



**The Trump Administration's
Mistreatment of Detained Immigrants:**

**Deaths and Deficient Medical Care by
For-Profit Detention Contractors**

Prepared for Chairwoman Carolyn B. Maloney and Chairman Jamie Raskin

**Staff Report
Committee on Oversight and Reform and
Subcommittee on Civil Rights and Civil Liberties
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EXECUTIVE SUMMARY

Last year, the Committee on Oversight and Reform initiated an investigation into the Trump Administration’s use of for-profit contractors to detain tens of thousands of immigrants.

Under the leadership of Chairman Elijah E. Cummings, the Committee began investigating troubling reports of deaths of adults and children, deficient medical care, prolonged detention, improper treatment, and filthy conditions at facilities operated by U.S. Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP).

As part of this investigation, Committee staff conducted oversight inspections of nearly two dozen detention facilities in Arizona, California, Georgia, Louisiana, Mississippi, and Texas. In some cases, conditions were so poor that Committee staff warned contractor officials during their visits about deficiencies in the treatment of detainees.

For example, after an inspection of the Irwin County Detention Center in Georgia—which has been the subject of new whistleblower reports regarding “jarring medical neglect” and hysterectomies performed on immigrant women—Committee staff were so alarmed by health and safety concerns that they raised them directly with the warden during their visit.

Following these inspections, Chairman Cummings wrote a letter to then-Acting Secretary of Homeland Security Kevin K. McAleenan that the inspections “revealed potentially serious ongoing problems with the treatment of children and adults in DHS custody.”

After Chairman Cummings passed away in the fall of 2019, Chairwoman Carolyn B. Maloney continued this investigation and pressed for aggressive action. For example, on November 18, 2019, she sent a letter asking the Department of Homeland Security (DHS) Inspector General to conduct its own investigation of the troubling conditions at the Irwin County Detention Center and other facilities operated by private contractors.

The Subcommittee on Civil Rights and Civil Liberties chaired by Rep. Jamie Raskin also has been spearheading this investigation, holding several hearings examining dangerous and overcrowded conditions at these detention facilities.

As part of its investigation, the Committee requested a broad range of documents and information from ICE and its two largest detention contractors, CoreCivic and GEO Group. Over the past several months, the Committee has also sought information regarding the spread of the coronavirus in DHS detention facilities. This staff report presents the results of this investigation, based on Committee staff review of thousands of documents totaling more than 60,000 pages.

Detainees Died After Receiving Inadequate Medical Care

The Committee obtained internal DHS reports examining the death of detainees in facilities run by private contractors. These documents reveal a widespread failure to provide

necessary medical care to detainees with serious and chronic medical conditions, along with critical medical staff shortages. For example:

- Huy Chi Tran, 47, died in June 2018 of a sudden cardiac arrest after being detained for eight days and placed in solitary confinement at CoreCivic’s Eloy Detention Center in Arizona. A guard failed to monitor him and then falsified logs to hide this failure. Mr. Tran had been a legal permanent resident since 1984.

A subsequent whistleblower complaint in 2019 stated that ICE health officials were “informed of multiple concerns regarding the care provided at the facility, particularly the facility’s psychiatrist misdiagnosing, failing to treat detainees appropriately, and the lack of readily available emergency medications.” The whistleblower also stated that ICE health officials were “very misleading” in a briefing to senior officials about the cause of Mr. Tran’s death.

- Vicente Caceres-Maradiaga, 46, died in May 2017 of an enlarged heart and liver after being detained for nine days at GEO Group’s Adelanto Detention Facility in California—and after his high blood pressure went unmonitored while detained. Mr. Caceres-Maradiaga was a construction worker who had been in the United States since 1999.

A subsequent review of this facility by the DHS Office for Civil Rights and Civil Liberties found: “The failure to hire an effective and qualified clinical leader contributed to the inadequate detainee medical care that resulted in medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees at ACF.”

- Jean Carlos Jimenez-Joseph, 27, died in May 2017 by suicide after being detained for 69 days at CoreCivic’s Stewart Detention Center in Georgia. Mr. Jimenez-Joseph was placed in solitary confinement at Stewart despite suffering from serious mental illnesses. Mr. Jimenez-Joseph came to the United States as a child and was granted Deferred Action for Childhood Arrivals status in 2016. ICE sought to deport him after a misdemeanor arrest.

ICE’s own review of Mr. Jimenez-Joseph’s death included damning findings of misconduct: “In addition to leaving the unit unsupervised on seven occasions the night of JIMENEZ’s suicide, Officer [Redacted] falsely logged that he completed security rounds at 12:00 a.m. and 12:28 a.m., neither of which were corroborated by video surveillance footage. These entries indicate Officer [Redacted] observed JIMENEZ alive at these times when he did not.”

- Roger Rayson, 47, died in March 2017 of a brain hemorrhage in ICE custody after being detained for 44 days at GEO Group’s LaSalle Detention Center in Louisiana. When Mr. Rayson was placed in solitary confinement, medical staff did not routinely open the cell door to check on him even though the intercom for his cell was broken the entire time he was there. ICE medical staff submitted a

subsequent complaint alleging that multiple detainees at this facility did not receive proper medical care, and stated: “Mr. Rayson’s healthcare was deplorable.”

ICE has failed to publicly release investigative reports on detainee deaths in custody—even though it is required to do so by federal law. Since 2018, Congress has required ICE to publicly release all in-custody death investigation reports within 90 days of any death, but ICE has not complied with that requirement for any deaths that have occurred since that time.

Deficient Sanitation and Mismanagement of Infectious Diseases

Documents obtained by the Committee reveal that immigrants in ICE custody also face serious risks due to deficient sanitation practices and poor handling of infectious diseases.

For example, in 2018 and 2019, an outbreak of the mumps infected nearly 900 detainees in 57 ICE detention facilities across 19 states. Documents also contain examples of improper treatment for tuberculosis, HIV, and in one case, an allegation of “grossly negligent” medical care when an ICE detainee died of meningitis in 2018.

These persistent deficiencies could aggravate the spread of coronavirus in DHS facilities. ICE has confirmed more than 6,000 detainees and 45 ICE staff have been infected with coronavirus at over 95 detention facilities. Information obtained by the Committee shows that as of mid-July 2020, more than 600 GEO Group and CoreCivic employees working in at least 29 facilities also tested positive.

Many ICE facilities, including those that house children, have had repeated sanitation problems, including dirty and moldy bathrooms, insufficient clean clothing, unsanitized dishes, dirty food preparation and service areas, and a lack of soap, toilet paper, paper towels, clean razors, and other hygiene items.

Rewarding Poor Performance with Billions of Dollars in Contracts for Private Detention

The documents described in this report confirm that the Trump Administration has known for years about systemic health and safety issues at immigration detention facilities operated by for-profit contractors. The Administration has continued to pay billions of taxpayer dollars to these for-profit companies without providing proper oversight.

Even though DHS’s own internal reports found that egregious medical deficiencies and negligence led to the deaths of multiple detainees and poor treatment for many others, the Trump Administration has continued to reward the companies that manage these facilities with lucrative contracts.

Since 2017, the Trump Administration has awarded its two biggest detention contractors, CoreCivic and GEO Group, more than \$5 billion in contracts to operate private detention facilities. Instead of holding contractors accountable and imposing financial penalties, ICE has

issued waivers to allow deficient practices to continue and exempt contractor facilities from certain health and safety standards.

The Administration must take immediate action to update detention standards and oversight to ensure that migrants in U.S. custody are treated humanely and consistent with legal obligations. ICE should use existing contract provisions to hold contractors accountable, should not renew contracts plagued by a history of serious health and safety issues without demonstrations of significant and major improvements, and should decrease the use of contractor facilities along with decreasing unnecessary immigration detention.

The DHS Inspector General should also increase its oversight work, as should other DHS components, such as the DHS Office for Civil Rights and Civil Liberties and the ICE Office of Professional Responsibility.

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I. BACKGROUND

A. The Committee's Investigation of the Treatment of Detained Immigrants

On July 10, 2019, the Committee launched an investigation into the Trump Administration's use of for-profit contractors to detain tens of thousands of immigrants. The Committee sent requests for documents to ICE and two for-profit contractors that operate ICE detention facilities, CoreCivic and GEO Group. These two companies operate facilities holding more than 80 percent of all people in ICE detention.¹

The Committee's investigation followed a series of troubling reports of health and safety violations at DHS facilities and rising costs to U.S. taxpayers for detention contracts, as well as reports that adults and children had died in DHS custody. A series of reports by the DHS Inspector General in 2019 showed dangerous overcrowding, prolonged detention, improper detainee treatment, and filthy conditions at various DHS facilities operated by ICE and CBP.² The Inspector General also issued reports in 2017 and 2018 that identified security risks, problems with detainee medical care, and inadequate oversight at ICE facilities that detain migrants. Since 2017, at least 49 people have died in ICE custody.³

In July 2019, the Oversight Committee and the Subcommittee on Civil Rights and Civil

¹ Letter from Chairman Elijah E. Cummings, Committee on Oversight and Reform, and Chairman Jamie Raskin, Subcommittee on Civil Rights and Civil Liberties, to Damon T. Hininger, President and Chief Executive Officer, CoreCivic (July 10, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2019-07-10.EEC%20JR%20to%20Hininger-CoreCivic%20re%20Detention%20Contractors.pdf>); Letter from Chairman Elijah E. Cummings, Committee on Oversight and Reform, and Chairman Jamie Raskin, Subcommittee on Civil Rights and Civil Liberties, to George C. Zoley, Chief Executive Officer, GEO Group (July 10, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2019-07-10.EEC%20JR%20to%20Zoley-GEO%20Group%20re%20Detention%20Contractors.pdf>); Letter from Chairman Elijah E. Cummings, Committee on Oversight and Reform, and Chairman Jamie Raskin, Subcommittee on Civil Rights and Civil Liberties, to Acting Director Matthew T. Albence, Immigration and Customs Enforcement (July 10, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2019-07-10.EEC%20JR%20to%20Albence-ICE%20re%20Detention%20Contractors.pdf>); *Justice-Free Zones: U.S. Immigration Detention Under the Trump Administration*, ACLU et al. (May 2020) (online at www.aclu.org/sites/default/files/field_document/justice-free_zones_immigrant_detention_report_aclu_hrwnijc_0.pdf).

² Department of Homeland Security, Office of Inspector General, *Management Alert—DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley* (July 2, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/2019-07/OIG-19-51-Jul19_.pdf); Department of Homeland Security, Office of Inspector General, *Concerns about ICE Detainee Treatment and Care at Four Detention Facilities* (June 3, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf); Department of Homeland Security, Office of Inspector General, *Management Alert—DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center* (May 30, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/2019-05/OIG-19-46-May19.pdf).

³ Immigration and Customs Enforcement, *List of Deaths in ICE Custody, 2003—2017* (online at www.ice.gov/doclib/foia/reports/detaineedeaths-2003-2017.pdf); Immigration and Customs Enforcement, *Death Detainee Reports* (online at www.ice.gov/death-detainee-report) (accessed Sept. 23, 2020); American Immigration Lawyers Association, *Deaths at Adult Detention Centers* (online at www.aila.org/infonet/deaths-at-adult-detention-centers) (accessed Sept. 23, 2020).

