

The American Civil Liberties Union

**Written Statement
For a Hearing on**

“Problems with Immigration Detainee Medical Care”

**Submitted to the House Judiciary Subcommittee on Immigration, Citizenship, Refugees,
Border Security, and International Law**

Wednesday, June 4, 2008

**Caroline Fredrickson, Director
ACLU Washington Legislative Office**

**Tom Jawetz, Immigration Detention Staff Attorney
ACLU National Prison Project**

The ACLU welcomes this opportunity to present to the House Judiciary Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law our written testimony about grossly inadequate medical care provided to immigration detainees and our support for H.R. 5950, the Detainee Basic Medical Care Act of 2008, which would improve medical care for this vulnerable population.

I. Introduction

The American Civil Liberties Union (“ACLU”) is a nationwide, non-partisan organization dedicated to the principles of liberty and equality embodied in our Constitution and our civil rights laws. It is the largest civil liberties organization in the country, with offices in 50 states and over 500,000 members. Consistent with its mission, the ACLU established the National Prison Project (“NPP”) in 1972 to protect and promote the civil and constitutional rights of people in detention. The NPP is the only program in the United States that litigates conditions of confinement cases on a national basis; at any given time we have cases pending in 20 to 25 states.

Immigration and Customs Enforcement (“ICE”) was created in 2003 as part of the creation of the Department of Homeland Security (“DHS”). ICE is responsible for, *inter alia*, overseeing the detention of persons charged with violating U.S. administrative immigration laws. In recent years, the use of immigration detention has skyrocketed, making immigration detention the fastest growing form of incarceration in this country. As a result, the NPP has developed an immigration detention initiative to protect the rights of this frequently unrepresented population.

During the past year, staff from the NPP have visited six facilities that together house more than 6,000 ICE detainees on any given day; staff from other ACLU projects and offices have visited many other ICE detention facilities. The NPP receives dozens of complaints from detainees, their family members, or other advocates about ICE detention conditions each month. NPP staff advocate on behalf of individuals in ICE detention and have brought three lawsuits against ICE facilities for failing to meet legally-mandated standards regarding living conditions for detainees. Through its efforts, the NPP has come in contact with many hundreds of ICE detainees.

II. The People in ICE Detention

Each year more than 300,000 people are taken into ICE custody.¹ On any given day, there are approximately 33,000 people in ICE detention,² including persons who are not security threats or flight risks; who are hardworking and came to the United States in search of the American Dream and the freedoms that this country offers; and who are particularly vulnerable, including asylum-seekers, torture survivors, and children. A person can end up in ICE custody simply because she arrived at the airport and asked to be protected from torture back home. Long-time lawful permanent residents of the United States can be detained—and ultimately deported—because of minor criminal convictions from 30 years prior, notwithstanding the fact that they have already served whatever criminal time they may have received for the offense. Not a single person in ICE custody is serving time for a criminal conviction.

More than 40% of immigration detainees are held in hundreds of local jails all around the United States. Although they are not charged with having committed any crime, they are held in facilities with criminal detainees, and are sometimes intermingled with that population. Many ICE detainees are held for weeks, others for months or years. We have received complaints from detainees who are often subjected to arbitrary punishment, including shackling, solitary confinement, neglect of basic medical and hygienic needs, denial of outdoor recreation, and verbal, physical and even sexual abuse.

Unlike persons charged with criminal offenses, immigration detainees have no right to appointed counsel paid by the government. As a result, approximately 90 percent of immigration detainees are forced to defend themselves and their right to enter or remain in the United States against a trained DHS trial attorney charged with prosecuting their deportation case.³ People held in ICE detention are frequently detained in facilities far from their homes, families, friends, co-workers, and neighbors. Therefore, they rarely have people on the outside to help advocate for them.

In addition, many immigration detainees fear retaliation for filing complaints about detention conditions, including deplorable medical care, because they are fighting their removal in immigration court. Many people are afraid they will be deported if they raise concerns with ICE officials about

¹ Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

² *Id.*

³ *Id.*

their detention. Finally, countless ICE detainees face language barriers, as English is frequently not their first language. Because of these factors unique to people in immigration detention, we are deeply concerned that the vast majority of this population is without a voice, and that the complaints that we have received, particularly about medical care, are just the tip of the iceberg.

