appropriately and timely transferred?

Answer:

The ICE National Detention Standards (NDS) require that medical records accompany detainees during transfers from one facility to the next.

When detainees are transferred from DIHS sites, they are accompanied by a written medical transfer summary and any current medications that are currently prescribed.

ICE maintains one of the most highly transient and diverse populations of any correctional or detention system in the world. On any given day, ICE has over 31,000 detainees in custody and transfers well over 700 detainees per day, from one facility to another for a number of reasons. Some examples of reasons to transfer are to be staged for deportation, to prevent overcrowding, to provide specialized medical care, and/or a change in security classification. ICE is not aware of any reoccurring issues regarding the transfer of detainee medical records, but understands the importance of ensuring that medication and medical records follow detainees during these transfers, as required.

ICE does not currently have a national system or other mechanism to track transfers of medication and/or medical records of detainees. Each Field Office is responsible for adhering to the guidelines set forth in the Detainee Transfer Standard, which includes, ensuring that a detainee's medication and/or medical records accompany them whenever transferred. A reminder was recently drafted and will be forwarded to all Field Office Directors reiterating the importance of this directive.

Question #:	4
Topic:	policies
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: What policies, if any, does ICE have to grant release on bond, parole, or another alternative to detention for detained immigrants for whom continued detention may present a risk to their physical or mental health?

What mechanisms, if any, does ICE have in place in order to ensure that all ICE offices across the country are complying with this policy uniformly?

What are the grant/denial rates for each ICE office of such requests?

Answer:

Current ICE policy specifically addresses the utilization of prosecutorial discretion in cases where there are humanitarian factors/concerns. The December 11, 2006 policy memorandum entitled "Discretion in Cases of Extreme or Severe Medical Concern," reviews the importance of exercising prosecutorial discretion when making custody determinations for aliens transferring from hospitals and social services or law enforcement agencies who have severe medical conditions. ICE's commitment to maintaining an end to "catch and release" of illegal aliens does not abrogate the responsibility of ICE personnel to utilize judicious discretion in identifying and responding to meritorious health related cases in which the arrest and/or detention may not be in the best interest of ICE or the alien's health. A favorable application of discretion requires officers to consider all factors, on a case-by-case basis, whenever a medical or psychiatric evaluation makes the alien's detention problematic and/or removal unlikely.

In situations where prosecutorial discretion is utilized, officers may choose to place an ICE detainee on an Alternative to Detention (ATD) program, release on an Order of Supervision, or release the alien on his or her own recognizance. The alien would then be directed to report to the Field Office at a later date, unless, of course, he or she is a threat to national security or the community as a whole.

In addition to providing periodic training on policies and procedures, all Field Office Directors are charged with the responsibility of ensuring DRO employees within their Area of Responsibility are in compliance with all ICE policies and procedures. It is the responsibility of each Field Office Director to ensure that prosecutorial discretion is exercised when appropriate and based on all factors relevant to each case.

ICE DRO does not currently track when prosecutorial discretion is exercised.

Question #:	5
Topic:	psychological treatment
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: Is there any psychological treatment or therapy being offered by government contractors or staff for persons in detention with psychological issues or diseases?

Answer:

All detainees receive a mental health screening within 12 hours of admission. At ICE staffed facilities medical/mental health screenings are routinely completed on detainees within 12 hours of arrival to the facility which is reflected in DIHS policy. Adherence to this time frame is monitored through our Performance Improvement Program. Detainees that exhibit dangerous behavior or appear to have symptoms requiring attention are seen immediately.

All detainees who request mental health services or are identified upon intake screening as needing further evaluation are referred to an appropriate mental health professional, usually a clinical psychologist or social worker. Detainees also receive mental status examination by a primary care provider within 14 days of admission.

Psychologists and social workers provide 23 different types of psychological services that are therapeutic in nature. These services include not just supportive therapy or counseling, but psychological assessment, psychoeducation, crisis intervention services, suicide risk assessment, suicide watch follow-up services to ensure safety, case management services and consultation with other medical professionals. Psychiatric services are also available in DIHS and psychologists and social workers may refer patients for appropriate psychiatric evaluation and follow up. Psychiatrists provide psychiatric evaluations, follow-up medication management, and they consult with the psychologists, social workers, and primary care providers when appropriate.

Question #:	6
Topic:	PTSD
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: What protective steps are being taken to provide examination and treatment for Post Traumatic Stress Disorder (PTSD) or other psychological diagnoses in appropriate cases?