Liberties held three hearings on immigration detention and issued a staff report examining the abuse of immigrant children by the Trump Administration.⁴

At the Committee's July 12, 2019, hearing, Chairman Cummings stated that the Trump Administration's "policies are contributing to massive overcrowding which is aggravating conditions, draining supplies, endangering the health and safety of both detainees and government personnel."⁵

In August and September 2019, the Committee sent bipartisan staff delegations across the country to conduct oversight inspections of DHS immigration detention facilities. Committee staff inspected 22 DHS facilities in six states, including 12 detention centers run by ICE and for-profit contractors, seven Border Patrol stations, and three ports of entry operated by CBP (see Appendix for complete list). DHS cancelled staff inspections of 11 CBP facilities a day before they were to occur.⁶

Eleven of the ICE facilities visited by Committee staff housed adult detainees, while one, the South Texas Family Detention Center, held mothers and minor children. Ten ICE facilities visited by staff were managed by contractors, while two were directly managed by ICE. Committee staff toured the facilities and interviewed facility leadership, staff, and detained immigrants when permitted to do so by DHS.

As part of this investigation, Committee staff reviewed detention contracts, audit reports, detainee death reports, detention policies, policy waivers, and emails.

B. The Committee's Investigation of Detained Immigrants During the Coronavirus Crisis

On March 11, 2020—before ICE announced its first confirmed case of the coronavirus in a detention center—the Committee sent a letter to Acting Secretary Chad Wolf requesting information on the Department's plan to address the coronavirus pandemic in ICE and CBP

⁴ Committee on Oversight and Reform, *Staff Report: Child Separations by the Trump Administration* (July 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2019-07-2019.%20Immigrant%20Child%20Separations-%20Staff%20Report.pdf>); Committee on Oversight and Reform, *Hearing with the Acting Secretary of Homeland Security Kevin K. McAleenan* (July 18, 2019); Committee on Oversight and Reform, *Hearing on the Trump Administration's Child Separation Policy: Substantiated Allegations of Mistreatment* (July 12, 2019); Committee on Oversight and Reform, Subcommittee on Civil Rights and Civil Liberties, *Hearing on Kids in Cages: Inhumane Treatment at the Border* (July 10, 2019).

⁵ Committee on Oversight and Reform, *Hearing on the Trump Administration's Child Separation Policy: Substantiated Allegations of Mistreatment* (July 12, 2019).

⁶ Letter from Chairman Elijah E. Cummings, Committee on Oversight and Reform, to Acting Secretary Kevin K. McAleenan, Department of Homeland Security (Aug. 29, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2019-08-29.EEC%20to%20McAleenan-%20%20DHS%20re%20StaffDels.pdf>).

detention and to protect detained immigrants and facility staff.⁷

During a March 20, 2020, staff briefing, ICE officials stated that they had no contingency plan for coronavirus treatment if local hospitals became overwhelmed and could not treat detainees. ICE officials also stated that they were monitoring 25 detainees with coronavirus symptoms or risk but had zero confirmed positive cases. The officials stated the agency was conducting a limited review to determine whether any detainees could be released.

On March 24, 2020, ICE announced that a detainee at Bergen County Jail in New Jersey had tested positive, the first confirmed detainee case.⁸

On April 7, 2020, Chairwoman Maloney and Chairman Raskin called on ICE “to immediately release non-violent detainees, prioritizing those who are at higher risk for complications from coronavirus.”⁹

On April 17, 2020, ICE Acting Director Albence and CBP Acting Commissioner Morgan briefed Committee Members on coronavirus preparedness in detention facilities. During this briefing, Acting Director Albence stated that “our review of our existing population has been completed” and that ICE does not plan to release other detainees to slow the spread of coronavirus in detention facilities. By that date, ICE had released fewer than 700 vulnerable individuals while continuing to detain more than 32,000 individuals.¹⁰

On May 14, 2020, the Committee sent another letter to DHS after reports of three deaths in ICE facilities due to the coronavirus, including a detainee and two contractor employees. The Committee noted that ICE appeared to be violating guidelines for social distancing and mitigating the risk of coronavirus spreading in detention. The Committee also noted that ICE appeared to have misled the Committee during the April 17 briefing about the scope of the agency’s review of the detainee population. The Committee requested additional briefings and

⁷ Letter from Chairwoman Carolyn B. Maloney, Committee on Oversight and Reform, and Chairman Jamie Raskin, Subcommittee on Civil Rights and Civil Liberties, to Acting Secretary Chad F. Wolf, Department of Homeland Security (Mar. 11, 2020) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-03-11.CBM%20and%20JR%20to%20Wolf-DHS%20re%20COVID-19.pdf>).

⁸ *First ICE Detainee Tests Positive for Coronavirus*, CNN (Mar. 24, 2020) (online at www.cnn.com/2020/03/24/us/ice-detainee-coronavirus/index.html).

⁹ Letter from Chairwoman Carolyn B. Maloney, Committee on Oversight and Reform, and Chairman Jamie Raskin, Subcommittee on Civil Rights and Civil Liberties, to Acting Secretary Chad F. Wolf, Department of Homeland Security, Acting Director Matthew T. Albence, Immigration and Customs Enforcement, and Acting Commissioner Mark Morgan, Customs and Border Protection (Apr. 7, 2020) (https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-04-07.CBM%20JR%20to%20DHS%20re%20Protecting%20Immigrants_0.pdf).

¹⁰ *ICE Releases Nearly 700 People Due to Coronavirus Concerns*, CNN (Apr. 14, 2020) (online at https://edition.cnn.com/world/live-news/coronavirus-pandemic-intl-04-14-20/h_8ef2ddab7743330468e5763c31d209f6).

information about coronavirus risks in ICE custody, which ICE has refused to provide.¹¹

Since this time, Committee staff have continued to monitor reports of ICE employees and detainees with confirmed coronavirus cases. In addition, Committee staff have continued to communicate with GEO Group and CoreCivic to receive information about contractor staff at ICE detention centers who have contracted the virus.

As of September 23, 2020, more than 6,000 detainees and 45 employees in more than 95 detention centers across 31 states and Puerto Rico, including at least 16 facilities run by GEO Group and 16 facilities run by CoreCivic, had confirmed cases of the coronavirus.¹² At least eight immigrants died after contracting coronavirus while detained by ICE, and DHS has not provided the Committee with the investigative or audit reports on these deaths:

- Carlos Ernesto Escobar-Mejia, 57, died from coronavirus complications on May 6, 2020, at CoreCivic's Otay Mesa Detention Center where more than 169 detainees and 11 ICE employees have tested positive.¹³
- Oscar Lopez Acosta, 42, died from coronavirus complications on May 10, 2020, after likely contracting it in ICE detention at the Morrow County Jail in Ohio.¹⁴
- Santiago Baten-Oxlaj, 34, died from coronavirus on May 24, 2020, after being detained at CoreCivic's Stewart Detention Center in Georgia.¹⁵
- Onoval Perez-Montufa, 51, died on July 12, 2020, after being detained at the Glades County Detention Center in Florida. Mr. Perez-Montufa tested positive for coronavirus on July 2, 2020.¹⁶

¹¹ Letter from Chairwoman Carolyn B. Maloney, Committee on Oversight and Reform, and Chairman Jamie Raskin, Subcommittee on Civil Rights and Civil Liberties, to Acting Secretary Chad F. Wolf, Department of Homeland Security, and Acting Director Matthew T. Albence, Immigration and Customs Enforcement (May 14, 2020) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-05-14.CBM%20JR%20to%20Wolf-%20DHS%20Albence-ICE%20re%20Coronavirus%20in%20Detention%20Centers.pdf>).

¹² Immigration and Customs Enforcement, *ICE Guidance on COVID-19, Confirmed Cases* (online at www.ice.gov/coronavirus) (accessed Sept. 23, 2020).

¹³ *Id.*; *How the Coronavirus Spread Through Otay Mesa Detention Center in San Diego*, CBS (July 19, 2020) (online at www.cbs8.com/article/news/health/coronavirus/how-the-coronavirus-spread-through-otay-mesa-detention-center-in-san-diego/509-15a45f6c-b25b-4eb1-a35d-fa60613cd058).

¹⁴ *A Honduran Man Has Died of COVID-19 After Leaving an ICE Jail Plagued by the Virus*, Mother Jones (May 14, 2020) (online at www.motherjones.com/politics/2020/05/a-honduran-man-has-died-of-covid-19-after-leaving-an-ice-jail-plagued-by-the-virus/).

¹⁵ *An Immigrant Man in ICE Custody Died After Contracting the Coronavirus*, BuzzFeed News (May 24, 2020) (online at www.buzzfeednews.com/article/hamedaleaziz/immigrant-ice-coronavirus-death).

¹⁶ *A 51-Year-Old Immigrant Man from Mexico Has Died in ICE Custody After Testing Positive for COVID-19*, BuzzFeed News (July 13, 2020) (online at www.buzzfeednews.com/article/adolfoflores/mexican-immigrant-dies-in-ice-custody).

- James Thomas Hill, 72, died on August 5, 2020, after being detained at the Immigration Centers of America (ICA) Farmville Detention Center in Virginia. Mr. Hill was admitted to Centra Southside Community Hospital in Farmville, Virginia, on July 10, 2020, after reporting shortness of breath. Mr. Hill tested positive for COVID-19 on July 11, 2020.¹⁷
- Jose Guillen-Vega, 70, died in ICE custody at the Stewart Detention Center in Georgia, after being hospitalized since August 1, 2020. The preliminary cause of death, per ICE, was determined by hospital medical staff to be “cardiopulmonary arrest, secondary to complications of coronavirus disease (COVID-19).”¹⁸
- Fernando Sabonger-Garcia, 50, died in ICE custody at the Joe Corley Processing Center in Conroe, Texas, on August 28, 2020. The preliminary cause of death, per ICE, is respiratory failure due to complications from COVID-19.¹⁹
- Cipriano Chavez-Alvarez, 61, died in ICE custody at the Stewart Detention Center, in Lumpkin, Georgia—the third known detainee to die from COVID-related complications at this facility—on September 21, 2020. According to ICE, the preliminary cause of death of Mr. Chavez Alvarez was, as with Mr. Guillen-Vega, “cardiopulmonary arrest, secondary to complications of coronavirus disease.”²⁰

II. FINDINGS

Set forth below are preliminary findings based on the information received by the Committee to date.

A. Detainees Died After Receiving Inadequate Medical Care

Documents obtained by the Committee reveal a disturbing pattern of immigrants receiving inadequate and delayed medical care at facilities operated by for-profit contractors, resulting in poor medical outcomes and in some cases, death. The Trump Administration has

¹⁷ *‘It’s a Story that Shouldn’t Have Happened’: 72-Year-Old Man in Farmville ICE Facility Dies After Testing Positive for COVID-19*, Richmond Times-Dispatch (Aug. 7, 2020) (online at www.richmond.com/news/virginia/its-a-story-that-shouldnt-have-happened-72-year-old-man-in-farmville-ice-facility/article_643fec10-cb95-5fed-af89-3b248338a162.html).