III. ACLU Efforts to Protect the Rights and Human Dignity of ICE Detainees

A. ACLU Litigation

In January 2007, the ACLU brought a class action lawsuit on behalf of ICE detainees at the San Diego Correctional Facility (“SDCF”), charging that chronically severe overcrowding at the facility was placing detainees’ health and safety at risk, in violation of the Fifth Amendment to the U.S. Constitution.⁴ SDCF is a contract detention facility operated by Corrections Corporation of America, Inc. (“CCA”), the largest private, for-profit provider of detention and corrections services in the nation. At the time the lawsuit was filed, the facility held approximately 1,000 ICE detainees. Approximately 675 detainees—more than two thirds of the ICE population at SDCF—were housed in pods that were triple-celled, meaning that three detainees were assigned to sleep and spend significant blocks of time during the day in small cells designed for two people. As a result, hundreds of detainees slept on plastic “boats” on the floor next to the toilet or crammed under bunk beds. Additional detainees slept in the common dayroom space. Within three days of the ACLU’s appearance in the case, ICE officials transferred more than 100 detainees out of the facility.

In March 2007, the ACLU filed a series of lawsuits on behalf of children held by ICE at the Hutto Detention Center in Taylor, Texas.⁵ ICE uses the Hutto facility, managed by CCA, to detain entire families, including infants; the facility was previously used by CCA as a medium-security adult prison. The lawsuits charged that ICE violated its duty to meet the legal standards for the housing and release of all minors in federal immigration custody. The ACLU’s original 10 plaintiffs included children as young as three who were forced to wear prison jumpsuits and live in prison-like cells. They had little access to education or exercise. No pediatrician was available on-site, and children did not receive timely physical examinations or screenings for infectious diseases.

⁴ *Kiniti v. Myers*, No. 05-cv-1013 (S.D. Cal.).

⁵ *In re Hutto Family Detention Center*, No. 07-cv-164 (W.D. Tex.).

In August 2007, the lawsuit was settled and major improvements were required as part of the settlement. Children are no longer required to wear prison uniforms and are allowed much more time outdoors. Educational programming has expanded, and guards have been instructed not to discipline children by threatening to separate them from their parents. In addition to making those improvements permanent, the settlement also requires ICE, among other things, to allow children over the age of 12 to move freely about the facility; provide a full-time, on-site pediatrician; eliminate the count system that forced families to stay in their cells 12 hours a day; install privacy curtains around toilets; and improve the nutritional value of food. ICE must also allow regular legal orientation programs by local immigrants' rights organizations. ICE's compliance with each of these reforms, as well as other conditions reforms, is subject to external oversight to ensure their permanence.

In June 2007, the NPP filed a class action lawsuit on behalf of ICE detainees at SDCF for the facility's failure to provide necessary medical and mental health care.⁶ SDCF detainees are routinely subjected to long delays before treatment, denied necessary medication for chronic illnesses, and refused essential referrals prescribed by medical staff. The lawsuit specifically names 11 detainees, including a woman refused treatment for a neurological disorder that has caused painful tumors to develop; detainees with untreated bipolar disorder and depression; and detainees with chronic health conditions such as Type 2 diabetes, hypercholesterolemia and hypertension that are inadequately monitored. The San Diego facility was prominently featured in the *Washington Post's* four-part series on inadequate medical care for ICE detainees that ran in May 2008.⁷ SDCF was the location where one detainee's cancer was allowed to spread undiagnosed and untreated for eight months, another detainee developed gangrene and a potentially fatal bone infection before being rushed to the emergency room after suffering through four weeks of neglect, and a third detainee died in his cell while his cellmate's cries for help were ignored by both correctional officers and medical personnel.

⁶ *Woods v. Myers*, No. 07-cv-1078 (S.D. Cal.).

⁷ Dana Priest and Amy Goldstein, *Careless Detention: Medical Care in Immigrant Prisons*, WASHINGTON POST, May 11-14, 2008, available at <http://www.washingtonpost.com/carelessdetention>.

B. ACLU Visits to ICE Detention Facilities in South Texas

In recent months ACLU staff members have traveled to south Texas on several occasions to interview dozens of immigration detainees at three immigration detention facilities.⁸ On May 7 and 8, 2008, the visits also included guided tours of all three facilities. ACLU staff visited the Port Isabel Service Processing Center (“Port Isabel SPC”), the Willacy County Detention Center (“Willacy”), and the South Texas Detention Complex (“STDC”). Although the Port Isabel SPC is operated by ICE, both Willacy and STDC are operated by private, for-profit corrections companies. Medical care at all three facilities is directly provided by the Division of Immigration Health Services (“DIHS”).

Together, the three facilities house more than 5,000 detainees on any given day—that is, more than 15 percent of all ICE detainees in the country. The Willacy facility—which is already the country’s largest ICE facility, housing 2,000 detainees in tents—is expected to house an additional 1,000 detainees as soon as this month.