Who decides what are "appropriate cases" and what standards are being used to make such a determination?

Answer:

All detainees receive a mental health screening within 12 hours of admission and also receive a mental status examination by a primary care provider within 14 days of admission. Detainees who are identified in either the intake screening or 14-day physical as needing mental health services or further evaluation or who request mental health services are referred to a social worker or psychologist for a psychological assessment. During the intake screening detainees are informed of the process by which they may request psychological or mental health services.

Licensed medical staff including physicians, nurses, physician assistants, and nurse practitioners, who have received training in identification of symptoms suggesting mental illness, determine whether a detainee is in need of further evaluation and mental health services. Detainees, as noted earlier, may also request mental health services. Psychologists and social workers conduct the psychological assessment and utilizing the criteria of Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition- Text Revision (DSM-IV-TR, Copyright - American Psychiatric Association) for Post Traumatic Stress Disorder (Anxiety Disorder) to diagnose Post Traumatic Stress Disorder. Those detainees who have been diagnosed with Post Traumatic Stress Disorder are offered psychotropic medications and supportive counseling consistent with medically accepted standards of care.

Question #:	7
Topic:	emotional status
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: What efforts are made to determine the stability and emotional status of each detainee at the time of admission? Are there periodic evaluations made at specific times during the term of detention?

Answer:

All detainees receive a mental health screening within 12 hours of admission and also receive a mental status examination by a primary care provider within 14 days of admission. Detainees who are identified in either the intake screening or 14-day physical as needing mental health services or further evaluation or who request mental health services are referred to a social worker or psychologist for a psychological assessment. During the intake screening detainees are also informed of the process by which they may request psychological or mental health services. At any time during the course of detention, detainees may request mental health services.

Question #:	8
Topic:	medications
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: How are medications being made available for detainees suffering from depression, anxiety, panic, insomnia, etc.?

How are medicine interactions being monitored for those taking medications?

Answer:

The local healthcare authority is responsible for providing mental health care services as needed under the minimum contracted services provided on site or through off site services covered under the Benefits Package. Detainees identified as suffering from a psychiatric illness may be referred to a physician or a psychiatrist. After receiving an appropriate evaluation by a medical provider detainees are offered psychotropic medications with informed consent. Once a detainee receives an order for a psychotropic medication, the medication is administered as direct observed therapy. As part of the minimum contracted services the local healthcare authority is responsible for monitoring detainees taking medications for any drug interactions.

Question #:	9
Topic:	sedating
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: There is anecdotal evidence that ICE is sedating detainees being moved. Detainees are apparently told the medicine is aspirin, or that it will make them feel better.

What is the ICE policy, if any, for sedating detainees?

What mechanisms, if any, does ICE have in place in order to ensure that contractors and/or staff are enforcing its policy on sedation uniformly?

Who administers the sedatives?

Answer:

ICE has a policy governing when an alien may be sedated during an escorted removal. This policy may be found in the Enforcement Standards on Use of Restraints and Escorts section of the ICE Office of Detention and Removal Operations (DRO) Policy and Procedure Manual. That policy states that only trained Department of Health and Human Services, Division of Immigration health Services (DIHS) healthcare providers may administer the sedation according to a prescribing physician's orders. The core principle of ICE's sedation policy is that an alien will not be sedated solely to facilitate transport. Under most circumstances, an alien will not be medically sedated for removal without a court order. An alien may be involuntarily sedated on an emergency basis if he or she presents an imminent threat to himself/herself.

The Public Health Service Officers providing the medical escort service for ICE removal officers follow the instructions of the ICE Officer-in-Charge during a removal as well as the policy of DIHS. This procedure is in accordance with ICE policy governing sedation. ICE ensures compliance with its policy by working with DIHS throughout the entirety of this process.

A trained DIHS healthcare provider (physician, nurse practitioner, physician's assistant, or registered nurse) administers the sedation according to the prescribing physician's orders. DIHS healthcare providers performing this service are trained to follow DIHS policies, procedures, and clinical practice guidelines. These policies many be found in DIHS National Policies and Procedures Manual, Standard Operating Procedure 8.28.1, Management of Combative Detainee During Transport and 8.28.2, In-Transit Progress Notes and Medical Summary for Medical Escort.

If sedation is not safe for a detainee, DIHS will not prescribe or administer sedation, and will notify ICE of its recommendation not to sedate.

