

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

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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

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

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/mgmt/rpts/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

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.