The *Washington Post*’s four-part series, *Careless Detention*, revealed serious problems with health care at two of the three facilities. According to the *Post*, the Willacy facility “has no clinical director, no pharmacist, and only a part-time psychiatrist.”⁹ In the summer of 2007 the facility was hit by an outbreak of chicken pox caused by poor disease screening and a lack of education about how to prevent the spread of infectious diseases.¹⁰ At the STDC the medical unit in January 2008 had a backlog of 2,097 appointments.¹¹ As of June 2007, the Chief of Psychiatry for DIHS identified a “crisis in the mental health care at [STDC],” with more than 140 patients awaiting chart review by the facility’s clinical director who appeared to be refusing to provide mental health care outright.¹²

The ACLU’s findings largely mirrored those of the *Washington Post*. During our tour of the medical facilities at the Port Isabel SPC, we were informed that approximately 40 percent of the medical positions are currently unfilled. The facility—which houses 1200 detainees—employs only one staff

⁸ These visits were conducted by ACLU staff from the Immigrants’ Rights Project, National Prison Project, Human Rights Program, and Racial Justice Program, as well as staff from the ACLU of Texas and the ACLU of New Mexico.

⁹ Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

¹⁰ *Id.*

¹¹ *Id.*

¹² Dana Priest and Amy Goldstein, *Suicides Point to Gaps in Treatment*, WASHINGTON POST, May 13, 2008.

physician. At the time of our visit, the facility's other position for a staff physician had been unfilled since March 2007 (*i.e.*, more than 14 months). At the Willacy facility we were not told how many medical staff positions were currently vacant. However, we were informed that for 2,000 detainees—soon to be 3,000 detainees—there was only one dentist, one staff physician, and one part-time psychiatrist. A simple search on the DIHS website shows that since 2007, the facility has been trying to hire a clinical director, staff physician, pharmacist, pharmacy technician, dentist, dental assistant, psychiatrist, medical records technician, and various nursing positions.¹³ At STDC the problems appeared even more stark. At the time of our visit, the facility of 1900 detainees had no dentist, no staff physician, minimal nursing support, and neither a psychiatrist nor a psychologist on-site. The facility, which was also missing a Health Services Administrator, estimated that only 50 to 60 percent of the medical staffing positions were filled, and that only one registered nurse and two licensed vocational nurses remained on duty each night.

Both Port Isabel SPC and Willacy are more than 230 miles from San Antonio, the nearest city of note. Even Pearsall is a one-hour drive from San Antonio. Because of the remote locations of these three facilities, the percentage of immigration detainees who are represented by counsel is minuscule. Not only does the lack of counsel typically doom the possibility of prevailing in immigration court, but it often means that no one outside of the detention facility is advocating for necessary detainee health care.

C. Individual Stories from ICE Detainees held in South Texas

During our visits to the facilities—which occurred just days before the *Washington Post's* investigative series ran in May 2008—the ACLU met with many detainees suffering from serious health problems who reported gross neglect. While these stories have not been vetted to the same extent as those appearing in the *Washington Post*, there is a lesson to be learned here. Unlike 90 percent of immigration detainees who are never represented by counsel, virtually every detainee whose story was profiled in the *Washington Post* series was represented. It was through the efforts of these attorneys that medical records were obtained, grievances were submitted, and letters demanding release from custody were filed. The level of medical neglect experienced by these detainees is not exceptional; what is exceptional is the fact that the public was ever able to learn of their abuse in such

¹³ Division of Immigration Health Services, Job Openings, at http://jobs-dihs.icims.com/dihs_jobs/jobs/candidate/intro.jsp (last visited May 29, 2008).

detail. The following stories were collected by the ACLU through interviews with detainees at two of the facilities in south Texas.

South Texas Detention Complex:

- In May 2007, Mr. D.1. was detained at the Santa Ana detention facility in California where he fell and seriously injured his shoulder. When he saw medical staff at the facility, he was given medication for the pain but no other treatment. Approximately eight days later, after he complained that he was unable to move as a result of the fall, he was transferred to the San Pedro Service Processing Center (“San Pedro SPC”), a detention facility where DIHS provides medical care to detainees. He was taken to an outside hospital, where he received an MRI and was told that he would require surgery to repair the injury. But before he could get the surgery, he would need DIHS approval. Mr. D.1. was then transferred to the El Centro Service Processing Center (“El Centro SPC”), another California facility where DIHS provides medical care. While at the El Centro SPC, Mr. D.1. developed a serious eye infection that resulted in itching and pus. He was eventually transferred back to the San Pedro SPC to receive treatment, but the on-site physician told him that he did not have the appropriate equipment to check Mr. D.1.’s eyes. Mr. D.1. was sent to have his eyes examined, and he was informed that his nerves were damaged. He was prescribed eye drops for treatment. Mr. D.1. was then transferred to STDC in Pearsall, Texas, where he arrived with three medications: prescription eye drops, Tylenol, and medication for his recently-diagnosed diabetes. During intake, Mr. D.1. was given only Tylenol, but did not receive his eye drops until 15 days after his arrival and did not receive his diabetes medication until 30 days after his arrival. At the time ACLU staff members visited STDC in March, Mr. D.1. was wearing dark glasses to protect his eyes from light and had a very difficult time keeping his eyes open without his glasses. In a recent letter to the ACLU from Mr. D.1., he explains that he is “going blind,” and that his requests for medical attention have yielded no additional care.
- Ms. D.2. is an HIV-positive, transgender woman who was transferred to the STDC from the San Pedro SPC. After her transfer, approximately eight days passed before she received the medications she had been taking to manage her disease. Shortly before our visit to the facility in March 2006, she stopped taking her medications because of the harsh side effects the

medications were causing, including diarrhea and inability to eat or keep any food in her stomach. Despite submitting several requests to have her medication modified, she has received little attention by the medical staff.

- Mr. D.3. speaks neither English nor Spanish, and requires the use of an interpreter to communicate. He was originally detained in the Santa Ana facility in California, and was later transferred to the San Pedro SPC. At San Pedro, the treating physician informed him that his thyroid cancer had returned and he was provided with some medication. After being transferred to STDC, he had to wait more than one month to resume his medication. During the time Mr. D.3. was not receiving his medication, he experienced serious pain in his throat and would hold his neck with his hand. Staff at the facility mistook this gesture as an indication that he was suffering from mental health problems, and referred him to a social worker. When Mr. D.3. finally met with the facility doctor, he was told that he did not have cancer, but he was prescribed medication that he was supposed to take twice daily for the rest of his life. After his lawyers began to complain about his deteriorating health, Mr. D.3. was given a blood test, but he was never told the results. As of our visit in March 2008, he had been waiting for four months to get a response to the daily medical requests he had been filing. He had regularly complained of back and arm pain, bleeding gums, a swollen hand, and the fact that he was coughing up blood every few days.
- Mr. D.4. was diagnosed as HIV-positive two years ago. Before entering detention, he would have his blood checked every one or two months and was prescribed a combination of three antiretroviral medications. After he was transferred to STDC from the San Pedro SPC, his medications were interrupted for two days. The last time his blood was drawn at STDC was approximately five months prior to our visit. He never received the results of that blood test. In January 2008, he and several other HIV-positive detainees were taken to an HIV clinic in San Antonio. Once there he met a doctor who informed him of his T-cell count and viral load, and asked that he return in March. As of May he had not yet been scheduled to return to the clinic and had not had another blood test. Mr. D.4. reported that another detainee living with HIV refused his medications because he believed he was having an allergic reaction to them.

Dr. Johnson, STDC's Clinical Director, verbally abused the detainee, and threatened to have him placed in restraints and sent to a segregation cell for refusing his medications.¹⁴

Port Isabel Service Processing Center:

- Ms. D.5 has been detained since January 2006. While in detention, she was diagnosed with diabetes and anemia. Initially she was provided no treatment for her diabetes, and she began to file multiple medical requests. When she was seen, her blood sugar level was found to be dangerously high, and she reported going blind for 15 days. The medical person who saw her confirmed that if she had continued like this, she would have gone into a coma or cardiac arrest. Ms. D.5. now requires insulin twice daily and receives additional medication for her kidneys and hypertension.
- Mr. D.6. entered ICE custody on September 2007. He was originally detained in the San Pedro SPC, was moved to STDC, and is now detained at the Port Isabel SPC. Mr. D.6 is HIV-positive and has also been diagnosed with herpes and depression. He received some initial blood tests at the San Pedro SPC, but he was scheduled to receive additional tests to determine his T-cell count and viral load at the time he was transferred to Texas. Since arriving in Texas in October 2007, he has had his blood drawn only two times, but he has not been told the results of the tests. The purpose of testing his blood is to determine what medication regimen Mr. D.6. requires to manage his HIV. He is currently receiving no medication for his HIV and is receiving medication only for herpes and depression. He informed us that he frequently gets sick and requires medical attention.