¹⁸ *2nd ICE Detainee in Georgia Dies from COVID-19 Complications*, Associated Press (Aug. 13, 2020) (online at www.apnews.com/74b26b5bdf7d3003d95080026be9af10).

¹⁹ *First Immigrant Died in ICE Custody in Texas from COVID*, Houston Chronicle (Sept. 3, 2020) (online at www.houstonchronicle.com/news/houston-texas/houston/article/Immigrant-in-ICE-custody-in-Conroe-dies-from-COVID-15537403.php).

²⁰ Immigration and Customs Enforcement, *Mexican Man in ICE Custody Passes Away at Georgia Hospital* (Sept. 22, 2020) (online at www.ice.gov/news/releases/mexican-man-ice-custody-passes-away-georgia-hospital).

awarded CoreCivic and GEO Group more than \$5 billion in contracts since 2017.²¹ The DHS Inspector General has found that ICE failed to hold contractors accountable and instead issued waivers that exempt contractors from having to comply with certain health and safety standards.²²

According to ICE, an inquiry is conducted after an immigrant dies in the agency's custody, and the results are shared with senior agency officials:

[T]he ICE Office of Professional Responsibility, in coordination with contract subject matter experts in correctional healthcare and security, conducts an objective examination of the facts and circumstances surrounding each individual's passing, to determine whether or not the relevant detention standards were complied with and to identify any other areas of concern regarding the individual's care and custody. Upon their completion, the results of these reports are provided to ICE senior management and the Department of Homeland Security's Office of [sic] Civil Rights and Civil Liberties.²³

The Committee obtained several of these reports, some of which had not been made public, related to the deaths of individuals detained in CoreCivic and GEO Group facilities. The Committee also obtained previously unreleased audit reports from ICE and investigative reports from DHS's Office for Civil Rights and Civil Liberties that shed further light on the deaths of detainees and the conditions in these facilities.

These documents reveal serious and widespread violations of ICE's health and safety standards, negligent medical care, unsanitary living conditions, understaffing, poor recordkeeping, and critically delayed emergency care. Key examples are described below.

1. Huy Chi Tran, Eloy Detention Center

Huy Chi Tran, 47, died of sudden cardiac arrest in June 2018 after being detained for eight days at CoreCivic's Eloy Detention Center in Arizona.²⁴ The ICE Health Service Corps

²¹ *Recipient Profile: CoreCivic, Inc.*, USASpending.gov (online at www.usaspending.gov/#/recipient/5286f50d-b2e1-44ce-7943-7adf68b2ea0e-P/latest) (accessed Sept. 23, 2020); *Recipient Profile: The GEO Group, Inc.*, USASpending.gov (online at www.usaspending.gov/#/recipient/d969aade-9caf-5fda-8c98-e88499ad6ef9-P/latest) (accessed Sept. 23, 2020).

²² Department of Homeland Security, Office of Inspector General, *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards* (Jan. 29, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf).

²³ Immigration and Customs Enforcement, *Death Detainee Report* (online at www.ice.gov/death-detainee-report) (accessed Sept. 23, 2020).

²⁴ Immigration and Customs Enforcement, *Findings—Death of ICE Detainee Huy Chi Tran* (July 5, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Huy%20Chi%20Tran%20Death%20Report%20June%202018%20%28Eloy%29.pdf>).

(IHSC) provides medical care at Eloy. Mr. Tran had been a legal permanent resident since 1984.²⁵

ICE's internal report on Mr. Tran's death, which was obtained by the Committee, identified several serious concerns regarding his medical care:

- A doctor prescribed a medication to treat Mr. Tran for symptoms related to schizophrenia and an anxiety disorder, but the medication was never provided to him.
- Medical staff prescribed Mr. Tran the antipsychotic medications that he had arrived with during intake but did not begin to administer these medications until he had been at the facility for two days. On one occasion, due to poor communication between medical staff, medication was provided to Mr. Tran twice on the same day, resulting in him receiving double the prescribed dose.
- Mr. Tran was placed in solitary confinement before he had been medically cleared and was found in his cell unconscious just three hours later. He died in a hospital a week later. The nurse that approved his placement in solitary confinement only reviewed Mr. Tran's medical records and did not obtain his vital signs or assess his physical condition.
- CoreCivic detention staff were supposed to check on Mr. Tran every 15 minutes, but the detention officer on duty left Mr. Tran unsupervised for 51 minutes just before Mr. Tran's cardiac arrest that led to his death.
- Investigators found that the officer falsified observation logs to hide the fact that he had failed to conduct welfare checks over that 51-minute period.
- Upon finding Mr. Tran unconscious in his cell, three Eloy staff arrived in response to the emergency call but declined to enter the cell where Mr. Tran lay unconscious on the floor, allegedly due to safety concerns. Instead, they waited for two additional officers to arrive before entering.

“IHSC leadership was informed of multiple concerns regarding the care provided at the facility, particularly the facility's psychiatrist misdiagnosing, failing to treat detainees appropriately, and the lack of readily available emergency medications.”

- *DHS Office for Civil Rights and Civil Liberties
Complaint regarding Eloy Detention Center, 2019*

²⁵ Immigration and Customs Enforcement, *ICE Detainee Passes Away at the Eloy Detention Facility* (June 16, 2018) (online at www.ice.gov/news/releases/ice-detainee-passes-away-ely-at-detention-facility).

- The lead nurse failed to adhere the automated external defibrillator (AED) pads correctly, rendering the AED ineffective in resuscitating Tran. He passed away in a local hospital seven days later.²⁶

Mr. Tran’s death was at least the 16th death at Eloy since 2004. The death report obtained by the Committee confirms the findings of several previously disclosed reports finding a troubling pattern of inadequate medical care at Eloy.

For example, in a December 2018 internal ICE email, an ICE supervisor informed ICE Acting Director Matthew Albence that a detainee with severely low blood sugar was forced to wait two hours for emergency medical services at Eloy, “making it a failure to rescue case.”²⁷

A March 2019 report by DHS’s Office for Civil Rights and Civil Liberties contained more than a dozen allegations by an ICE Health Service Corps whistleblower regarding inadequate medical care at several ICE facilities, including Eloy. The report alleged:

IHSC leadership was informed of multiple concerns regarding the care provided at the facility, particularly the facility’s psychiatrist misdiagnosing, failing to treat detainees appropriately, and the lack of readily available emergency medications.²⁸

Regarding Mr. Tran, the complaint stated that “during a briefing with ERO [Enforcement and Removal Operations] on the preliminary cause of death, IHSC leadership’s report was ‘very misleading,’ and the more likely causes of death given the detainee’s medication and symptoms (neuroleptic malignant syndrome and/or serotonin syndrome) were not raised.”²⁹

The DHS Office for Civil Rights and Civil Liberties report also identified other instances of inadequate medical care at Eloy. In one case, a man suffering from psychosis-related symptoms who was not treated by the facility psychiatrist “became so unstable that he lacerated his penis, requiring hospitalization and surgery.”³⁰ In another case, a man suffering from psychotic-like symptoms was improperly prescribed an anti-depressant, rather than an anti-

²⁶ Immigration and Customs Enforcement, *Findings—Death of ICE Detainee Huy Chi Tran* (July 5, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Huy%20Chi%20Tran%20Death%20Report%20June%202018%20%28Eloy%29.pdf>).

²⁷ *ICE Detainee Deaths Were Preventable: Document*, The Young Turks (June 3, 2019) (online at <https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h>).

²⁸ Memorandum from Cameron P. Quinn, Department of Homeland Security, Office for Civil Rights and Civil Liberties, and Marc Pachon, Department of Homeland Security, Office of Legal Counsel, to Ronald Vitiello, Deputy Director and Senior Official Performing the Duties of the Director, Immigration and Customs Enforcement, and Michael P. Davis, Executive Deputy Principal Legal Advisor, Office of the Principal Legal Advisor, Immigration and Customs Enforcement (Mar. 20, 2019) (online at www.documentcloud.org/documents/6575024-ICE-Whistleblower-Report.html).

²⁹ *Id.*

³⁰ *Id.*

psychotic, likely worsening his symptoms. The Subcommittee on Civil Rights and Civil Liberties is continuing to investigate these complaints.³¹

2. Kamyar Samimi, Aurora ICE Processing Center

Kamyar Samimi, 64, died in December 2017 after being detained for 15 days at GEO Group’s Aurora ICE Processing Center in Colorado, also referred to as the Denver Contract Detention Facility (DCDF). GEO Group contracts with Correct Care Solutions to provide medical care at the facility.³² Mr. Samimi was a mechanic and father of three who had lived in the United States for more than 40 years and had been a legal permanent resident since 1978.³³

ICE’s death report for Mr. Samimi identified numerous deficiencies and concerns regarding Mr. Samimi’s medical care, including:

- “DCDF medical staff failed to transfer SAMIMI to an ER even though he exhibited life-threatening withdrawal symptoms during the week following his intake.”³⁴
- Nurses charged with caring for Mr. Samimi admitted they were not trained in understanding opioid withdrawal symptoms. Nurses interviewed by ICE stated that they thought Mr. Samimi was malingering.³⁵
- “DCDF’s physician never physically examined the detainee.”³⁶

“The magnitude of failures to care for this detainee is only surpassed by the number of such failures.”

- *Medical Expert Report for DHS Office for Civil Rights and Civil Liberties on Aurora ICE Processing Center, 2018*

³¹ Letter from Chairman Jamie Raskin, Committee on Oversight and Reform, Subcommittee on Civil Rights and Civil Liberties, to Cameron Quinn, Department of Homeland Security, Office for Civil Rights and Civil Liberties (Dec. 23, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2019-12-23.JR%20to%20DHS%20CRCL%20re%20ICE.pdf>).

³² Immigration and Customs Enforcement, *Findings—Death of ICE detainee Kamyar Samimi* (May 22, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Kamyar%20Samimi%20Death%20Report%20Dec%202017%20%28Denver-Aurora%29.pdf>).

³³ *ACLU Sues GEO Group and Doctor for Wrongful Death of Immigrant Detainee in Aurora, Colorado* Independent (Nov. 12, 2019) (online at www.coloradoindependent.com/2019/11/12/aclu-family-kamyar-samimi-wrongful-death-lawsuit/).

³⁴ Immigration and Customs Enforcement, *Findings—Death of ICE Detainee Kamyar Samimi* (May 22, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Kamyar%20Samimi%20Death%20Report%20Dec%202017%20%28Denver-Aurora%29.pdf>).