Question #:	10
Topic:	informed consent
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: Is ICE obtaining informed consent from the detainee before any medication is given? Where is informed consent recorded and kept? If the detainee does not speak English, is the informed consent being obtained in a language that the detainee speaks or reads fluently?

Answer:

Yes, ICE does obtain informed consent from detainees before any medication is given. The informed consent is kept as part of the medical record. If the detainee does not speak English, an interpreter service is used to communicate with the detainee.

Question #:	11
Topic:	isolation
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: What assessment is made, if any, as to a detainee's possible response to isolation, detention, or other deprivation in relation to their past experiences and current condition? If such assessments are not regularly made, please explain the rationale for not making such assessments on a routine basis, particularly for people detained while seeking asylum.

Answer:

During the intake screening detainees are informed of the process by which they may request psychological or mental health services. At any time during the course of detention, detainees may request mental health services. While in segregation, all detainees are seen on a daily basis by a healthcare provider. Detainees who are placed in segregation receive a mental health screening upon their placement in segregation.

Administrative Segregation is a form of separation from the general population used when the continued presence of the detainee in the general population would pose a threat to life, property, self, other detainees, or staff or to the security or orderly running of the facility. This housing status also includes detainees who require protective custody, those who cannot be placed in the local population because they are awaiting a hearing before a disciplinary panel, and those requiring separation for medical/mental health reasons.

All ICE Detainees are provided with an initial medical screening, primary medical care, and emergency care. ICE Detainees also receive specialized health care, mental health care, and hospitalization within the local community whenever deemed necessary by facility medical staff. The initial medical assessment includes observation and interview items related to the detainee's potential suicide risk and possible mental disabilities, including mental illness and mental retardation.

Medical and Mental Health Assessments are conducted on every ICE Detainee and when detainees are identified as high risk, these assessments occur more frequently. Thus, detainees in a segregation status are observed/evaluated more frequently than those in general population.

In accordance with DIHS policy all detainees placed in segregation (whether for administrative, punitive or protective reasons) are evaluated by a medical provider once each day. Upon notification that a detainee is in segregation, a qualified medical person reviews the record to determine if medical, dental, or mental health needs contraindicate placement. Detainees are questioned during the visit to find out if they have any medical needs or requests. Any significant problems are referred to the appropriate level of provider and any treatment interventions are documented in the medical record.

Question #:	12
Topic:	private care
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: What opportunities, if any, are provided to allow examination of a detainee by private forensic psychologists, or meetings with personal therapists?

Answer:

Upon approval by local ICE authorities, detainees have been and will continue to be allowed access to private forensic psychologists, psychiatrists or any other licensed mental health professionals.

Question #:	13
Topic:	GAO cooperation
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: Please describe your cooperation with GAO of providing data and entire files of detainees who died in immigration custody for GAO's independent analysis and any withheld documents or files in GAO's investigation.

Answer:

DIHS cooperated fully with GAO and provided them with all available information on detainee deaths. This was specifically addressed in GAO review 440515.

I would also like to note the following. The ICE Medical Program follows health care industry standards for quality and performance improvement activities, in accordance with the Joint Commission, the American Correctional Association, and the National Commission for Correctional Health Care. ICE spent over $91 million in FY 07 on the medical program for detainees, up from $74 million in FY 06.

It is tragic when any person dies in ICE custody, but the mortality rate among ICE detainees is lower than many comparable detention and corrections institutions, as published by the Bureau of Justice Statistics for local jails and state prisons in the United States. See The Bureau of Justice Statistics Special Report, "Suicide and Homicide in State Prisons and Local Jails," by Christopher J. Mumola, August 2005, p. 5.

I am familiar with the GAO report you mentioned and, although that report found no systemic problems with the provision of health care, it did find isolated cases of perceived difficulties that reflect the need for improved communications between the ICE Medical Program and the many facilities that house ICE detainees. Some local jails with whom we contract may be unaware of the health-care-related components of their contractual arrangement with ICE, and the jails may need assistance to comply with the business rules established by the ICE Medical Program. To address this difficulty, the ICE Medical Program has created simple business rules for providers to access and obligate Federal funds for outside medical care. This last year, we implemented a web-based system that enables providers to submit requests for outside services, and the system has reduced paperwork and reduced the time needed to process these requests. ICE processes more than 40,000 Treatment Authorization Requests annually for medical care that cannot be provided within local detention facilities. The requests receive a response within 1.4 days on average and 90 per cent of the requests are approved.