IV. Systemic Problems with Medical Care in ICE Detention

This section outlines the major problems with medical care in ICE detention that the ACLU and others have identified. It also includes details about how H.R. 5950, the Detainee Basic Medical Care Act of 2008, will help alleviate some of these problems.

¹⁴ Dr. Johnson's apparent refusal to provide medical care to detainees at STDC is heavily documented in the *Washington Post's* story on mental health care in immigration detention. The *Washington Post* obtained internal emails from two supervisory officials within DIHS, including the chief of psychiatry who performs telepsychiatric services to STDC detainees from his office in Miami, Florida. In one email, the top mental health official in DIHS suggested that the DIHS medical director "issue a clear order for Dr. Johnson to begin to provide treatment to mentally ill detainees. . . . If he fails to follow the order, then this behavior needs to be interpreted as insolence and insubordination and documented as such." Dana Priest and Amy Goldstein, *Suicides Point to Gaps in Treatment*, WASHINGTON POST, May 13, 2008.

Problem: People in ICE Detention are Regularly Denied Basic Medical Care

ICE has promulgated 38 detention standards, which cover issues such as medical care, environmental health and safety, and use of force. But these standards are completely unenforceable and are regularly violated. This conclusion is based not simply on the ACLU's experience, which is derived from direct communication with detainees around the country, but on independent sources. In December 2006 the DHS Office of Inspector General ("OIG") issued a report on the treatment of ICE detainees.¹⁵ According to the report, the OIG observed instances of non-compliance with the detention standards at all five facilities reviewed.¹⁶ The OIG specifically noted serious failures in the medical care programs at four of the five facilities, including SDCF.¹⁷

In July 2007 the U.S. Government Accountability Office ("GAO") issued a report that similarly identified violations of the detention standards at various detention facilities around the country.¹⁸ The GAO report highlighted deficiencies in the provision of medical care to detainees at several facilities.¹⁹ The ACLU receives complaints from ICE detainees from around the country who are not receiving adequate medical treatment. They complain about long delays in treatment, incorrect prescription medications, and refusals to provide necessary specialty care. Our conclusion, based upon decades of advocating for the humane and just treatment of incarcerated persons, is that immigration detainees around the country are at risk of avoidable suffering, and even death, because of ICE's failure to ensure that they receive necessary medical and mental health care.

Fix: Congress Must Pass H.R. 5950, the Detainee Basic Medical Care Act of 2008

The Detainee Basic Medical Care Act of 2008 requires DHS to develop policies and procedures to provide ICE detainees with adequate medical care.

¹⁵ U.S. Department of Homeland Security, Office of Inspector General, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, OIG-07-07 (Dec. 2006) (hereinafter the "OIG Audit Report").

¹⁶ *Id.* at 1.

¹⁷ *Id.*

¹⁸ 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).

¹⁹ *Id.* at 5.

Problem: Untimely and Inadequate Medical Screenings Upon Intake

The OIG's December 2006 audit report found that more than half of the detainees at SDCF whose files were reviewed did not receive a physical examination within two weeks of arriving at the facility.²⁰ The *Washington Post's* exhaustive investigation into medical neglect in ICE facilities similarly found failures to properly detect and contain infectious diseases such as tuberculosis and chicken pox at the outset, before they have an opportunity to spread to other detainees and members of the detention staff.²¹ When a person enters a detention facility, it is critical that he receive a comprehensive initial screening, and a follow-up health assessment, by a qualified health care professional. The purpose of these examinations is to identify the detainee's serious health needs to ensure proper treatment as well as continuity of care throughout the detention process.

Fix: Procedures to Ensure Timely Medical Screenings and Examinations

The Detainee Basic Medical Care Act of 2008 requires DHS to develop procedures to ensure that upon intake, ICE detainees receive a thorough screening by a qualified health care professional and a follow-up examination and assessment within 14 days of arrival.

Problem: Gaps in Treatment

When a person arrives at an immigration detention facility with prescription medications, those medications are routinely confiscated as contraband by correctional personnel with no medical training. This is generally true even when a detainee was prescribed the medication at an earlier detention facility from which he has just been transferred. The result of this practice, when combined with the delays that detainees often face in seeing a physician capable of writing a new prescription, is that detainees often experience drastic interruptions in their treatment of serious health conditions.

The NPP has spoken with detainees suffering from chronic conditions such as hypertension, hypercholesterolemia, and seizure disorders who were unable to continue their medication regimens because of this practice. The dire consequences of interrupting treatment are particularly serious for people living with HIV. It is common knowledge that persons who take antiretroviral medications can quickly develop a permanent resistance to a particular medication if the medication regimen is

²⁰ OIG Audit Report at 4.