³⁵ *Id.*

³⁶ *Id.*

- Mr. Samimi suffered withdrawal from methadone, which is used to treat opioid addiction, and was prescribed medication for anxiety, restlessness, nausea, and pain. However, he was given only a fraction of the prescribed doses.³⁷
- Medical staff never completed the required initial physical assessment when Mr. Samimi was housed at the facility, a failure ICE attributed to understaffing. At the time of Mr. Samimi’s death, key medical positions at the facility, including the nursing director, had been vacant for more than six months.
- Nurses failed to consistently perform medical assessments of Mr. Samimi every shift and failed to take his vital signs every eight hours as a doctor had ordered.
- During Mr. Samimi’s last hours, he was placed on suicide watch. He exhibited seizure symptoms and vomited and urinated on himself, but multiple calls to the on-call physician, who is required to be available 24 hours per day, were never answered.
- A GEO Group committee in an internal review found that “both medical and security staff acted properly and in accordance with policy and procedures” in connection with Mr. Samimi’s death.
- ICE rejected those internal findings by GEO Group, explaining:

The committee’s findings are purportedly based on the detainee’s medical record and reports from medical staff; however, the report contains many statements that are inconsistent with the medical record, and findings that are unsupported by the medical record, which are examined in detail by Creative Corrections [an ICE contractor].³⁸

The Committee obtained internal documents showing that Mr. Samimi’s death resulted from egregious violations of medical standards and that these violations were part of systemic issues at the Aurora facility.

The Committee obtained a 2018 report by DHS’s Office for Civil Rights and Civil Liberties that examined Mr. Samimi’s death and detention conditions at Aurora and appended a report by a medical expert. The medical expert concluded:

While the medical examiner ruled the cause of death “undetermined,” the complete lack of medical leadership, supervision and care that this detainee was exposed to is simply astonishing and stands out as one of the most egregious failures to provide optimal care in my experience. The magnitude of failures to care for this detainee is only surpassed by the number of such failures. It truly appears that this system failed at every aspect of care possible beginning from using the correct withdrawal assessment tool to performing basic

³⁷ *Id.*

³⁸ *Id.*

nursing functions including the ability to recognize medical emergency situations to an astonishing lack of physician supervision, leadership and accountability.³⁹

This internal DHS expert report also raised significant concerns regarding systemic failures in medical care at the facility. The medical expert discovered “areas of poor performance some of which rise to the level of an unsafe environment of detention; and care that puts the health and wellbeing of ADF detainees at risk.”⁴⁰ For example, the report stated:

- “We found several examples of unacknowledged or untreated medical conditions of different severity including HIV, diabetes, hypothyroidism and chronic hematuria. ... Additionally, the chronic care clinic system appears to be broken and detainees are not receiving routinely scheduled chronic care clinic visits.”⁴¹
- A detainee who had been diagnosed with metastatic cancer was not seen by a doctor when he arrived at the facility for nearly two weeks and then did not see an oncologist for nearly three months.
- Another detainee with high blood pressure, high cholesterol, and chronic kidney disease did not first see a provider for over two months and did not get evaluated for his chronic diseases until more than four months after he arrived at Aurora.
- Vacancies in the medical department at Aurora were found to be “in part responsible for ADF’s failures to meet the minimum standards of care.”⁴²

“[T]he chronic care clinic system appears to be broken and detainees are not receiving routinely scheduled chronic care clinic visits.”

- *Medical Expert Report for DHS Office for Civil Rights and Civil Liberties on Aurora ICE Processing Center, 2018*

Based on those issues, DHS’s Office for Civil Rights and Civil Liberties identified several “major concerns for” ICE in November 2018, including:

- “DCDF lacked a centralized and dependable tracking tool for all the health care services and functions.”

³⁹ Department of Homeland Security, Office for Civil Rights and Civil Liberties, *Medical Expert Report on the Denver Contract Detention Facility* (Sept. 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Aurora%20CRCL%202018%20Expert%20Report.pdf>).

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

- “There were instances where DCDF medical staff failed to timely diagnose chronic care conditions and failed to provide adequate treatment for these conditions.”
- “In some instances, there was little to no documentation in the medical record of medications received.”
- “It was documented that DCDF medical did not transfer an acutely ill detainee to a facility capable of treating the detainee at the correct level of care in a timely manner.”
- “In many instances, detainees are not receiving routinely scheduled chronic care clinic visits.”⁴³

The Committee also obtained a GEO Group audit of the Aurora ICE Processing Center from June 2018, approximately seven months after Mr. Samimi’s death. This report recorded 86 deficiencies, 46 of which were related to health services. The audit found that none of the patients that needed to be treated for withdrawal symptoms were treated properly, which was a repeat finding from a 2017 audit. The 2018 audit also found that none of the detainees on suicide watch were checked every eight hours by medical staff as required, also a repeat problem from the prior year. The audit determined that medical personnel continued to fail to notify ICE of detainees with special needs and maintained detainees’ medical files in a disorganized manner.⁴⁴

In 2019, GEO Group audited the facility again and found that many of those serious issues with the facility remained. GEO Group’s 2019 audit, which was also obtained by the Committee, determined that many deficiencies that had been categorized in the previous audit as a “serious life safety” issue or one that “indicates the existence of a systemic failure” were not resolved. Half of the authorized medical positions remained unfilled. Detainees with chronic conditions were not provided timely medical care and were not treated in accordance with medical guidelines. Medical staff were also not timely responding to detainees’ sick calls, and medical records continued to be disorganized. The audit also found that other required audits had not been completed and that corrective action plans for medical issues were not being monitored to ensure identified issues were addressed.⁴⁵

⁴³ Department of Homeland Security, Office for Civil Rights and Civil Liberties, *Report on the Denver Contract Detention Facility* (Nov. 5, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Aurora%20CRCL%202018%20Expert%20Report.pdf>).

⁴⁴ GEO Group, *Annual Corporate Audit, Aurora ICE Processing Center* (2018).

⁴⁵ GEO Group, *Annual Corporate Audit, Aurora ICE Processing Center* (2019).

3. Vicente Caceres-Maradiaga, Adelanto Detention Facility

Vicente Caceres-Maradiaga, 46, died of an enlarged heart and liver in May 2017 after being detained for nine days at GEO Group’s Adelanto Detention Facility in California.⁴⁶ This facility is also referred to as the Adelanto Correctional Facility (ACF) or the Adelanto ICE Processing Center. GEO Group contracts with Correct Care Solutions to provide medical care at the facility. Mr. Caceres-Maradiaga was a construction worker who had been in the United States since 1999.⁴⁷

Mr. Caceres-Maradiaga’s death report identified several deficiencies and concerns, including:

- “A physician discharged CACERES from the infirmary on May 23, 2017 with an order for blood pressure monitoring which nurses never carried out.”⁴⁸
- Mr. Caceres-Maradiaga died eight days later after collapsing on a soccer field with chest pains. The blood pressure medication that Mr. Caceres-Maradiaga was administered when he first arrived was never recorded in his medical chart.
- When responding to the emergency call for Mr. Caceres-Maradiaga after he collapsed, medical staff encountered a number of equipment issues. The “ambu bag” used to aid a person’s breathing did not function properly, the stretcher could not accommodate an oxygen tank, there was no security strap on the back board used to get a person on to the stretcher, and there was no bulb syringe to remove liquid from a person’s airway.⁴⁹

“The failure to hire an effective and qualified clinical leader contributed to the inadequate detainee medical care that resulted in medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees at ACF.”

- *DHS Office for Civil Rights and Civil Liberties, 2018*

At least five other immigrants have died at Adelanto since 2012, including two deaths in the two months before Mr.

⁴⁶ Immigration and Customs Enforcement, *Investigative Findings—Death of ICE Detainee Vicente Caceres* (July 31, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Vincente%20Caceres%20Death%20Report%20May%202017%20%28Adelanto%29.pdf>).

⁴⁷ *Death Valley: Profit and Despair Inside California’s Largest Immigrant Detention Camp*, Project on Government Oversight (Dec. 22, 2018) (online at www.pogo.org/investigation/2018/12/death-valley-profit-and-despair-inside-californias-largest-immigrant-detention-camp/).

⁴⁸ Immigration and Customs Enforcement, *Investigative Findings—Death of ICE Detainee Vicente Caceres* (July 31, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Vincente%20Caceres%20Death%20Report%20May%202017%20%28Adelanto%29.pdf>).

⁴⁹ *Id.*

Caceres-Maradiaga died.⁵⁰ Internal documents obtained by the Committee show that the issues that led to Mr. Caceres-Maradiaga's death were systemic at Adelanto:

- In a 2018 internal DHS report on Adelanto obtained by the Committee, DHS's Office for Civil Rights and Civil Liberties (CRCL) stated:

In 2015, CRCL clearly informed Adelanto that clinical leadership was not competent and that problematic medical care was occurring as a result. In 2017—two years since the 2015 onsite—the experts found no evidence that corrections were made to address this issue. The failure to hire an effective and qualified clinical leader contributed to the inadequate detainee medical care that resulted in medical injuries, including bone deformities and detainee deaths, and continues to pose a risk to the safety of other detainees at ACF [Adelanto].⁵¹

- The 2018 report further stated:

In 2015, CRCL recommended that ACF should hold facility staff accountable for substantiated abusive and disrespectful treatment of detainees, as determined by the Grievance Coordinator and/or other facility personnel. This was not corrected.⁵²

- A June 2018 report obtained by the Committee shows that ICE informed GEO Group of “inadequate medical care” at Adelanto, noting that GEO Group was in “serious non-compliance with generally accepted medical practices.”⁵³ ICE found delayed treatment, unqualified staff in charge of administering medication to detainees, disorganized and inaccurate medical records, a “lack of leadership,” and the absence of an internal review process to prevent repeated medical errors.⁵⁴
- GEO Group's 2019 audit of Adelanto, also obtained by the Committee, showed additional violations regarding health services. The 2019 audit found that women

⁵⁰ Immigration and Customs Enforcement, *Investigative Findings—Death of ICE Detainee Sergio Alonso Lopez* (undated) (online at www.ice.gov/doclib/foia/reports/ddrLopez.pdf); Immigration and Customs Enforcement, *Investigative Findings—Death of ICE Detainee Osmar Epifanio Gonzalez-Gadba* (undated) (online at www.ice.gov/doclib/foia/reports/ddrGonzalez.pdf).

⁵¹ Department of Homeland Security, Office for Civil Rights and Civil Liberties, *Adelanto Correctional Facility* (Apr. 25, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Adelanto%20CRCL%20Investigation%202018.pdf>).

⁵² *Id.*

⁵³ Immigration and Customs Enforcement, *Contract Discrepancy Report for Adelanto ICE Processing Center* (June 4, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Adelanto%20ICE%20Contract%20Discrepancy%20Report%20June%204%202018.pdf>).