Question #:	14
Topic:	death in custody
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: It is surprisingly difficult to get an accurate number of detainees who have died in ICE custody.

On June 26, 2007, the New York Times reported 62 deaths in ICE custody since 2004. On August 15, 2007, the Washington Post reported three additional in custody deaths, the earliest of which took place on July 20, 2007. In your written testimony, you indicated that 64, not 65, deaths took place in ICE custody. In your oral testimony, you stated that 66 deaths took place during this same time period.

Please provide the Subcommittee with an up to date figure for the number of detainees who have died in ICE custody since 2004, including each detainee's name, date of death, and a list of facilities and hospitals where the detainee was housed while in ICE custody up to the point of death.

Answer:
From the beginning of fiscal year 2004 to October 31, 2007, there have been 69 deaths in ICE custody. As of calendar year 2004 to October 31, 2007, there have been 66 deaths in ICE custody. Please see attachment document:

I have enclosed a roster of those detainee deaths that occurred in ICE custody since fiscal year 2004. The number of examinations by a medical practitioner for 14 of the detainees is included. However, the remaining detainees' information would require a manual search because the Intra-Governmental Service Agencies keep these records, not ICE. We will provide this information to your office when it is available.

Over the past 4 fiscal years, as illustrated below, detainee deaths that occurred while in the ICE custody have declined even though the detained population has increased.

Fiscal Year	Deaths	Total Detainee Population	Per Capita
2004	25	204,663	0.0122%
2005	16	206,600	0.0077%
2006	17	225,905	0.0075%
2007	11	254,609	0.0043%

Question #:	15
Topic:	reports to OIG
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: In your written testimony, you stated that the death of every detainee in ICE custody is reported to the DHS Office of Professional Responsibility and the DHS Office of Inspector General for possible investigation. Yet the Subcommittee has identified at least one death – that of Maria Inamagua Merchan that was not automatically reported to the OIG in 2006.

Please produce a copy of any policy guidelines demonstrating that the OIG is notified of each in custody death and a date on which such policies were adopted.

If there have been any detainee deaths that were not automatically reported to ICE, please provide each detainee's name, date of death, and a list of facilities and hospitals where the detainee was housed while in ICE custody up to the point of death, and an explanation of why the death was not automatically reported to the OIG.

Response:

All detainee deaths are reported to ICE headquarters via the Significant Event Notification (SEN) system, outlined in a memorandum dated November 9, 2004 from Acting Director of DRO, Victor X. Cerda, to all DRO employees. SEN notices are automatically forwarded to the ICE Command Center and the Joint Intake Center (JIC). DRO reports all detainee deaths to the ICE Office of Professional Responsibility (OPR) and the DHS Office of the Inspector General (OIG) so that they have an opportunity to conduct an independent review or investigation into the circumstances of any detainee's passing. Deaths are also referred to the local medical examiner or coroner's office, which will decide whether to perform an autopsy. The JIC forwards all reports of detainee deaths to the OIG. The OIG may accept the case for investigation or may decline to investigate it and refer it back to the JIC for referral to DRO Management or the Office of Professional Responsibility.

In the case of Ms. Maria Inamagua-Merchan, DRO followed its procedures by completing two Significant Incident Reports concerning Ms. Inamagua-Merchan's health and ultimate death at Regions Hospital in St. Paul, Minnesota. DRO forwarded a notice to the Significant Event Notification system. Likewise, DRO informed OIG and Office of Professional Responsibility concerning Ms. Inamagua-Merchan's death.

Question #:	16
Topic:	covered services package
Hearing:	ICE Oversight
Primary:	The Honorable Zoe Lofgren
Committee:	JUDICIARY (HOUSE)

Question: In your written testimony, you wrote that "[m]edical conditions which the local treating physician believes would cause suffering or deterioration of the detainee's health are also assessed and evaluated through the DIHS Managed Care Program." However, this assertion appears to contradict the language of the Covered Services Package, which states that "[o]ther medical conditions which the physician believes, if left untreated during the period of ICE/BP custody, would cause deterioration of the detainee's health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care." (emphasis added).

Please clarify the apparent discrepancy between your testimony and the language of the Covered Services Package. Does this mean that if a detainee is experiencing uncontrolled suffering that will not affect ICE's ability to deport that person, that condition will not be assessed and evaluated for care?

Response:

No, if detainees experience uncontrolled suffering the detainee will be provided with all necessary and appropriate medical care to relieve such uncontrolled suffering regardless of his or her deportation status.