²¹ Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

interrupted. Yet many HIV positive detainees report serious delays in getting their medications upon intake to a new detention facility.

Even when a detainee has been properly diagnosed with a serious medical problem and prescribed medication at a facility, there is still no guarantee that proper treatment will be provided. Detainees typically rely upon medical or correctional personnel to deliver their medications on a timely basis, and to ensure that prescription refills are ordered to prevent treatment interruptions. Yet detainees at several facilities report that prescription medications are often provided in a haphazard manner, with delays of several days or weeks in between prescription refills.

Last year, when the ACLU was investigating poor medical care at the SDCF in preparation for a class action lawsuit, we learned about a detainee whose leg was rotting and had been causing a putrid smell in his housing unit for several weeks. After numerous requests for medical attention, the man—Martin Hernandez Banderas—was taken to the facility’s medical unit and diagnosed with uncontrolled diabetes and a diabetic ulcer that had become gangrenous. Although Timothy Shack, the former Medical Director for DIHS, stated publicly that Mr. Banderas received 24-hour care and was not among the general population, this was completely untrue.²² After eight days of intravenous antibiotics in the facility’s medical unit, Mr. Banderas was returned to the general population for the next four weeks, where his diabetes continued to go largely unchecked and he was not even given assistance over the weekend in changing the dressings on his wound. When Mr. Banderas was finally taken to the emergency room, doctors found that he still had gangrene in his foot and leg and had developed a potentially fatal bone infection. For several days in a row, medical staff at SDCF 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. Fortunately for him, it did not come to that.

Fix: Procedures to Ensure Continuity of Care

The Detainee Basic Medical Care Act of 2008 requires DHS to develop procedures to ensure continuity of care. Beginning with intake, and ending with transfer, release, or removal,

²² Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASHINGTON POST, June 13, 2007.

detainees should not experience delays or gaps in necessary treatment. Instead of allowing correctional officers without medical training to effectively deny a detainee prescriptions medications upon intake, the bill will place the decision to terminate a particular treatment in the hands of a qualified health care professional who has examined the detainee. The bill also requires DHS to design procedures to ensure that prescribed medications are provided on schedule and without interruption, and that a detainee's serious health needs are considered when contemplating the transfer of a detainee from one facility to another.

Problem: People with Serious Medical Conditions Are Unnecessarily Detained

People who are suffering from serious medical and mental health problems are particularly at risk of neglect and abuse in immigration custody. Reverend Joseph Dantica, an 81-year-old Baptist minister from Haiti, was taken into custody at the Miami airport in 2004 despite the fact that he possessed a valid visa and had routinely traveled between the United States and Haiti without ever overstaying a visa. The sole reason he was detained in 2004 was that he fled gang violence in Haiti and applied for asylum in the U.S. Rev. Dantica was detained despite the fact that he had serious health problems, including hypertension and an inflamed prostate. He died in detention shortly thereafter.

Sandra Marina Kenley was a lawful permanent resident for nearly 33 years. In 2005 she was stopped at the airport in connection with old, minor criminal charges, and was asked to appear at another ICE office to answer questions. After she voluntarily appeared at the ICE office in Dulles Airport on multiple occasions, she was taken into custody and sent to a regional jail in Virginia. At the airport, Ms. Kenley and her sister explained that she suffered from high blood pressure, high cholesterol, and a bleeding uterine fibroid that required surgery. She died in detention a few months later.

Both Rev. Dantica and Ms. Kenley had family in the United States and had no record of violating any immigration laws. In fact, both had repeatedly demonstrated their respect for our immigration laws, and were neither a danger to society nor a flight risk. Both were clearly too sick to be placed in a system incapable of meeting their medical needs.

Fix: Procedures to Make Seriously Ill Detainees Priority for Alternatives to Detention

The Detainee Basic Medical Care Act of 2008 requires DHS to design procedures ensuring that detainees with serious medical or mental health problems receive priority consideration

for release on parole, bond, or into a community-based secure alternative to detention program.