⁵⁴ *Id.*

at Adelanto were not receiving appropriate medical care, detainees with mental health concerns were not being monitored by medical staff, some medications on hand were expired, and chronically ill patients were not being routinely seen by medical staff.⁵⁵

These newly released documents confirm the findings of a DHS Inspector General report that identified serious issues at Adelanto that “pose significant health and safety risks,” including “Untimely and Inadequate Detainee Medical Care.”⁵⁶ They also confirm a previously disclosed 2017 report by a DHS consultant, which noted that staff vacancies “can create life threatening conditions for detainees held at this facility.”⁵⁷ Finding that detainees had filed hundreds of medical grievances over the past two years, the consultant concluded, “This large number of healthcare related grievances is not typical in a correctional setting and is a key indicator that the healthcare needs of the detainee population is not being met.”⁵⁸

The documents obtained by the Committee also confirm the findings of a doctor who inspected Adelanto for DHS in 2017 and wrote:

My review of medical records and interviews with detainees supported the allegations that access to medical care was slow and, in some cases, never happened. For example, I found that treatment for fractures is not undertaken with appropriate urgency at ACF. In a number of cases, injured detainees with documented fractures had to wait for initial evaluation, emergency medical consultation (if it happened at all), and definitive orthopedic care. Providers often failed to note or act on significant findings or recommendations made by outside medical specialists. The facility also continues to experience long delays for access to care for both acute and chronic medical conditions.⁵⁹

This report also described other examples of inadequate care at Adelanto:

For example, a detainee who underwent surgery to remove her gallbladder received no post-operative visit. Another patient who saw a urologist for an infection did not receive the antibiotics that were recommended. Yet, [sic] another patient saw a cardiologist who

⁵⁵ GEO Group, *Annual Corporate Audit, Adelanto ICE Processing Center* (2019).

⁵⁶ Department of Homeland Security, Office of Inspector General, *Management Alert—Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (Sept. 27, 2018) (online at www.oig.dhs.gov/sites/default/files/assets/2018-10/OIG-18-86-Sep18.pdf).

⁵⁷ *Despite Findings of ‘Negligent’ Care, ICE to Expand Troubled Calif. Detention Center*, NPR (Jan. 15, 2020) (online at www.npr.org/2020/01/15/794660949/despite-findings-of-negligent-care-ice-to-expand-troubled-calif-detention-center).

⁵⁸ Department of Homeland Security, Office for Civil Rights and Civil Liberties, *Corrections Expert’s Report on Adelanto Correctional Facility* (Nov. 16, 2017) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Adelanto%20CRCL%20Investigation%202018.pdf>).

⁵⁹ Department of Homeland Security, Office for Civil Rights and Civil Liberties, *On-Site Investigation Report on Adelanto Correctional Facility* (Dec. 12, 2017) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Adelanto%20CRCL%20Investigation%202018.pdf>).

made recommended medication changes that were ignored by the ACF physician, yet no comments or reasons were recorded in the detainee's medical record.⁶⁰

4. Mergensana Amar, Northwest Detention Center

Mergensana Amar, 40, died of suicide in November 2018 after being detained for approximately 11 months at the Northwest Detention Center (NWDC) in Washington state.⁶¹ The ICE Health Service Corps provides medical care at NWDC. Mr. Amar arrived in the United States seeking asylum on December 2, 2017.⁶²

An ICE Health Service Corps Report of Findings from December 2019 on Mr. Amar's death stated:

A mortality review committee (MRC) determined that Mr. AMAR's medical and behavioral health care at NWDC was not provided within the safe limits of practice. However, Mr. AMAR's multiple refusals made it difficult to manage his care and prevented NWDC's staff's ability to rule out an organic cause to his repeated non-compliance with his care.⁶³

This report found several "weaknesses" in Mr. Amar's care, including:

- Facility staff had difficulty communicating with Mr. Amar, including a "refusal to engage with behavioral health staff." However, the report also found: "Initially, medical staff utilized Russian interpreter services; however, medical staff stopped using an interpreter, stating Mr. AMAR, 'picked up the English language.'"⁶⁴
- A facility psychiatrist "discontinued Mr. AMAR's SW [suicide watch] within 24 hours after a six-foot rope was found under his mattress" on October 26, 2018. The report described this rope as "a handmade rope made of torn sheet pieces."

⁶⁰ *Id.*

⁶¹ Memorandum from [Redacted], Investigator, Immigration and Customs Enforcement Health Service Corps, to Stewart D. Smith, Assistant Director, Immigration and Customs Enforcement Health Service Corps (Dec. 3, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Amar%20Mortality%20Review%20-%20IHSC%20Report%20of%20Findings%202019.pdf>).

⁶² *Conditions at the NWDC: Allegations of Medical Neglect*, University of Washington Center for Human Rights (Apr. 16, 2020) (online at <https://jsis.washington.edu/humanrights/2020/04/16/nwdc-medical/>); *ICE Detainee Hanged Himself After Being Taken Off Suicide Watch*, Washington Post (Nov. 29, 2018) (online at www.washingtonpost.com/local/immigration/ice-detainee-hanged-himself-after-being-taken-off-suicide-watch/2018/11/28/67a62e74-edb8-11e8-baac-2a674e91502b_story.html).

⁶³ Memorandum from [Redacted], Investigator, Immigration and Customs Enforcement Health Services Corps, to Stewart D. Smith, Assistant Director, Immigration and Customs Enforcement Health Service Corps (Dec. 3, 2019) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Amar%20Mortality%20Review%20-%20IHSC%20Report%20of%20Findings%202019.pdf>).

⁶⁴ *Id.*

About three weeks later, Mr. Amar was found hanging in his cell on November 15 “with a self-made ligature around his neck.” A doctor at a nearby hospital declared Mr. Amar brain dead on November 18, and Mr. Amar died on November 24 after being taken off life support.⁶⁵

- “On November 4, 2018 custody staff found a sheet, that had been ripped into thirds, in Mr. AMAR’s cell. Custody staff documented the finding on a search log and disposed of the torn sheet. Custody did not submit a formal incident report.”⁶⁶ Notably, this incident occurred less than two weeks before Mr. Amar was found in his cell on November 15, 2018, and a little over one week after his one day on suicide watch on October 26 when staff discovered a rope made from torn sheets.
- The report found that “[t]he COs [custody officers] and medical staff did not stabilize Mr. AMAR’s head and neck when moving him from the cell floor to the stretcher” and “[p]er the video surveillance footage, the CO and medical staff had difficulty providing rescue breaths to Mr. AMAR.”⁶⁷

5. Jean Carlos Jimenez-Joseph, Stewart Detention Center

Jean Carlos Jimenez-Joseph, 27, died of suicide in May 2017 after being detained for 69 days at CoreCivic’s Stewart Detention Center in Georgia.⁶⁸ The ICE Health Service Corps provides medical care at Stewart. Mr. Jimenez-Joseph came to the United States as a child and was granted Deferred Action for Childhood Arrivals status in 2016. Mr. Jimenez-Joseph was detained by ICE in March 2017 following a misdemeanor arrest.⁶⁹

Mr. Jimenez-Joseph’s death report identified numerous deficiencies and concerns, including:

- Mr. Jimenez-Joseph repeatedly sought to have his medications increased or adjusted because he reported hearing voices and had been acting erratically and inappropriately. He jumped off a second-floor balcony and then informed medical staff that he had intended to commit suicide.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ Immigration and Customs Enforcement, *Findings—Death of ICE Detainee Jean Carlos Jimenez-Joseph* (July 1, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Jean%20Carlos%20Jimenez-Joseph%20Death%20Report%20May%202017%20%28Stewart%29.pdf>).

⁶⁹ *ICE Review Found Failures in Care of Mentally Ill Detainee Who Died by Suicide*, CBS News (Aug. 22, 2019) (online at www.cbsnews.com/news/jean-carlos-jimenez-joseph-ice-review-documented-failures-in-care-of-mentally-ill-detainee-who-died-by-suicide/).

- Due to mental health professional vacancies, staff postponed Mr. Jimenez-Joseph's next psychiatric evaluation by several weeks instead of addressing his repeated complaints.⁷⁰
- Instead of placing Mr. Jimenez-Joseph on suicide watch and getting him an urgent mental health assessment, Stewart staff disciplined him for jumping off the balcony and ordered him held in solitary confinement for 20 days. Staff that completed the written order for him to be placed in solitary failed to complete the section on mental health.⁷¹
- Officers failed to conduct the required surveillance of Mr. Jimenez-Joseph in the hours before he hung himself from the sprinkler head in his cell using a bed sheet. The report found: "In addition to leaving the unit unsupervised on seven occasions the night of JIMENEZ's suicide, Officer [Redacted] falsely logged that he completed security rounds at 12:00 a.m. and 12:28 a.m., neither of which were corroborated by video surveillance footage. These entries indicate Officer [Redacted] observed JIMENEZ alive at these times when he did not."⁷²
- Video surveillance shows the officer finally looked into Mr. Jimenez's cell at 12:43 a.m., after Mr. Jimenez had already hung himself.
- The death report found that the officer's supervisor also failed to monitor Jimenez: "Video surveillance footage shows Lieutenant [Redacted] reviewed documents outside JIMENEZ's cell at 11:58 p.m. and 12:11 a.m., but did not look directly into the cell on either occasion."⁷³
- The officer that discovered Mr. Jimenez-Joseph had hung himself left the unit to obtain a cut down tool instead of calling for another officer to bring one, leading to a delay in opening the cell and relieving the pressure on Mr. Jimenez-Joseph's neck. The ICE investigation also found staff delayed calling 911 after discovering Mr. Jimenez-Joseph hanging.⁷⁴

⁷⁰ Immigration and Customs Enforcement, *Findings—Death of ICE Detainee Jean Carlos Jimenez-Joseph* (July 1, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Jean%20Carlos%20Jimenez-Joseph%20Death%20Report%20May%202017%20%28Stewart%29.pdf>).

⁷¹ The United Nations sets 15 days as the point at which solitary confinement could be considered torture and does not recommend solitary confinement for people with mental health issues. See United Nations, *Solitary Confinement Should Be Banned in Most Cases, UN Expert Says* (Oct. 18, 2011) (online at <https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says>).

⁷² Immigration and Customs Enforcement, *Findings—Death of ICE Detainee Jean Carlos Jimenez-Joseph* (July 1, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Jean%20Carlos%20Jimenez-Joseph%20Death%20Report%20May%202017%20%28Stewart%29.pdf>).

⁷³ *Id.*

⁷⁴ *Id.*

Mr. Jimenez-Joseph's death was one of at least eight that have occurred at Stewart since 2008. Previously unreleased documents obtained by the Committee show the systemic deficiencies that led to his death at Stewart. Along with other documents described below, these documents show serious issues at Stewart persisting over several years:

“CoreCivic’s negligence was a contributing factor in the death of both detainees at the Stewart Detention Center.”

- ICE Report, 2018

- An October 2018 ICE report obtained by the Committee discussing Mr. Jimenez-Joseph’s death and the death of a second detainee, Efrain de la Rosa, stated that “CoreCivic’s negligence was a contributing factor in the death of both detainees at the Stewart Detention Center.”⁷⁵
- Mr. de la Rosa, 40, also died by suicide at Stewart in July 2018. The report says that CoreCivic’s “gross negligence” and “egregious and non-compliant” infractions of detention standards led to Mr. de la Rosa’s death.⁷⁶
- The two deaths display alarming similarities: both detainees were placed in solitary confinement despite having serious mental illnesses, neither receive recommended mental healthcare, and in both incidents, officers failed to properly monitor their cells, falsified observation logs, and bungled the emergency response.⁷⁷
- A December 2017 internal ICE memorandum obtained by the Committee shows that ICE found “a pattern of excessive uses-of-force” at Stewart and that even after the incidents were reported “effective corrective action has yet to result.”⁷⁸
- A February 2018 ICE report obtained by the Committee shows that Stewart guards failed to conduct appropriate medically-ordered one-on-one observation of a suicidal individual during a 13-hour period.⁷⁹

⁷⁵ Immigration and Customs Enforcement, *Contract Discrepancy Report, Stewart Detention Center* (Dec. 11, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Stewart%20Contract%20Discrepancy%20Dec%202018.pdf>).