I respectfully disagree with your assertion that the above statements are somehow contradictory. All ICE detainees receive medical treatment when DIHS determines such care is required, regardless of whether the alien is about to be deported or not.

Question #:	17
Topic:	Victoria Arellano
Hearing:	ICE Oversight
Primary:	The Honorable Linda T. Sánchez
Committee:	JUDICIARY (HOUSE)

Question: Victoria Arellano was apparently taken off her strict HIV medication regimen when she entered ICE custody, even though there are well known risks of developing drug resistant infections. According to media reports, it was only when her health had already begun to significantly deteriorate that she was finally put back on any medication, and experts suggest that the antibiotic she was prescribed is simply inappropriate for persons with HIV.

What is ICE/DIHS policy with respect to making sure HIV positive detainees continue on their medications when they enter ICE custody?

Is it ICE/DIHS policy to not provide medication to HIV positive detainees even if they were on meds before entering custody unless they have already developed an illness? If not, why does this appear to be what happened to Victoria?

Is there any reason why you would continue to deny medications to detainees who are willing to pay for and arrange delivery of their own medications?

On several documented occasions, HIV positive detainees have been denied medication or not given the proper medication to treat their HIV. One of the reasons often cited is that the facilities do not have the proper medication or that the pharmacies used have not processed the orders in time.

Is there a list of medications that must be available to a detention facility to access in order to treat detainees, and what HIV medications are included in this list?

If there is no such list, why not?

Why Ms. Arellano was given Amoxicillin, an antibiotic that experts have said is not appropriate for people with HIV?

Answer:

Due to a pending lawsuit, I am unable to comment any further on Ms. Arellano's case at this time.

I note that DIHS policy requires that all detainees with medical issues are provided appropriate and necessary care to the medical standard of care. DIHS has a formulary or list of medications available on our web page at: *http://www.inshealth.org/ManagedCare/DIHS_Formulary.pdf*. .

All antiretroviral medications are available and listed on the formulary.

Question #:	18
Topic:	transgendered
Hearing:	ICE Oversight
Primary:	The Honorable Linda T. Sánchez
Committee:	JUDICIARY (HOUSE)

Question: In addition to having HIV, Victoria was transgendered. I understand that like many transgendered people, Victoria was receiving hormone therapy until she entered ICE custody, at which point that stopped.

Is it the policy of ICE/DIHS to not treat transgender immigrants with hormone therapy regardless of the health consequences?

If not, is there policy governing hormone therapy treatment for transgender detainees?

Answer:

I cannot comment specifically about Ms. Arellano's situation because of the pending litigation.

While no policy specifically addresses the provision of hormone therapy to transgender detainees, DIHS policy requires that all detainees with medical issues are provided appropriate and necessary care to the medical standard of care. As such, the standard of medical care states that hormone therapy is to be provided to transgender detainees who have completed sex reassignment surgery.

Question #:	19
Topic:	Victoria (2)
Hearing:	ICE Oversight
Primary:	The Honorable Linda T. Sánchez
Committee:	JUDICIARY (HOUSE)

Question: What investigations have been done or are being done to discover what went wrong in Victoria's case?

Answer:
I cannot comment specifically about Ms. Arellano's situation because of the pending litigation.

Question #:	20
Topic:	press cooperation
Hearing:	ICE Oversight
Primary:	The Honorable Linda T. Sánchez
Committee:	JUDICIARY (HOUSE)

Question: I have seen reports that many of the detainees who spoke to the press about Victoria's death were later transferred to facilities as far away as Texas. Some of those detainees, who were HIV positive, then reported that they did not get their HIV medications.

Please explain why these detainees were transferred to Texas are they still there, or have they been returned to California?

Don't you think that transfers like this send a clear signal to other detainees that they should not speak out about problems they see around them?

Response:

Without specific information regarding the detainees who were allegedly transferred and the locations they were transferred to, it is impossible for us to determine whether any individuals detained with Ms. Arellano were transferred to Texas, if they are still in Texas or if they have been returned to California. In general, in addition to complying with the National Detention Standard on Detainee Transfer, ICE has the authority to determine the location and detention of aliens in removal proceedings and, therefore, to transfer aliens from one detention facility to another. Appropriate care and conditions of confinement are our primary concerns. Some typical examples to transfer a detainee may include preparation for deportation, prevention of overcrowding, or to provide specialized medical care, and/or a change in security classification.

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