Problem: Excessive Delays in Responding to Requests for Medical Attention

Detainees regularly report to us that they are often forced to wait long periods of time to get a response to request for medical attention. At three of the five facilities audited by the OIG in connection with its December 2006 report, nearly half of the medical files reviewed showed that requests for medical attention were not responded to in the timeframe required by each facility's own policies.²³ At SDCF, more than half of the files reviewed demonstrated response times exceeding three days.²⁴

Yusif Osman was a detainee at SDCF who died an avoidable death due to delays in treatment. His tragic story was featured in the recent *Washington Post* series about ICE's failure to provide adequate medical care to people in its custody.²⁵ Mr. Osman, a national of Ghana, who had previously complained to medical staff of chest pain, was found dead while locked in his cell one morning in June 2006. He died of coronary vasculitis, a heart condition that was neither diagnosed nor treated while he was detained, despite his efforts to receive medical attention. On the night of his death, Mr. Osman and his cellmate requested immediate medical attention, and a correctional officer observed Mr. Osman, who was suffering from severe chest pain, kneeling on the floor of his cell. The officer notified medical personnel of the situation, but the nurse on duty told the correctional officer to advise Mr. Osman to submit a written sick call request. By the time Mr. Osman was next observed in his cell, he was completely unresponsive and cool to the touch. More than one hour passed between the time Mr. Osman and his cellmate requested urgent medical attention and the time that a 911 call was made in response to the medical emergency.

Fix: Procedures to Ensure Timely Access to Treatment

The Detainee Basic Medical Care Act of 2008 requires DHS to design procedures ensuring that detainees receive prompt responses to requests for medical or mental health care.

²³ OIG Audit Report at 4.

²⁴ *Id.*

²⁵ Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

Problem: Off-Site Bureaucrats Make Medical Care Decisions

Right now, professional clinical judgments made by qualified on-site medical personnel can be trumped by Managed Care Coordinators (MCC) within DIHS. These MCCs—who are nurses, not doctors—are able to deny requests for necessary off-site care without physician review, and with no meaningful, independent review of their decisions. Moreover, the policies that guide the decisions of the MCCs are fatally flawed. DIHS primarily provides health care services for emergency care only.²⁶ Emergency care is defined as “a condition that is threatening to life, limb, hearing, or sight.”²⁷ When a detainee has a medical condition that a physician believes, “if left untreated during the period of [ICE] custody, would cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status,” the condition will be assessed and evaluated for care.²⁸ The introduction of a non-medical consideration such as whether the detainee’s “uncontrolled suffering” will affect the government’s ability to effectuate deportation is entirely inappropriate. In myriad ways, DIHS’s policies and practices are inconsistent with established principles of constitutional law and basic notions of decency. This system is designed to fail, and it does daily.

Fix: Procedures to Ensure Only Qualified Medical Professionals Determine Care

The Detainee Basic Medical Care Act of 2008 requires DHS to design procedures to ensure that treatment decisions are based solely on the expertise of qualified medical professionals.

Problem: Bureaucratic Decisions to Deny Necessary Medical Care Cannot Be Appealed

The treatment authorization process for off-site care results in both unreasonable delays in the provision of medical care, and unjustifiable refusals to provide authorization. In 2005 only the DIHS Medical Director or a person designated by the Medical Director had authority to deny a request for treatment authorization. In the event that the Medical Director chose to deny authorization, the on-site health professional could file an administrative appeal with DIHS and have his concerns heard by an impartial panel of three DIHS physicians with the power to overturn the Medical Director’s denial. That appeals system was abolished sometime in 2007. As a result, there is currently no administrative

²⁶ Division of Immigration Health Services, *DIHS Medical Dental Detainee Covered Services Package*, undated, available at <http://icehealth.org/ManagedCare/Combined%20Benefit%20Package%202005.doc>.

²⁷ *Id.* at 1.

²⁸ *Id.*

reconsideration or appeals process for authorization denials, and the registered nurses who work as MCCs now have the last word in denying authorization for treatment requested by on-site medical professionals. Although there are 33,000 detainees in custody on any given day, the task of evaluating all requests for treatment falls on three regional MCCs.²⁹ A fourth MCC was once assigned to oversee requests pertaining to detainees requiring hospitalization, but even that task has now been placed on the shoulders of the three regional MCCs.³⁰

Francisco Castaneda was one victim of DIHS's deficient benefits package and lack of appeals process. He entered SDCF in March 2006 and immediately complained about increasingly painful lesions on his penis. After being examined by an on-site doctor, he was told he needed to see a specialist for his condition. Many months later, during which time Mr. Castaneda's condition worsened and he began bleeding and discharging from his penis, DIHS approved the request. During his 11-month stay in immigration detention, eight of which were at SDCF, Mr. Castaneda saw multiple specialists who agreed he needed a biopsy to determine whether his condition was cancerous. Medical staff at SDCF, acting in accordance with DIHS policy, repeatedly refused to schedule Mr. Castaneda for a biopsy, stating it was "elective surgery."