⁷⁶ *Id.*

⁷⁷ *Newly Released Documents Reveal Mounting Chaos and Abuse at a Troubled ICE Detention Center*, Fast Company (Jan. 29, 2019) (online at www.fastcompany.com/90298739/newly-released-documents-reveal-mounting-chaos-and-abuse-at-a-troubled-ice-detention-center).

⁷⁸ Memorandum from Immigration and Customs Enforcement, Detention Monitoring Unit, to Immigration and Customs Enforcement, Atlanta Field Office (Dec. 18, 2017) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Stewart%20ICE%20Memo%20Dec%202017.pdf>).

⁷⁹ Immigration and Customs Enforcement, *Contract Discrepancy Report, Stewart Detention Center* (Feb. 28, 2018) (online at

These documents confirm earlier findings from the DHS Inspector General and DHS Office for Civil Rights and Civil Liberties:

- In December 2017, the Inspector General issued a report detailing findings from inspections of five detention facilities that “identified problems that undermine the protection of detainees’ rights, their humane treatment, and the provision of a safe and healthy environment.” At Stewart, the Inspector General found security risks and problems with detainee medical care due to inadequate staffing and oversight.⁸⁰
- In a March 2019 report, the DHS Office for Civil Rights and Civil Liberties informed ICE of a complaint regarding a case at Stewart in which “a delay in care occurred after medical staff were notified of the detainee’s critical lab result that should have resulted in immediate medical intervention.”⁸¹ The detainee was reportedly bleeding through his skin and having vision changes, and despite having extremely thin blood, the physician kept him on an aspirin regimen for six days, “resulting in his coughing up large amounts of blood.”⁸² The complaint stated the detainee was not expected to survive and that, after an internal review determined the aspirin therapy may lead to a fatality, “The findings were forwarded to IHSC leadership for consideration of a root cause analysis, yet IHSC leadership failed to take appropriate action.”⁸³
- Finally, in a July 2020 report on unannounced ICE facility inspections, the DHS Inspector General found that staff at a county-run ICE facility similarly failed to properly monitor detainees in solitary confinement. The report noted: “Proper monitoring of detainees in segregation is particularly critical given that research has found segregation can have damaging effects and is an established risk factor for suicide.”⁸⁴

<https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Stewart%20Contract%20Discrepancy%20Feb%202018.pdf>.

⁸⁰ Department of Homeland Security, Office of Inspector General, *Concerns about ICE Detainee Treatment and Care at Detention Facilities* (Dec. 11, 2017) (online at www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf).

⁸¹ Memorandum from Cameron P. Quinn, Department of Homeland Security, Office for Civil Rights and Civil Liberties, and Marc Pachon, Department of Homeland Security, Office of Legal Counsel, to Ronald Vitiello, Deputy Director and Senior Official Performing the Duties of the Director, Immigration and Customs Enforcement, and Michael P. Davis, Executive Deputy Principal Legal Advisor, Office of the Principal Legal Advisor, Immigration and Customs Enforcement (Mar. 20, 2019) (online at www.documentcloud.org/documents/6575024-ICE-Whistleblower-Report.html).

⁸² *Id.*

⁸³ *Id.*

⁸⁴ Department of Homeland Security, Office of Inspector General, *Capping Report: Observations of Unannounced Inspections of ICE Facilities in 2019* (July 7, 2020) (online at www.oig.dhs.gov/sites/default/files/assets/2020-07/OIG-20-45-Jul20.pdf).

Committee staff inspected the Stewart Detention Center in September 2019 and identified additional concerns regarding medical care. The facility, which can house more than 2,000 detainees, reported having only one doctor on staff. Stewart also lacked defibrillators throughout the facility, even though a man waiting to be deported had died of cardiopulmonary arrest in July 2019.⁸⁵ Staff observed that given the large size of the facility, a single defibrillator located in the medical care unit may not be sufficient to deal with cardiovascular emergencies such as the one that led to the detainee’s death.

6. Roger Rayson, LaSalle Detention Facility

Roger Rayson, 47, died of a brain hemorrhage in ICE custody in March 2017 after being detained for 45 days at GEO Group’s LaSalle Detention Facility in Louisiana and at local hospitals.⁸⁶ The ICE Health Service Corps provides medical care at LaSalle.

Mr. Rayson’s death report, which has previously been released, identified numerous deficiencies and concerns, including:

- Medical staff never developed a plan to treat Mr. Rayson’s intense pain caused by medical conditions including diabetes, HIV, cancer, and mobility issues. Staff repeatedly failed to treat Mr. Rayson for that pain and allowed him to be placed in non-medical housing units where it was not possible to effectively monitor and treat him.
- When Mr. Rayson was placed in solitary confinement, medical staff did not routinely open the cell door to check on him even though the intercom for his cell was broken the entire time he was there. After moving Mr. Rayson out of solitary confinement and to a hospital, medical staff found his cell covered in blood, urine, vomit, and fecal matter.
- Medical staff determined that Mr. Rayson needed a higher level of care than was available at LaSalle, but never secured such treatment.
- Mr. Rayson never received a recommended consultation from an infectious disease specialist, despite having HIV.⁸⁷

“Mr. Rayson’s healthcare was ‘deplorable.’”

- *Complaint submitted by IHSC staff*

⁸⁵ Immigration and Customs Enforcement, *ICE Detainee Passes Away at Georgia Hospital* (July 25, 2019) (online at www.ice.gov/news/releases/ice-detainee-passes-away-georgia-hospital-2).

⁸⁶ Immigration and Customs Enforcement, *Findings—Death of ICE Detainee Roger Rayson* (2017) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Roger%20Rayson%20Death%20Report%20Mach%202017%20%28LaSalle%29.pdf>).

⁸⁷ *Id.*

The Committee obtained a previously unreleased March 2019 DHS Office for Civil Rights and Civil Liberties complaint that discussed Mr. Rayson's death and identified broader concerns about healthcare at LaSalle. According to the report, a whistleblower stated that "Mr. Rayson's healthcare was 'deplorable.'"⁸⁸ The complaint alleged multiple detainees at LaSalle were forcibly medicated for behavioral issues in violation of ICE policy, and that IHSC leadership did not further investigate the incidents.

Mr. Rayson's death follows at least five others at the facility since 2008.⁸⁹

B. Lack of Transparency About Detainee Deaths

Since 2018, Congress has required ICE to publicly release all in-custody death investigation reports within 90 days of any death, but ICE has failed to fully comply with that requirement. Federal law states:

ICE is directed to ... complete and make public an initial report regarding any in-custody death within 30 days of such death, with subsequent reporting to be completed and released within 60 days of the initial report unless additional time is required for redacting personally identifiable information.⁹⁰

ICE posts cursory factual summaries of each detainee death within the initial 30 days of a death in custody, but it has not made public the investigative detainee death reports, which identify deficiencies in compliance with detention standards.⁹¹

For example, ICE posted a brief "Detainee Death Report" regarding the death of Huy Chi Tran. However, this report does not describe the delayed and inadequate care and mishandled emergency care Mr. Tran received at Eloy Detention Facility in June 2018.⁹² The Committee obtained the complete investigative report on Mr. Tran only in response to its request, more than a year after Mr. Tran's death.

⁸⁸ Memorandum from Cameron P. Quinn, Department of Homeland Security, Office for Civil Rights and Civil Liberties, and Marc Pachon, Department of Homeland Security, Office of Legal Counsel, to Ronald Vitiello, Deputy Director and Senior Official Performing the Duties of the Director, Immigration and Customs Enforcement, and Michael P. Davis, Executive Deputy Principal Legal Advisor, Office of the Principal Legal Advisor, Immigration and Customs Enforcement (Mar. 20, 2019) (online at www.documentcloud.org/documents/6575024-ICE-Whistleblower-Report.html).

⁸⁹ Human Rights Watch et al., *Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention* (June 2018) (online at www.aclu.org/sites/default/files/field_document/coderedreportdeathsicedetention.pdf).

⁹⁰ House Committee on Appropriations, Department of Homeland Security Appropriations Bill, 2018, Rep. No. 115-239 (online at www.congress.gov/115/crpt/hrpt239/CRPT-115hrpt239.pdf).

⁹¹ See Immigration and Customs Enforcement, *Death Detainee Report* (online at www.ice.gov/death-detainee-report) (accessed Sept. 23, 2020).

⁹² Immigration and Customs Enforcement, *Death Summary, Huy Chi Tran* (undated) (online at www.ice.gov/doclib/foia/reports/ddrTranHuyChi.pdf).

ICE has failed to publicly release detailed investigative death reports for any of the more than 25 detainee deaths covered by the 2018 law.

C. Widespread Failures in Medical Care for Detainees

Documents obtained by the Committee, including ICE and contractor audit documents, identify glaring deficiencies in the medical care provided to detainees at facilities operated by for-profit contractors. According to these internal documents, detainees in these facilities often do not receive critical treatment or face delays, and many facilities lack sufficient medical staff and fail to provide necessary care to detainees with chronic medical conditions. For example:

- The Committee obtained an internal report from the ICE Health Service Corps regarding CoreCivic’s Northeast Ohio Correctional Center. This report substantiated an allegation of an “unacceptably long” delay in treatment for a detainee with possible lymph node cancer even after an outside doctor wrote to the facility stressing the urgency of treatment. The report concluded, “This delay and [sic] resulted in an effective denial in access to care for a serious medical condition.”⁹³
- In 2018, ICE discovered that a physician at CoreCivic’s Laredo Processing Center in Texas was making outside referrals for detainees to his own private medical practice. ICE informed CoreCivic:

As you can understand, whether it is the current LPC Agreement, or the upcoming new ICE IGSA, this is a clear conflict of issue [sic], for the physician will be profiting when sending the patient out for treatment at his private facility. This can certainly drive up risk for a variety of reasons, such as unnecessary treatment and failure to provide treatment at the detention center which may have been able to have been performed there.⁹⁴

- In 2019, auditors found that the Laredo facility was not operating its health care clinic in compliance with state and local laws. The 2019 audit report obtained by the Committee noted: “Detainees in chronic care were not in compliance with medical standard,” “Follow up visits were not completed within required time frame,” and “Medications were discontinued as a result of the missed visits.”⁹⁵

⁹³ Immigration and Customs Enforcement, *ICE Health Service Corps, Health Care Compliance Assessment, North East Ohio Correctional Center* (2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Northeast%20Ohio%20CAP%202018.pdf>).

⁹⁴ Email from Immigration and Customs Enforcement Contracting Officer to [Redacted], CoreCivic (June 14, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Laredo%20Email%20%20June%202018%20re%20Health%20Care%20Staff.pdf>).

⁹⁵ CoreCivic, *2019 Operational Audit Tool, Laredo Processing Center* (Feb. 28, 2019).

- A 2017 audit of GEO Group’s Joe Corley Detention Facility in Texas found that non-medical staff handled sick calls for detainees—a problem also identified in a previous audit. The 2017 audit also noted that one doctor at the facility did not have an active medical license.⁹⁶
- In 2018, ICE found that a significant lack of physician coverage at CoreCivic’s Webb County Detention Center in Texas was “providing a degradation of services to detainee health care.”⁹⁷
- Internal audit reports of GEO Group’s Mesa Verde ICE Processing Center in California reveal a host of concerns regarding medical treatment that have gotten worse over the past three years:
 - A 2017 audit found that the medical team was understaffed, detainees with mental health needs were not being consistently monitored or treated, sick calls were not triaged based on severity, and female detainees did not receive appropriate medical screenings.⁹⁸
 - A 2018 audit found that sick calls were still not appropriately triaged, some medical care for women was delayed, and some health assessments were conducted by untrained nurses.⁹⁹
 - A 2019 audit contained a “significant number of findings” related to medical care, including that the medical team was understaffed, chronic care follow-up appointments were not completed, lab tests were not ordered or reviewed timely, annual examinations were not conducted, and recordkeeping was poor.¹⁰⁰
- A 2018 internal audit at CoreCivic’s Cibola County Correctional Center in New Mexico found persistent delays in medical care for detainees. Initial health visits, sick calls, and chronic care for cardiovascular, pulmonary and infectious diseases were all found not to occur within the required time frames. The audit also found that due to staffing shortages officers were pulled from their posts to cover security positions and were unable to provide sufficient support to detainees.¹⁰¹

⁹⁶ GEO Group, *Annual Corporate Audit, Joe Corley Detention Facility* (Aug. 15, 2017).

⁹⁷ Email from Immigration and Customs Enforcement Contracting Officer to [Redacted], CoreCivic (June 14, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Laredo%20Email%20%20June%202018%20re%20Health%20Care%20Staff.pdf>).

⁹⁸ GEO Group, *Annual Corporate Audit, Mesa Verde Detention Facility* (May 8, 2017).

⁹⁹ GEO Group, *Annual Corporate Audit, Mesa Verde ICE Processing Center* (Apr. 4, 2018).

¹⁰⁰ GEO Group, *Annual Corporate Audit, Mesa Verde ICE Processing Center* (Apr. 15, 2019).

¹⁰¹ CoreCivic, *2018 ICE PBNDS 2011 and USMS Inspection Audit Tool, Cibola County Correctional Center* (Oct. 4, 2018).

D. Concerns Raised in Committee Staff Inspections

During Committee staff inspections of detention facilities, many detainees reported that when facility personnel did not deem medical issues to be emergencies, they did not take them seriously. Individuals suffering from migraine headaches, hernias, and high blood pressure reported that their conditions went untreated.

At ICE's Port Isabel Detention Center in Texas, a detainee reportedly remained in medical quarantine for nine days with facial swelling before doctors diagnosed him with mumps. By that time, the pain had migrated to his groin, and he had permanently lost hearing in one ear.

At the Otay Mesa Detention Center in California, multiple detainees reported that a female detainee had exhibited symptoms of a stroke, but facility staff failed to take the issue seriously or call 911 in a timely manner. According to these accounts, the woman survived, but was partially paralyzed.

A detainee at CoreCivic's T. Don Hutto Residential Center in Texas reported to staff that food is moldy or rotten about twice a week, and that the detainee has become sick from eating food at the facility. A detainee at the Folkston ICE Processing Center said that detainees were once served rotten meat.

A detainee at the South Texas Detention Center informed staff that a guard refused multiple requests for medical attention throughout a night when the detainee reported a sudden and severe migraine. The guard informed the detainee that he would have to wait until the sick call the following morning to get medical attention, even though the facility reported that it had medical staff available 24 hours per day.

At GEO Group's Folkston ICE Processing Center in Georgia, detainees told staff that the toilets at their facility are filthy and were cleaned only prior to the staff's inspection. These detainees said that more than 60 detainees are forced to share approximately three toilets, a ratio that fails to comply with ICE detention standards.¹⁰²

Detainees at the Irwin County Detention Center, operated by contractor LaSalle Corrections in Georgia, reported to staff that bathroom facilities are dirty and that toilets and sinks at the facility often malfunction. Detainees at this facility also reported numerous untreated medical concerns. One detainee said that his medicine was taken away when he arrived at the facility, even though he had come from another ICE detention center. Another detainee said that staff removed lifts he needed in his shoes due to unequal leg length, forcing him to walk with a cane. Another detainee said he had not been treated for ongoing tooth pain, while yet another said he had not received medication for his high blood pressure. Several detainees also reported that a detainee was given a wheelchair that did not function properly and was forced to rely on assistance from other detainees to use the restroom.

¹⁰² Immigration and Customs Enforcement, Department of Homeland Security, *Performance-Based National Detention Standards 2011 § 4.5 (V)(E)(1)* (2016) (online at www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf).

Finally, at CoreCivic's Adams County Correctional Center in Mississippi, a detainee shouted through a glass partition that he was being abused and humiliated and wished to urgently speak with Committee staff. Rather than permit him to speak, an ICE official threatened to end the tour immediately and cancel future site visits if Committee staff attempted to communicate with the detainees.

E. Deficient Sanitation and Mismanagement of Infectious Diseases

The dangers faced by immigrants in custody have been compounded during the coronavirus pandemic as a result of deficient sanitation practices and poor handling of infectious diseases.

ICE has confirmed that more than 6,000 detainees and ICE staff have contracted coronavirus at more than 95 detention facilities.¹⁰³ At least four detainees have died after contracting the coronavirus in ICE custody.¹⁰⁴ The Committee has learned from GEO Group that, as of July 7, 2020, there were 130 confirmed coronavirus cases among GEO Group employees at ICE facilities.¹⁰⁵ The Committee has also learned from CoreCivic that, as of July 16, 2020, three of its employees at ICE facilities had died from coronavirus infections, 37 were in quarantine, 155 had confirmed cases, and 349 had previously recovered from the virus. These numbers include an alarming cluster at the Eloy Detention Center in Arizona where, as of July 16, 2020, there were 43 confirmed cases and 120 staff who previously recovered.¹⁰⁶

Documents obtained by the Committee raise concerns that these numbers will continue to rapidly increase because detainees often are not provided basic immunizations and are forced to live and eat in unsanitary conditions. Documents indicate that detainees in ICE facilities are not receiving recommended vaccinations for contagious diseases on a consistent basis or at all and are not appropriately treated for other infectious diseases such as tuberculosis, HIV, MRSA, meningitis, and hepatitis.

¹⁰³ Immigration and Customs Enforcement, *ICE Guidance on COVID-19, Confirmed Cases* (online at www.ice.gov/coronavirus) (accessed Sept. 23, 2020).

¹⁰⁴ *A 51-Year-Old Immigrant Man from Mexico Has Died in ICE Custody After Testing Positive for COVID-19*, BuzzFeed News (July 13, 2020) (online at www.buzzfeednews.com/article/adolfoflores/mexican-immigrant-dies-in-ice-custody); *An Immigrant Man in ICE Custody Died After Contracting the Coronavirus*, BuzzFeed News (May 24, 2020) (online at www.buzzfeednews.com/article/hamedaleaziz/immigrant-ice-coronavirus-death); *A Honduran Man Has Died of COVID-19 After Leaving an ICE Jail Plagued by the Virus*, Mother Jones (May 14, 2020) (online at www.motherjones.com/politics/2020/05/a-honduran-man-has-died-of-covid-19-after-leaving-an-ice-jail-plagued-by-the-virus/); *San Diego Detainee is First in ICE Custody to Die of COVID-19*, Los Angeles Times (May 6, 2020) (online at www.latimes.com/california/story/2020-05-06/first-ice-detainee-dies-coronavirus-otay-mesa-detention-center).

¹⁰⁵ Email from Attorney for GEO Group to Staff, Committee on Oversight and Reform (July 15, 2020).

¹⁰⁶ Letter from Attorneys for CoreCivic to Chairwoman Carolyn B. Maloney, Committee on Oversight and Reform (July 17, 2020).

For example, in 2016, an outbreak of measles at CoreCivic's Eloy Detention Center infected 22 detainees and staff.¹⁰⁷ In 2018, hundreds of detainees were diagnosed with the flu and chickenpox at multiple facilities.¹⁰⁸ In 2018 and 2019, an outbreak of the mumps infected nearly 900 detainees in 57 ICE detention facilities across 19 states.¹⁰⁹ According to the documents obtained by the Committee:

- Numerous ICE facilities do not consistently provide vaccinations for the flu or pneumonia. Those facilities include Karnes County Residential Center, which houses adults and children, Cibola County Correctional Center, Laredo Processing Center, West Tennessee Detention Facility, Webb County Detention Facility, La Palma Correctional Center, Tallahatchie County Correctional Facility, Nevada Southern Detention Center, and Adams County Correctional Center.¹¹⁰
- A 2018 ICE inspection of the Northeast Ohio Correctional Center found that a detainee who had been prescribed a multi-drug treatment for tuberculosis had not been provided 17 dosages over a span of 33 days.¹¹¹
- An IHSC supervisor alleged in 2018 that a detainee at CoreCivic's Houston Processing Center was removed from isolation despite having tuberculosis.¹¹² At least 145 detainees and two ICE employees at this facility have tested positive for coronavirus.¹¹³

¹⁰⁷ *Measles Outbreak Ends at Eloy Migrant Detention Center*, AZ Central (Aug. 4, 2016) (online at www.azcentral.com/story/news/local/pinal/2016/08/04/measles-outbreak-ends-eloy-migrant-detention-center/88046278/).

¹⁰⁸ *Mumps, Other Outbreaks Force U.S. Detention Centers to Quarantine Over 2,000 Migrants*, Reuters (Mar. 10, 2019) (online at www.reuters.com/article/us-usa-immigration-outbreaks/mumps-other-outbreaks-force-us-detention-centers-to-quarantine-over-2000-migrants-idUSKBN1QR0EW).

¹⁰⁹ *Nearly 900 Immigrants Had the Mumps in Detention Centers in the Last Year*, BuzzFeed News (Aug. 29, 2019) (online at www.buzzfeednews.com/article/stephaniemlee/mumps-ice-immigrant-detention-cdc).