The ACLU sent several demand letters to DHS and DIHS on his behalf and finally, in February 2007, Mr. Castaneda's biopsy was scheduled. But before sending him for the biopsy, ICE released Mr. Castaneda—who had by this time developed multiple tumors on and around his penis—from detention. Mr. Castaneda immediately went to the emergency room for a biopsy, at which point he learned that he was suffering from penile cancer. His penis was immediately amputated, and the doctors determined that the cancer had already spread to his lymph nodes. Despite undergoing numerous rounds of aggressive chemotherapy treatment and having his lymph nodes surgically removed, Mr. Castaneda's cancer continued to spread. He died on February 16, 2008. Throughout his battle he remained a staunch advocate for others like him who were refused necessary medical care while in ICE detention. He testified before the House Subcommittee on Immigration in October 2007, just five months before he died, about the inadequate treatment he received while in ICE custody.

²⁹ Division of Immigration Health Services, Managed Care Coordinators at <http://icehealth.org/ManagedCare/ManagedCare.shtm> (last visited May 30, 2008).

³⁰ *See id.*

Fix: Development of an Administrative Appeals Process

The Detainee Basic Medical Care Act of 2008 requires DHS to develop an administrative appeals process for people in ICE detention whose treatment requests are denied. It also creates protocols to ensure DIHS provides written explanations for denying treatment.

Problem: Medical Records are not Transferred with Detainees and are Largely Inaccessible

Detainee medical records are critical to ensuring that proper health care is provided throughout detention. DHS's current policy is that when a detainee is transferred between facilities at which DIHS provides medical care, a detainee's medical records are transferred along with the detainee. However, when a detainee is transferred between all other facilities, no medical records are sent. In some cases, all that is sent along with a detainee is a one-page transfer summary listing the prescription medications that the detainee takes. The obvious result of this policy is that detainees with the most complex medical needs often pose a serious problem for the medical personnel of a receiving facility.

This problem is exacerbated by the difficulty that detainees and their advocates have in obtaining medical records from detention facilities. The ICE Detention Standard on Medical Care states that detainees may request their medical records.³¹ But it is the ACLU's experience that in many facilities, detainees who request copies of their medical records may be refused such access, are told that they can get their medical records only upon release from the facility, or have their requests completely ignored. When the ACLU has submitted medical records requests to ICE, these requests are processed as requests submitted under the Freedom of Information Act ("FOIA"). At best, it takes several weeks to get medical records by filing a FOIA request. In one instance, when the ACLU was attempting to get medical records for Francisco Castaneda, who at the time was still in detention and was suffering extraordinary pain and medical neglect regarding his undiagnosed and untreated penile cancer, it took more than 19 weeks to get the records.

³¹ Immigration and Customs Enforcement, *INS Detention Standard on Medical Care*, Sept. 20, 2000, 9, available at <http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf>.

Fix: Procedures to Make Medical Records Accessible to Detainees and Appropriate Personnel

The Detainee Basic Medical Care Act of 2008 requires that DHS develop protocols to make medical records more easily available to appropriate personnel and detainees, and expedite the transfer of medical records when a detainees is moved from one facility to another.

Problem: In-Custody Deaths Go Unreported

ICE has no legal obligation to report in-custody deaths. Since the creation of ICE in 2003, at least 83 people have died in immigration custody or shortly after being released from ICE custody, and according to records released to the ACLU by ICE pursuant to a Freedom of Information Act, at least 9 of these deaths were AIDS-related. The *Washington Post* estimates that 30 of the 83 deaths may have resulted from medical neglect.³²

Fix: Procedures to Ensure Oversight of Deaths in ICE Custody

The Detainee Basic Medical Care Act of 2008 would require DHS to report all in-custody deaths to the Department of Justice Inspector General's Office, the Department of Homeland Security Inspector General's Office, and to Congress. This reporting and accountability requirement is necessary to ensure that Congress, the public, and detainees' family members are no longer kept in the dark about deaths of detainees.

V. Conclusion

The ACLU has found that medical care in immigration detention is grossly inadequate and insufficiently regulated by any government body. Increased oversight and procedures to ensure people in ICE detention receive constitutional and humane care are urgently needed. Too many people in ICE detention have been forced to suffer and even die unnecessarily. Such degrading and deplorable treatment contradicts American values. It is imperative that Congress take action to protect the rights and human dignity of people with serious medical or mental health conditions in ICE detention. The Basic Medical Care Act of 2008 will bring us closer to reaching that goal.

³² Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.