¹¹⁰ GEO Group, *Annual Corporate Audit, Karnes County Residential Center* (Oct. 2017); CoreCivic, *2018 ICE PBND S 2011 and USMS Inspection Audit Tool, Cibola County Correctional Center* (Oct. 4, 2018); CoreCivic, *2019 Operational Audit Tool, Laredo Processing Center* (Feb. 28, 2019); CoreCivic, *2017 ICE PBND S08 (2013 version), USMS FPBDS, and BOP Inspection Tool, West Tennessee Detention Facility* (Sept. 14, 2017); CoreCivic, *2017 USMS FPBDS and ICE NDS Audit Tool, Webb County Detention Facility* (Aug. 10, 2017); CoreCivic, *2018 California Audit Tool, La Palma Correctional Center* (Nov. 8, 2018); CoreCivic, *California PPCHC (Medical Monitoring) Audit Tool, Tallahatchie County Correctional Facility* (Aug. 3, 2017); CoreCivic, *2018 ICE PBND S08 (2013 version), USMS FPBDS, and BOP Inspection Audit Tool, Nevada Southern Detention Center* (Sept. 20, 2018); CoreCivic, *2018 BOP Audit Tool, Adams County Correctional Center* (Aug. 16, 2018).

¹¹¹ Immigration and Customs Enforcement, Office of Detention Oversight, *Compliance Inspection, Northeast Ohio Correctional Center* (Mar. 2018) (online at www.ice.gov/doclib/foia/odo-compliance-inspections/2018-NortheastOhioCC-YoungstownOH-0313-152018.pdf).

¹¹² *ICE Detainee Deaths Were Preventable: Document*, The Young Turks (June 3, 2019) (online at <https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h>).

¹¹³ Immigration and Customs Enforcement, *ICE Guidance on COVID-19, Confirmed Cases* (online at www.ice.gov/coronavirus) (accessed Sept. 23, 2020).

- An IHSC complaint alleged that the death of detainee Ronald Cruz in 2018 at ICE’s Port Isabel Detention Center in Texas due to meningitis was the result of “grossly negligent” medical care.¹¹⁴ At least 148 detainees at this facility have tested positive for coronavirus.¹¹⁵
- Audit documents from 2017 and 2018 at the Adams County Correctional Center found repeated issues with the treatment of detainees for infectious diseases, including incomplete treatments and monitoring for hepatitis, tuberculosis, and HIV, and improper treatment protocols used for a detainee with MRSA.¹¹⁶ ICE has reported that Adams County has identified at least 82 detainees infected with coronavirus.¹¹⁷
- Audits of Cibola County Correctional Center, Adelanto Detention Facility, Central Arizona Florence Correctional Complex, Laredo Processing Center, and Broward Transitional Center found that detainees with HIV were not receiving necessary medical care or monitoring.¹¹⁸ At Aurora ICE Processing Center, one detainee tested positive for HIV, but was not informed of

“I also discovered several [sic] areas of poor performance some of which rise to the level of an unsafe environment of detention; and care that puts the health and wellbeing of ADF detainees at risk.”

- *DHS Office for Civil Rights and Civil Liberties Doctor regarding Aurora ICE Processing Center, 2018*

¹¹⁴ Memorandum from Cameron P. Quinn, Department of Homeland Security, Office for Civil Rights and Civil Liberties, and Marc Pachon, Department of Homeland Security, Office of Legal Counsel, to Ronald Vitiello, Deputy Director and Senior Official Performing the Duties of the Director, Immigration and Customs Enforcement, and Michael P. Davis, Executive Deputy Principal Legal Advisor, Office of the Principal Legal Advisor, Immigration and Customs Enforcement (Mar. 20, 2019) (online at www.documentcloud.org/documents/6575024-ICE-Whistleblower-Report.html).

¹¹⁵ Immigration and Customs Enforcement, *ICE Guidance on COVID-19, Confirmed Cases* (online at www.ice.gov/coronavirus) (accessed Sept. 23, 2020).

¹¹⁶ CoreCivic, *2017 BOP Audit Tool, Adams County Correctional Center* (July 27, 2017); CoreCivic, *2018 BOP Audit Tool, Adams County Correctional Center* (Aug. 16, 2018).

¹¹⁷ Immigration and Customs Enforcement, *ICE Guidance on COVID-19, Confirmed Cases* (online at www.ice.gov/coronavirus) (accessed Sept. 23, 2020).

¹¹⁸ CoreCivic, *2018 ICE PBNDS 2011 and USMS Inspection Audit Tool, Cibola County Correctional Center* (Oct. 4, 2018); Immigration and Customs Enforcement, *ICE Health Service Corps, Quality of Care Assessment, Adelanto Detention Facility* (Jan. 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Adelanto%20IHSC%20Quality%20of%20Care%20Assessment%202018.pdf>); Department of Homeland Security, *ICE Health Service Corps, Final Report of Findings, Laredo Processing Center* (Oct. 23, 2017) (<https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Laredo%20Processing%20Center%20-%20Final%20Report%20of%20Findings%20Oct%202017.pdf>); GEO Group, *Annual Corporate Audit, Broward Transitional Center* (2018); Immigration and Customs Enforcement, *ICE Health Service Corps, Quality of Care Assessment, Central Arizona Florence Correctional Complex* (Dec. 2017) (online at

the diagnosis.¹¹⁹ ICE has reported more than 225 detainees who have tested positive for coronavirus at these facilities, including 146 at Broward Transitional Center.¹²⁰

- At La Palma Correctional Center, ICE found that detention staff were not informing visitors that there was an active case of varicella and mumps at the facility.¹²¹ ICE has reported that La Palma identified 366 detainees infected with coronavirus.¹²²

Detainees are frequently held in unsanitary conditions that make it easier for contagious diseases to spread, especially during the ongoing coronavirus pandemic when detainees frequently must clean the facilities themselves without appropriate personal protective equipment.¹²³

Documents obtained by the Committee reveal that many ICE facilities, including those that house children, have had repeated sanitation problems. For example, detainees have experienced food that is cold or contains bugs, dirty and moldy bathrooms, insufficient clean clothing, unsanitized dishes, dirty food preparation and service areas, and a lack of soap, toilet paper, paper towels, clean razors, and other hygiene items.¹²⁴

<https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Florence%20County%20IHSC%20Assessment%202017.pdf>).

¹¹⁹ Department of Homeland Security, Office for Civil Rights and Civil Liberties, *Investigation of the Denver Contract Detention Facility* (Nov. 5, 2018) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Aurora%20CRCL%202018%20Expert%20Report.pdf>).

¹²⁰ Immigration and Customs Enforcement, *ICE Guidance on COVID-19, Confirmed Cases* (online at www.ice.gov/coronavirus) (accessed Sept. 23, 2020).

¹²¹ Immigration and Customs Enforcement, Office of Detention Oversight, *External Audit, La Palma Correctional Center* (Mar. 2019).

¹²² Immigration and Customs Enforcement, *ICE Guidance on COVID-19, Confirmed Cases* (online at www.ice.gov/coronavirus) (accessed Sept. 23, 2020).

¹²³ *Detainees Can't Get Gloves, Gowns for Virus Cleaning Duties*, Law360 (Apr. 23, 2020) (online at www.law360.com/articles/1266665/detainees-can-t-get-gloves-gowns-for-virus-cleaning-duties).

¹²⁴ See, e.g., CoreCivic, *2017 ICE PBNDS and USMS FPBDS Audit Tool, Northeast Ohio Correctional Center* (Mar. 30, 2017) (cold food); CoreCivic, *2018 BOP Audit Tool, Adams County Correctional Center* (Aug. 16, 2018) (cold food); Immigration and Customs Enforcement, *Detention Services Manager Report, Houston Contract Detention Facility* (Mar. 2017) (dirty bathrooms) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Houston%20Detention%20Facility%20March%202017.pdf>); Immigration and Customs Enforcement, Office of Detention Oversight, *Compliance Inspection, South Texas Family Residential Center* (Dec. 2018) (dirty bathrooms) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/South%20Texas%20Detention%20Facility%20Inspection%202018.pdf>); Immigration and Customs Enforcement, Office of Detention Oversight, *Compliance Inspection, Joe Corley ICE Processing Center* (July 2018) (dirty living units) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Corley%20Compliance%20Inspection%20Report%202018.pdf>); GEO Group, *Annual Corporate Audit, Aurora ICE Processing Center* (June 2019) (unsanitary food service area); CoreCivic, *2019 Operational Audit Tool, La Palma Correctional Center* (Apr. 18, 2019) (dirty

III. CONCLUSION

The Committee's investigation found that immigrants in detention centers operated by for-profit contractors are facing negative health outcomes and even death as a result of inadequate medical care, poor conditions, understaffing, and delayed emergency care. At times, facility staff have falsified records to cover up these problems.

Documents obtained by the Committee show that ICE has not properly managed infectious and chronic diseases and failed to maintain a sanitary environment for detainees and staff, making these facilities a particularly dangerous environment as the coronavirus continues to spread.

Immediate changes to detention standards and how those standards are monitored are needed to ensure that immigrants in U.S. custody are treated humanely and consistent with domestic and international legal obligations.

ICE should use existing contract provisions to hold contractors like CoreCivic and GEO Group accountable, should not renew contracts plagued by a history of serious health and safety issues without demonstrations of significant and major improvements, and should decrease the use of contractor facilities along with decreasing unnecessary immigration detention.

More robust oversight by the DHS Inspector General and the ICE Office of Professional Responsibility is also warranted.

The Administration has known for years about systemic health and safety issues at detention facilities operated by for-profit contractors. Yet, the Administration has continued to renew contracts with these companies and pay them billions of taxpayer dollars without providing proper oversight. These actions have led to the deaths of immigrants in custody and dangerously deficient conditions for many more.

bathrooms, lack of soap); Immigration and Customs Enforcement, *COR Monthly Performance Report, Otay Detention Facility* (June 2018) (issuing used razors) (online at <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Otay%20Mesa%20Performance%20Report%202018.pdf>).

APPENDIX

DHS Facilities Visited by Bipartisan Committee Staff Delegations **August—September 2019**

ICE Detention Facilities:

1. Adams County Correctional Center, Natchez, MS (CoreCivic)
2. Catahoula Correctional Center, Harrisonburg, LA (LaSalle Corrections)
3. Pine Prairie ICE Processing Center, Pine Prairie, LA (GEO Group)
4. Otay Mesa Detention Center, San Diego, CA (CoreCivic)
5. Port Isabel Detention Center, Los Fresnos, TX
6. T. Don Hutto Residential Center, Taylor, TX (CoreCivic)
7. South Texas Family Residential Center, Dilley, TX (CoreCivic)
8. South Texas Detention Complex, Pearsall, TX (GEO Group)
9. ICE Processing Center, El Paso, TX
10. Stewart Detention Center, Lumpkin, GA (CoreCivic)
11. Irwin County Detention Center, Ocilla, GA (LaSalle Corrections)
12. Folkston ICE Processing Center, Folkston, GA (GEO Group)

CBP Facilities:

1. Yuma, AZ Border Patrol Station
2. El Centro, CA Border Patrol Station
3. Chula Vista, CA Border Patrol Station
4. Imperial Beach, CA Border Patrol Station
5. Weslaco, TX Border Patrol Station
6. Fort Brown, TX Border Patrol Station
7. Donna, TX Holding Facility
8. Calexico, CA Port of Entry
9. San Ysidro, CA Port of Entry
10. Brownsville, TX Port of Entry